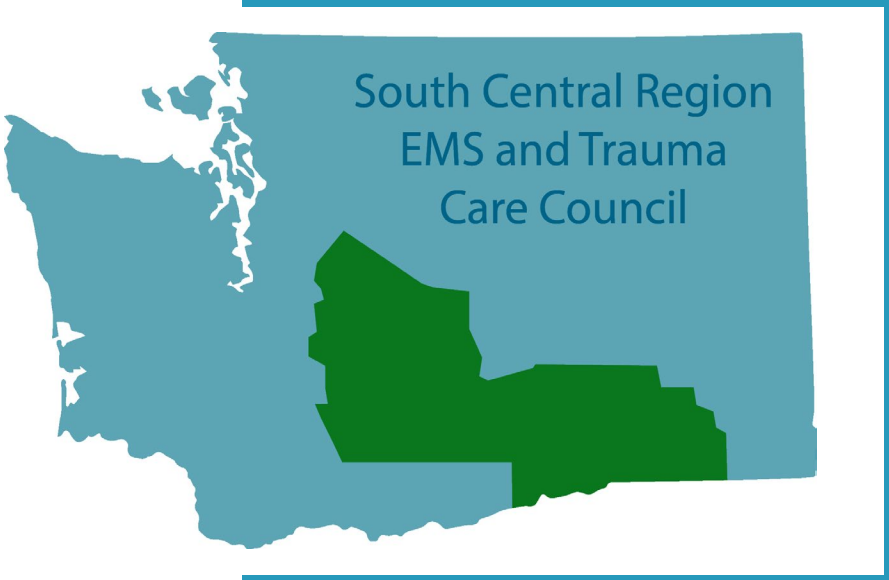
Strategic Plan:

7/2025-6/2027



SOUTH CENTRAL REGION

Emergency Medical Services & Trauma Care Council

TABLE OF CONTENTS

INTRODUCTION

EXECUTIVE SUMMARY

As one of the eight regional EMS trauma care councils mandated in the WAC, the South Central Region EMS and Trauma Care Council (SCREMS&TCC), bases our purpose and work on the following state strategic plan for EMS and Trauma:

"**VISION**: Washington has an emergency care system that reduces death, disability, human suffering, and costs due to injury and medical emergencies.

MISSION: We work to maintain and strengthen an accessible, efficient, high quality, well-coordinated, statewide emergency care system.

CHALLENGES: Rapidly changing healthcare environment, limited and declining resources, increasing demand, workforce shortages, barriers to quality assurance and improvement, unequal access, rapidly changing technology, drivers of public expectations, and sustainability of community collaboration.

PRIORITIES: Quality, cost, access, data driven decision making, education and outreach, improving integration and collaboration, resource and workforce development, regulatory adjustment.

GOALS: The overarching goals of the Washington State Emergency Care System as reflected in the state strategic plan are to:

1. Increase access to quality, affordable, and integrated emergency care for everyone in Washington;
2. Prepare for, respond to, and recover from public health threats;
3. Promote programs and policies to reduce the incidence and impact of injuries, violence and illness;
4. Promote and enhance continuous quality improvement of emergency care systems for Washington;
5. Work toward sustainable emergency care funding, enhance workforce development, and demonstrate impact on patient outcomes."

With this in mind, the biennial regional trauma plan is developed to work collaboratively with local, regional, and state partners to enhance and improve EMS and trauma care throughout the South Central Region of Washington State. The work set forth in this plan is designed, as directed by the RCW and WAC, to provide an objective, system-level analysis, and make recommendations for system quality improvements to support and advance the emergency care system within the region. The Regional EMS and Trauma Care Council will accomplish the work as outlined in the goals, objectives, and strategies section of this plan and each objective in this plan has been crafted to build upon previous work, so time is spent as efficiently as possible. Council work is completed through structured council meetings, ad hoc committees, collaborations with local EMS councils, and administrative support from contracted staff.

REGIONAL SUMMARY

The South Central Region Emergency Medical Services and Trauma Care Council is a 501c3 non-profit which works as a quasi-governmental agency and receives funding through the Washington State Department of Health. The Region Council was established in 1990 as a part of the Washington EMS & Trauma Care system through the Revised Code of Washington (RCW 70.168.100-70.168.130) and Washington Administrative Code (WAC 246.976.960). RCW and WAC task the Region EMS & Trauma Care Council to administer and facilitate EMS & Trauma Care System coordination, evaluation, planning, and develop system recommendations for the WA State EMS and Trauma Steering Committee and the Department of Health (DOH). The Region Council works to improve the emergency medical care system in the region by providing training grants to local EMS and Trauma Care Councils, providing system guidance through the development of Patient Care Procedures, and sharing information with stakeholders.

MISSION AND VISION

SCREMS & TCC Mission: Advance the Emergency Medical Service (EMS) and Trauma Care System.

SCREMS & TCC Vision: A Region EMS and Trauma Care System of coordinated planning to provide the highest quality continuum of care from injury prevention to return to the community.

COMPOSITION AND STRUCTURE OF COUNCIL

The South Central Region EMS and Trauma Care Council is composed of 27 volunteer representatives from a number of EMS and EMS-related services within the region. Each county in the region has a local EMS and Trauma Care Council which sends pre-hospital representatives to sit on the Regional EMS and Trauma Care council. There are also council members that represent each of the hospitals in the region, air medical services, emergency management, emergency communications, Medical Program Directors (MPDs), as well as representatives from law enforcement, local government, local elected officials, and consumer (non-EMS related) representatives. The Region Council is led by a paid Executive Director and a volunteer Executive Board which directs the activities of the Regional EMS Council. There are no standing committees; ad hoc committees are formed as needed. The regional QI committee is headed and coordinated by local hospital representatives. Additionally, the South Central Region EMS and Trauma Care Council entered into a contract several years ago to have the Southwest Region EMS & Trauma Care Council provide administrative services for the Region Council.

The South Central Region EMS and Trauma Care Council meets online via Zoom every other month. Topics at the region council meetings include the business of the council (approving financial documents, election of officers, updates on trauma plan work and updates on grant funding work) as well as discussions about any business pertinent to the council (such as updated rules or documents provided by the DOH, discussing local topics that may impact EMS and trauma care, and other council work as outlined in the goals section below). The council as a whole works on major projects such as providing system guidance through the maintenance and development of Patient Care Procedures (PCPs) and updating the region's biennial trauma plan. Meetings may also include presentations that

are useful for stakeholders which they can then share with their own organizations (injury data presentations and a presentation on how law enforcement and EMS providers can work better together in the field are recent examples) and also include updates on what is happening in member's organizations as well as reports from state DOH representatives.

ROLE OF MPDs

Medical Program Directors (MPDs) provide clinical oversight and medical guidance within the regional EMS and Trauma Care system. Each county has an assigned MPD who is responsible for implementing and maintaining the medical direction framework as required under state regulation.

The responsibilities of MPDs include:

- Developing and maintaining county-specific medical treatment protocols for EMS providers.
- Assisting local EMS and Trauma Care Councils with the creation and review of County Operating Procedures (COPs).
- Collaborating with the regional council on the development and review of Patient Care Procedures (PCPs).
- Supporting the credentialing of EMS providers and the licensing of EMS agencies in accordance with state guidelines.
- Participating in EMS provider education and training activities.
- Contributing to quality improvement initiatives and regional clinical discussions.

MPDs are typically board-certified physicians with emergency medicine experience who serve in both hospital and prehospital advisory roles. Their involvement ensures that patient care protocols are evidence-based, regionally consistent, and aligned with the standards of the Washington State EMS and Trauma Care system.

COLLABORATIVE PARTNERSHIPS

The Region Council collaborates with several organizations throughout the region and the state. The regional QI Committee, which reviews data and cases that show trending EMS and trauma care topics in the region, includes doctors, nurses, public health, MPDs, EMS, private ambulance reps, air medical reps, and other interested parties. Region staff participate in regional healthcare coalition/preparedness activities as available, and also participates in several state TACs and workgroups (Pre-Hospital TAC, RAC TAC, Pediatrics TAC, WEMSIS workgroup, to name a few) which allows collaboration with agencies and representatives from around the state with the goal of improving emergency care services at all levels.

REGIONAL PROFILE

The South Central Region EMS and Trauma Care Council oversees emergency medical care services in Columbia, Mid Columbia (Benton/Franklin), Kittitas, Walla Walla, and Yakima counties. The region is

diverse in its population—there are large cities as well as many rural, remote towns—and diverse in its geography--the region is bordered by the Cascade Mountains on the west, the high desert in the east, and the Columbia River bisects the region and serves as the southern border for part of the region. The region also includes well-funded EMS agencies but there are also many small agencies that rely solely on volunteer EMS providers. Many areas of the region have experienced increases in population, and this part of the state is also a draw for tourists who enjoy year-round outdoor activities in the region which can surge population at various times throughout the year.

COUNTY PROFILES

Columbia County

Columbia County Overview					
Chairperson: Marty Hall			MPD: Dr Lewis Neace		
	2000	**2010**	**2020**	**2023 (est)**	
Population	4,064	4,078	3,952	4,053	
	White	**Native American**	**Asian**	**Hispanic**	**Live Below Poverty Line**
Race Demographics	82.7%	1.8%	1.7%	8.2%	11.8%
Age Demographics	4.4% <5	18% <18	48.5% 19-64	29.1%>65	
Leading causes of injury death	*Numbers were too low for inclusion in fatal data tables				
Description of county	873 sq mi; mostly rural/wilderness				
Major infrastructure	Ranching, tourism, farming, windmills				
Seasonal influences	Bluewood Ski area is a popular winter destination in the county.				
Unserved/underserved areas	Some remote parts of this county may take up to an hour for an EMS response. Most of this county has very small, rural communities.				
Other considerations	Half of the EMS providers live out of county and work seasonally at Bluewood. Air Ambulance provides ALS service most of the time but may not be able to respond due to adverse weather especially in the winter				

Columbia County Resource Statistics					
EMS Providers	20 - BLS	2 - ILS	1 - ALS	48% Volunteer	52% Paid
	Trauma Verified	**EMS Licensed**	**ESSO**	**Air Ambulance**	
EMS Agencies	2	0	1	0	
Hospitals	**Designated Trauma Level**	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Dayton General Hospital	V	0	0	II	III
Training Program	None				**# SEIs in the county: 0**
Training Program					
Training Program					

Testing sites	None	

Kittitas County

Kittitas County Overview					
Chairperson: Lee Hadden			MPD: Dr Jack Horsley		
	2000	**2010**	**2020**	**2023 (est)**	
Population	33,362	40,915	44,337	45,508	
	White	**American Indian**	**Asian**	**Hispanic**	**Live Below Poverty Line**
Race Demographics	81.4%	1.4%	2.1%	10.5%	11%
Age Demographics	4.4% <5	17.4% <18	59.2% 19-64	19% >65	
Leading causes of injury death	Unintentional poisoning/overdose (23%), falls (18%), motor vehicle crash (14%)				
Description of county	2297.27 sq mi; mostly rural/wilderness				
Major infrastructure	Central Washington University, the southeastern corner of the county is part of the U.S. Army's Yakima Training Center.				
Seasonal influences	Tourism (outdoor seasonal recreation and Ellensburg Rodeo), farming				
Unserved/ underserved areas	Kittitas County Fire District #4 dropped BLS verified Aid license; ALS ambulance responds to this area with at least 25-minute response time.				
Other considerations	Snoqualmie Pass winter closures and high volume of transient population on I90, I82, and HWY 97 and seasonal recreation.				

Kittitas County Resource Statistics					
EMS Providers	154 - BLS	0 – ILS (IV Tech)	34 - ALS	46% Volunteer	54% Paid
	Trauma Verified	**EMS Licensed**	**ESSO**	**Air Ambulance**	
EMS Agencies	10	0	2	0	
Hospitals	**Designated Trauma Level**	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Kittitas Valley Healthcare	IV	0	0	II	II
Training Program	CWU EMS Paramedicine Program				**# SEIs in the county: 5**
Training Program	Kittitas County EMS Division				
Training Program					
Testing sites	Central Washington University				

Mid Columbia (Benton/Franklin) County

Benton County Overview

Chairperson: Michael VanBeek			MPD: Dr Kevin Hodges		
	2000	**2010**	**2020**	**2023 (est)**	
Population	142,475	175,177	206,873	215,219	
	White	**Black**	**Asian**	**Hispanic**	**Live Below Poverty Line**
Race Demographics	65%	1.9%	3.5%	25%	10.9%
Age Demographics	6.2% <5	25.9% <18	51.7% 19-64	16.2% <65	
Leading causes of injury death	Unintentional poisoning/overdose (25%), falls (16%), motor vehicle crash (12%), suicide by firearm (12%)				
Description of county	1700.38 sq mi; the Columbia River forms the county's border on three sides, the Yakima River bisects the county from west to east.				
Major infrastructure	Hanford nuclear site; wineries; farming				
Seasonal influences	Farming, tourism (fishing, Ironman, Water Follies)				
Unserved/ underserved areas	Many areas are served by volunteers with 45+ minute response times. Benton County FD 5 is underserved.				
Other considerations	The Benton and Franklin EMS Councils have historically worked together under one EMS Council (Mid Columbia EMS & TCC).				

Benton County Resource Statistics					
EMS Providers	387 - BLS	43 - ILS	131 - ALS	18.3% Volunteer	81.7% Paid
	Trauma Verified	**EMS Licensed**	**ESSO**	**Air Ambulance**	
EMS Agencies	11	2	0	0	
Hospitals	**Designated Trauma Level**	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Kadlec Regional Medical Center	II	0	III P	I	II
Trios Health	III	0	0	I	II
Prosser Memorial Hospital	IV	0	0	II	III
Training Program	Columbia Basin College				**# SEIs in the county: 9**
Training Program	Columbia Safety				
Training Program	Mid Columbia EMS & TCC				
Testing sites	None				

Franklin County Overview					
Chairperson: Michael VanBeek			MPD: Dr Kevin Hodges		
	2000	**2010**	**2020**	**2023 (est)**	
Population	49,347	78,163	96,749	99,034	
	White	**Black**	**Asian**	**Hispanic**	**Live Below**

					Poverty Line
Race Demographics	38%	2.8%	2.6%	55%	10.8%
Age Demographics	7.5% <5	30.5% <18	51.4% 19-64	10.6% >65	
Leading causes of injury death	Unintentional poisoning/overdose (32%), falls motor vehicle crash (18%), falls (10%)				
Description of county	1224.17 sq mi; rural/agricultural area				
Major infrastructure	Columbia Basin College				
Seasonal influences	Farming				
Unserved/ underserved areas	Unincorporated areas of the county				
Other considerations	The Benton and Franklin EMS Councils have historically worked together under one EMS Council (Mid Columbia EMS & TCC).				

Franklin County Resource Statistics					
EMS Providers	107 - BLS	32 - ILS	44 - ALS	34.4% Volunteer	65.6% Paid
	Trauma Verified	**EMS Licensed**	**ESSO**	**Air Ambulance**	
EMS Agencies	4	0	0	0	
Hospitals	**Designated Trauma Level**	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Lourdes Medical Center	IV	II R	0	II	II
Training Program	Columbia Basin College				**# SEIs in the county: 0**
Training Program	Columbia Safety Training Center				
Training Program	Mid Columbia EMS and Trauma Care Council				
Testing sites	Charter College				

Walla Walla County

Walla Walla County Overview					
Chairperson: Todd Reiswig			MPD: Dr Lewis Neace		
	2000	**2010**	**2020**	**2023 (est)**	
Population	55,180	58,781	62,584	61,568	
	White	**Black**	**Asian**	**Hispanic**	**Live Below Poverty Line**
Race Demographics	67%	2.1%	1.9%	24.4%	13.1%
Age Demographics	4.8% <5	20.5% <18	54.1% 19-64	20.6% >65	
Leading causes of injury death	Unintentional poisoning/overdose (25%), falls (23%), suicide by firearm (14%)				
Description of	1270.13 sq mi; Walla Walla County is in the foothills of the Blue Mountains,				

county	with the Columbia River to the west and the Snake River to the north. The county is a popular destination for wine and arts tourism and has three higher education campuses (Whitman College, University of Walla Walla, and Walla Walla Community College).
Major infrastructure	The City of Walla Walla watershed is in the Blue Mountains; the watershed provides 95% of the City of Walla Walla's water supply. The county infrastructure includes highway, rail, and barge traffic.
Seasonal influences	The county is largely agricultural based on crops like wheat, onions, potatoes, and wine grapes. The county population is impacted at certain times of the year by higher education enrollment.
Unserved/ underserved areas	There are no unserved or underserved areas.
Other considerations	The City of Walla Walla is home to the Washington State Penitentiary, as well as the Johnathan M. Wainwright Memorial Healthcare and Veteran's Affair facility (VA).

Walla Walla County Resource Statistics					
EMS Providers	115 - BLS	5 - ILS	45 - ALS	52.7% Volunteer	47.3% Paid
	Trauma Verified	**EMS Licensed**	**ESSO**	**Air Ambulance**	
EMS Agencies	10	0	0	0	
Hospitals	**Designated Trauma Level**	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Providence St Mary Medical Center	III	II R	0	I	II
Training Program	Walla Walla County EMS				**# SEIs in the county: 1**
Training Program					
Training Program					
Testing sites	Walla Walla Community College				

Yakima County

Yakima County Overview					
Chairperson: Ken Frazier			MPD: Dr Kevin Hodges		
	2000	**2010**	**2020**	**2023 (est)**	
Population	222,581	243,231	256,728	256,643	
	White	**American Indian**	**Asian**	**Hispanic**	**Live Below Poverty Line**
Race Demographics	39%	6.9%	1.7%	53%	16.5%
Age Demographics	6.9% <5	28.6% <18	49.8% 19-64	14.7% >65	
Leading causes of injury death	Unintentional poisoning/overdose (30%), motor vehicle crash (20%), assault by firearm (10%)				
Description of county	4295.40 sq mi; Yakima County is the second-largest county in Washington by land				

	area and third largest by total area. Yakima County is reputed to be one of the most difficult places on earth to predict weather because of its surrounding mountains.
Major infrastructure	Yakima Indian Reservation, Yakima Military Training Center, agriculture, wineries
Seasonal influences	White Pass Ski area is a popular winter destination.
Unserved/ underserved areas	Some remote parts of the county take up to an hour for EMS response, with longer response times in the winter.
Other considerations	None.

Yakima County Resource Statistics					
EMS Providers	423 - BLS	13 - ILS	54 - ALS	30.6% Volunteer	69.4% Paid
	Trauma Verified	**EMS Licensed**	**ESSO**	**Air Ambulance**	
EMS Agencies	20	1	2	0	
Hospitals	**Designated Trauma Level**	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
MultiCare Yakima Valley Memorial Hospital	III	0	III P	I	II
Astria Sunnyside Community Hospital	IV	0	0		III
Astria Toppenish Community Hospital	IV	0	0	II	II
Training Program	Yakima County Dept of EMS				**# SEIs in the county: 3**
Training Program					
Training Program					
Testing sites	Pearson Vue Professional Center				

HISTORICAL SNAPSHOT/ACCOMPLISHMENTS

Within the last trauma plan period, the Region has experienced some significant changes and has also had some major accomplishments:

- At the beginning of the last trauma plan period, the region's Executive Director passed away unexpectedly. This had a huge impact on the entire region but between DOH staff, the region's Executive Board, and the region's bookkeeper, the Region was able to remain on track with the contracted work deliverables. This situation pointed out the need for a business continuity plan which was developed over the plan period.
- Some of the local EMS and Trauma Care Councils still had unused training grant funds since the early covid years. All carryover grant funds were spent during FY2024 and the Region is now up-to-date with its grant funds.
- The region's Patient Care Procedures (PCPs) were updated and are pending approval by the DOH.

- Technology has been an important way to increase participation in region meetings; it is much easier for EMS providers, MPDs, and clinical staff to Zoom into a meeting instead of taking time off work and driving a long distance to participate in meetings. The counties have also been able to utilize technology to receive remote/hybrid online classes and improve record retention and record reporting to the DOH WEMSIS program.
- The DOH office has been a very good resource for several issues the Region has faced. Prior to WEMSIS reporting becoming mandatory, WEMSIS office staff attended regional and local council meetings to explain more about the reporting requirements and worked one-on-one with rural agencies to get them set up for reporting. Despite the trauma registry issue, the DOH's Research, Analysis and Date team has given very good injury and hospitalization data presentation to the Regional council.

CHALLENGES AND PRIORITIES

Among the challenges the Region has faced recently:

- Local county agencies have reported problems with recruitment and retention of volunteer EMS providers.
- There have been some issues with accessing updated trauma registry data, however the DOH's Research, Analysis, and Data Team has been good about finding other ways to access and present the data needed for IVP and QI projects.
- Funding continues to be an issue. In FY2004, the DOH provided $210,925 annually to each region but by FY2024, that amount had dropped to $152,880. Currently the region is able to provide local EMS and Trauma Care Councils a total of $76,440 in annual training grant funds through the DOH, however, additional funding/funding sources should be developed.
- The population in the region has increased by nearly 175,000 people since 2000; this impacts the number of EMS calls received as well as the number of providers needed in the region.
- Certain causes of death (overdoses, suicide, falls) have increased over the past decade; this impacts the need for services, the types and costs of services provided, and the need for more effective prevention programs.

Priorities for this trauma plan period include:

- Assisting with the trauma services assessment.
- Continuing to support EMS training programs within the region with particular emphasis on assisting rural agencies.
- Continuing to collaborate with local, regional, and state partners on a variety of projects to improve emergency care services within the region (ie: participate in state-level TACs and workgroups, participate in the soon-to-be established emergency preparedness healthcare coalition, etc).
- Enhancing and improving the regional QI program (encourage participation, provide timely information and useful data, regularly review KPIs, have case reviews that provide useful learning opportunities, etc).

- Continuing to increase regional Council participation by encouraging participation by the local EMS and Trauma Care Council representatives, reviewing the bylaws to ensure the current positions meet council needs, and filling vacant council positions.

GOALS

GOAL 1: MAINTAIN, ASSESS, AND INCREASE EMERGENCY CARE RESOURCES

The Region will review and assess existing EMS and trauma resources within the region. We will gather information to identify system gaps and develop a plan to address our findings.

GOAL 1: Maintain, Assess, and Increase Emergency Care Resources		
Objective 1: Develop and conduct a needs assessment to determine the number of designated and categorized hospitals, and EMS services, needed to support public access to emergency care services. Include the identification of any unserved or underserved areas.	**1**	**Strategy 1:** When requested, Region will work with the DOH and other regions to develop an assessment process to determine the number of designated and categorized hospitals, and EMS services needed to support public access to emergency care services.
	2	**Strategy 2:** When requested, Region will work with local EMS and Trauma Care Councils and other region partners including hospitals to conduct the needs assessment.
	3	**Strategy 3:** When available, the results of the needs assessment will be provided to the local EMS and Trauma Care Councils, other regional partners, and the DOH.
	4	**Strategy 4:** Upon completion, Region will work with the DOH to determine how to move forward with the findings of the needs assessment.
Objective 2: Determine min/max numbers for verified EMS services.	**1**	**Strategy 1:** By September 2025, an updated list of current min/max numbers will be provided to each county EMS council.
	2	**Strategy 2:** Ongoing, the Region will work with any local EMS and Trauma Care council that requests updates or changes to their county min/max numbers in order to complete the process needed for DOH approval.

GOAL 1: Maintain, Assess, and Increase Emergency Care Resources		
Objective 3: Determine min/max numbers for designated trauma and rehabilitation services.	**1**	**Strategy 1:** By January 2026, the Region will collaborate with the Regional QI Committee to review the designated trauma and rehabilitation services min/max numbers and determine if any updates or changes are needed.
	2	**Strategy 2:** Ongoing, the Region and the Regional QI Committee will work with any entity that requests an update or change to the min/max numbers for designated trauma and rehabilitation services in the region.
Objective 4: Make recommendations to improve public access to categorized cardiac and stroke hospitals.	**1**	**Strategy 1:** Ongoing, the Region will work with the DOH and other regions to determine ways to improve public access to categorized cardiac and stroke hospitals.
	2	**Strategy 2:** As available, the Region will participate in any processes recommended by the DOH to improve public access to categorized cardiac and stroke hospitals.
Objective 5: Review and update Patient Care Procedures (PCPs) biannually or as directed by the DOH. Participate in statewide standardization of PCPs.	**1**	**Strategy 1:** By November 2025, the Region will collaborate with the local EMS and Trauma Care Councils and MPDs to review and update the PCPs.
	2	**Strategy 2:** Ongoing, any changes to the region PCPs will be made in accordance with the standardized PCP guidance.
	3	**Strategy 3:** By March 2026, the Region will ask MPDs and local EMS and Trauma Care Councils to review County Operating Procedures (COPs) and update if needed.
	4	**Strategy 4:** By March 2026, the Region will ask MPDs to review county MPD protocols and update if needed.
Objective 6: Identify specific challenges for EMS workforce in the region including recruitment and retention of EMS providers (both paid and volunteer) and provide a report to the DOH of this work.	**1**	**Strategy 1:** By September 2025, the Region will conduct a survey of all EMS agencies in the region to identify challenges to recruitment and retention of paid and volunteer EMS providers.
	2	**Strategy 2:** By November 2026, the Region will summarize the results of the survey, prioritize the challenges, and provide this information to all local EMS and Trauma Care councils and the DOH.

GOAL 1: Maintain, Assess, and Increase Emergency Care Resources		
Objective 7: Identify specific challenges for EMS services (both paid and volunteer) within the region. Truth out and summarize the challenges. Prioritize the challenges and suggest solutions. Provide a report to DOH of this work.	**1**	**Strategy 1:** By September 2026, the Region will conduct a survey of all EMS services in the region to determine specific challenges.
	2	**Strategy 2:** By November 2026, the Region will summarize the results of the survey and provide this information to all local EMS and Trauma Care Councils and the DOH.
Objective 8: Identify specific challenges for EMS training programs and instructors and provide a report to DOH of this work.	**1**	**Strategy 1:** By November 2026, the Region will conduct a survey of all EMS training programs and instructors in the region to determine specific challenges.
	2	**Strategy 2:** By January 2027, the Region will summarize the results of the survey, prioritize challenges, and provide this information to all local EMS and Trauma Care Councils and the DOH.

GOAL 2: SUPPORT EMERGENCY PREPAREDNESS, RESPONSE, AND RESILIENCE ACTIVITIES

The Region will work with emergency preparedness partners to ensure emergency preparedness response and resiliency systems are in place in the event of a medical surge or disaster incident within the region.

GOAL 2: Support Emergency Preparedness, Response, and Resilience Activities		
Objective 1: Work with emergency preparedness partners to identify roles and responsibilities for regional councils and coalitions during a medical surge or disaster event.	**1**	**Strategy 1:** As available, the Region will participate with emergency preparedness partners to determine how local EMS and Trauma Care councils and regional partners can support response during a medical surge/disaster event.
	2	**Strategy 2:** When available, the Region will share identified roles and responsibilities for the local EMS Trauma Care Councils and other regional partners for review and possible inclusion in local MCI disaster plans.
Objective 2: Identify ways to improve regional EMS council participation and coordination with local,	**1**	**Strategy 1:** By January 2026, Region staff will encourage all local EMS and Trauma Care Council MCI plans to include information for working collaboratively during a region-wide medical surge or disaster event.

GOAL 2: Support Emergency Preparedness, Response, and Resilience Activities		
state, regional public health, health care coalitions, and local emergency managers. This includes identifying relevant partners, developing relationships, identifying activities where regional EMS council participation will improve emergency preparedness, response and resiliency of the emergency care system.	**2**	**Strategy 2:** As available, the Region will work to determine what collaborative efforts should be made to support the region in the event of a region-wide medical surge/disaster incident
Objective 3: Identify activities, strategies, and goals to improve emergency care system preparedness, response, and resilience to public health emergencies, all hazards incidents, and planning and exercise activities to the extent possible with existing resources.	**1**	**Strategy 1:** Ongoing, the Region will disseminate preparedness activities, drills, and exercise information to local and regional partners and encourage them to participate.
	2	**Strategy 2:** As available, the Region will participate with emergency preparedness partners in planning activities, drills, exercises, and after actions report/hot wash activities.
	3	**Strategy 3:** As available, the Region will participate in emergency preparedness meetings.
Objective 4: Work with the DOH to develop guidance for patient care procedures for all hazards, disaster triage, special pathogens transport, and other emergency preparedness topics as identified. Develop and revise PCPs in accordance with DOH guidance.	**1**	**Strategy 1:** Biannually, the Region will review the region's PCP document and make any needed revisions to the All Hazards/MCI/HazMat PCPs.
	2	**Strategy 2:** As needed, the Region will incorporate any HazMat/disaster-related procedures/guidances into the Region's Patient Care Procedures (PCPs) as requested by the DOH.
Objective 5: Monitor for disaster, MCI, and special pathogens related drills and exercises, advocate for EMS to be included in exercises and drills and communicate	**1**	**Strategy 1:** Ongoing, the Region will share information on upcoming drills and exercises with local and regional partners.
	2	**Strategy 2:** As available, the Region will participate in drills and exercises with emergency preparedness partners and share these opportunities with stakeholders.

GOAL 2: Support Emergency Preparedness, Response, and Resilience Activities		
opportunities for EMS to participate.		
Objective 6: Work with the DOH and emergency preparedness partners to develop situational awareness reports that can be used to help inform partners of disaster events that could impact EMS.	**1**	**Strategy 1:** Ongoing, Region staff will share situational awareness reports with local and regional partners, including the NWHRN weekly briefing and any reports sent by the DOH.
	2	**Strategy 2:** As opportunities become available, the Region will participate with the DOH and emergency preparedness partners in developing situational awareness reports.

GOAL 3: PLAN, IMPLEMENT, MONITOR AND REPORT OUTCOMES OF PROGRAMS TO REDUCE THE INCIDENCE AND IMPACT OF INJURIES, VIOLENCE AND ILLNESS IN THE REGION

The region will share best practices, disseminate information on IVP-related activities, and provide IVP information and opportunities with region partners. The region will also participate on the state IVP TAC.

GOAL 3: Plan, Implement, Monitor, and Report Outcomes of Programs to Reduce the Incidence and Impact of Injuries, Violence, and Illness in the Region		
Objective 1: Promote and support programs and best practices for regional IVP programming based on regional data-driven priorities.	**1**	**Strategy 1:** Ongoing, the Region will disseminate IVP information, opportunities, and best and promising IVP practices and programs with regional partners.
	2	**Strategy 2:** At region council meetings, local EMS and Trauma Care Council reps will be encouraged to share IVP success stories from within their counties.
	3	**Strategy 3:** Ongoing, the Region will participate in the state IVP TAC.
Objective 2: Maintain prevention partnerships with pre-hospital providers,	**1**	**Strategy 1:** Semi annually, the Region will provide a list of leading causes in fatal and non-fatal injuries to all regional partners.

GOAL 3: Plan, Implement, Monitor, and Report Outcomes of Programs to Reduce the Incidence and Impact of Injuries, Violence, and Illness in the Region		
hospitals, public health and for-profit and non-profit organizations.	**2**	**Strategy 2:** Ongoing, the Region will share IVP opportunities and information with all local EMS and Trauma Care Councils in the region.

GOAL 4: ASSESS WEAKNESSES AND STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS IN THE REGION

The region will create and enhance a regional quality improvement program that will benefit the entire region. We will improve participation in the QI process within the region and encourage regional partners to submit data to, and use, the data sources available from regional and state partners.

GOAL 4: Assess Weakness and Strengths of Quality Improvement Programs in the Region		
Objective 1: Identify and implement strategies to increase EMS service participation in the state EMS data registry and to improve the quality of data.	**1**	**Strategy 1:** By September 2025, Region staff will provide information to all regional partners on the data sources available and how to access these sources to pull reports for informational/program development/grant use.
	2	**Strategy 2:** By December 2025, the Region will encourage regional partners to submit data to state data registries.
Objective 2: Encourage participation in the regional QI program.	**1**	**Strategy 1:** Ongoing, Region staff will participate in Regional QI Committee meetings and will encourage increased participation in the meetings by local and regional partners.
	2	**Strategy 2:** Ongoing, the Region will share any information developed or recommended by the Regional QI Committee with regional council partners to improve outcomes.
	3	**Strategy 3:** Ongoing, the Region council will include a QI Committee report at all Region Council meetings.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY

The Region will monitor and complete the work required by the DOH contract. Region will also manage the business of the Council in an efficient and effective way.

GOAL 5: Promote Regional System Sustainability		
Objective 1: Manage work and deliverables required by the DOH contract.	**1**	**Strategy 1:** Ongoing, Region will hold region council meetings, take accurate meeting minutes, and encourage participation by all region partners.
	2	**Strategy 2:** Annually, Region will review region council documents and update if needed (agency contact lists, bylaws, council policies, ED succession handbook, etc).
	3	**Strategy 3:** Ongoing, Region will maintain financial documents and practices in compliance with state auditor requirements (monthly accounting, annual budget approval, annual SOS/990/auditor filings, participate in biennial SAO audit, sign biennial contract with DOH, submit A19 and Exhibit BCD according to schedule).
	4	**Strategy 4:** Ongoing, Region will participate in meetings pertinent to region work (local EMS council, Steering Committee, RAC TAC, and other TAC/workgroup meetings as available).
	5	**Strategy 5:** Ongoing, Region will do work that relates to council business (update website, regularly back up files off-site, ensure region has an active insurance policy, etc).
	6	**Strategy 6:** Ongoing, Region will share news and information from the DOH and region partners with all stakeholders in the region.
	7	**Strategy 7:** By January 2027, Region will write the biennial Regional Trauma Plan and submit it to the DOH by the required deadline.
	8	**Strategy 8:** As needed, Region will participate in other projects and programs as requested by the DOH.
Objective 2: Support education for EMS providers	**1**	**Strategy 1:** By May annually, the Region Council will allocate funds to the training grant program.

GOAL 5: Promote Regional System Sustainability		
and prioritizing initial education programs particularly in rural communities.	**2**	**Strategy 2:** By May annually, Region will initiate the training grant process by distributing the grant application/agreement and training needs assessment to the local EMS and Trauma Care Councils.
	3	**Strategy 3:** By June, annually, local EMS and Trauma Care Councils will submit a completed training grant application/agreement and training needs assessment to the Region Council office.
	4	**Strategy 4:** By June annually, the Region Council will establish training grant agreements with each local EMS and Trauma Care Council.
	5	**Strategy 5:** Throughout the grant period, Region will disburse training grant funds as RFPs and completed documentation is received at the Region Council office.
	6	**Strategy 6:** By September annually, the Region Council will collect, analyze, and report information to understand the outcomes of the training grants.
	7	**Strategy 7:** Ongoing, Region will regularly share training information and opportunities with all stakeholders in the region.
Objective 3: Share leadership course opportunities, prioritizing rural EMS providers.	**1**	**Strategy 1:** When available, leadership training opportunities will be shared with all stakeholders in the region.
Objective 4: Share wellness course for EMS and other first responders.	**1**	**Strategy 1:** When available, Region will share wellness course opportunities with all stakeholders in the region.
Objective 5: Support EMS instructor development.	**1**	**Strategy 1:** As available, Region will share information on EMS instructor classes, pilot programs, and training opportunities with all SEIs in the region.

GOAL 5: Promote Regional System Sustainability		
Objective 6: Promote opportunities to improve sustainable practices for rural EMS systems. Consider using DOH education materials that have been developed to support rural EMS sustainability.	**1**	**Strategy 1:** As available, Region will share news, training opportunities, and other related information on rural EMS sustainability with all agencies in the region.
Objective 7: Manage regional council membership to ensure all medical, and other partners and stakeholders, are represented.	**1**	**Strategy 1:** Ongoing, Region will keep an active council membership roster and work to fill vacant spots
	2	**Strategy 2:** Ongoing, Region staff will attend local EMS and Trauma Care Council meetings to share information.
	3	**Strategy 3:** As needed, Region will provide information to region council members on conflict of interest, open public meeting training, and provide updated region council membership information developed by the DOH.

APPENDICES

APPENDIX 1:

Adult and Pediatric Trauma Designated Services and Rehab Facilities

WA Department of Health Trauma Designated Services					
REGION	Trauma Designation			Facility	City
	Adult	Pediatric	Rehab		
SOUTH CENTRAL	II	III P		Kadlec Regional Medical Center	Richland
	III		II R	Providence St Mary Medical Center	Walla Walla
	III			Trios Health	Kennewick
	III	III P		MultiCare Yakima Valley Memorial Hospital	Yakima
	IV			Kittitas Valley Healthcare	Ellensburg
	IV			Sunnyside Community Hospital	Sunnyside
	IV			Toppenish Community Hospital	Toppenish
	IV		II R	Lourdes Medical Center	Pasco
	IV			Prosser Memorial Hospital	Prosser
	V			Dayton General Hospital	Dayton

REF: DOH 530-101 /July 2024

https://doh.wa.gov/sites/default/files/2022-02/530101.pdf

APPENDIX 2

Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Services

REGION	Level	State Approved		Current Status (#)
		MIN	MAX	
SOUTH CENTRAL	I	0	0	0
	II	1	2	1
	III	5	6	3
	IV	4	5	5
	V	1	2	1
	* I P	0	0	0
	* II P	0	1	0
	* III P	3	3	2

* Pediatric

REF: DOH 689-163 / August 2023

https://doh.wa.gov/sites/default/files/2022-02/689163.pdf?uid=6431cc49d8cb6

APPENDIX 3

Approved Minimum/Maximum Numbers of Designated Rehabilitation Trauma Care Services

REGION	Level	State Approved		Current Status (#)
		MIN	MAX	
SOUTH CENTRAL	I R	0	0	0
	II R	3	4	2

REF: DOH 689-163 / August 2023

https://doh.wa.gov/sites/default/files/2022-02/689163.pdf?uid=6431cc49d8cb6

APPENDIX 4

Washington State Emergency Cardiac and Stroke (ECS) System Categorized Hospitals

Washington State
Emergency Cardiac and Stroke System
Participating Hospitals by Region

REGION	Categorization Level		Facility	City	County
	Cardiac	Stroke			
SOUTH CENTRAL	II	III	Dayton General Hospital	Dayton	Columbia
	I	II	Kadlec Regional Medical Center	Richland	Benton
	I	II	Trios Healthcare	Kennewick	Benton
	II	II	Kittitas Valley Healthcare	Ellensburg	Kittitas
	II	II	Lourdes Medical Center	Pasco	Franklin
	II	III	Prosser Memorial Hospital	Prosser	Benton
	I	II	Providence St Mary Medical Center	Walla Walla	Walla Walla
	II	III	Sunnyside Community Hospital	Sunnyside	Yakima
	II	II	Toppenish Community Hospital	Toppenish	Yakima
	I	II	MultiCare Yakima Memorial Hospital	Yakima	Yakima

NP = Not Participating
* Meets requirements of a Level I or Level II Stroke Center with all aspects of Emergent Large Vessel Occlusion (ELVO) therapy available on a 24 hour per day, seven day per week (24/7) basis.

REF: DOH 345-299 / March 2025

https://doh.wa.gov/sites/default/files/2022-02/345299.pdf

APPENDIX 5: EMS Resources, Prehospital Verified Services

Appendix 5A: EMS Agency Report/Data

SOUTH CENTRAL REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Benton	AID.ES.60013634	Horn Rapids Motorsports Complex	West Richland	Private for Profit	AID BLS	0	1	0	0	0
Benton	AID.ES.60355652	Mid Columbia Pre Hospital Care Association	Kennewick	Private Volunteer Association	AID BLS	0	1	17	0	0
Benton	AIDV.ES.60583166	West Benton Regional Fire Authority	Prosser	Fire District	AIDV BLS	0	0	10	0	0
Benton	AMBV.ES.00000008	Benton County Fire Protection District #2	Benton City	Fire District	AMBV ILS	4	4	18	10	1
Benton	AMBV.ES.00000011	Benton County Fire District 6	Patterson	Fire District	AMBV ILS	2	0	8	0	1
Benton	AMBV.ES.00000017	Kennewick Fire Department	Kennewick	City Fire Dept	AMBV ALS	6	0	60	1	28
Benton	AMBV.ES.00000018	Richland Fire and Emergency Services	Richland	City Fire Dept	AMBV ALS	7	14	24	18	40
Benton	AMBV.ES.00000026	Prosser Memorial Health - EMS	Prosser	Hospital District	AMBV ALS	4	1	9	3	6
Benton	AMBV.ES.60202198	Benton County Fire Protection District #4	West Richland	Fire District	AMBV BLS	3	4	16	1	15
Benton	AMBV.ES.60661332	Life Flight Network LLC	Aurora	Private Non Profit	AMBV ALS	4	0	4	0	8
Benton	AMBV.ES.60789012	American Medical Response	Richland	Private For Profit	AMBV ALS	5	1	16	0	0
Benton	AMBV.ES.61044713	Fire Dist #1 Benton County	Kennewick	Fire District	AMBV BLS	2	10	36	2	1
Benton	AMBV.ES.61137289	Hanford Fire Department	Richland	Federal Fire Dept	AMBV ALS	6	0	85	5	15
Columbia	AIDV.ES.00000092	Columbia County Fire District #1	Starbuck	Fire District	AIDV BLS	0	1	3	0	0
Columbia	AMBV.ES.00000093	Columbia County Fire District #3	Dayton	Fire District	AMBV BLS	3	1	12	1	0

SOUTH CENTRAL REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Columbia	ESSO.ES.60281391	Ski Bluewood	Dayton		ESSO	0	0	5	1	1
Franklin	AMBV.ES.00000024	American Medical Response	Richland	Private For Profit	AMBV ALS	7	1	15	0	3
Franklin	AMBV.ES.00000132	Pasco Fire Department	Pasco	City Fire Dept	AMBV ALS	7	9	47	13	38
Franklin	AMBV.ES.00000133	Public Hospital Dist #1 Franklin County	Mesa	Municipality City/County	AMBV BLS	6	5	31	15	1
Franklin	AMBV.ES.60334626	Franklin County Fire Protection District #3	Pasco	Fire District	AMBV ILS	2	3	26	4	2
Kittitas	AIDV.ES.00000344	Kittitas County Fire District #1	Thorp	Fire District	AIDV BLS	0	8	5	0	0
Kittitas	AIDV.ES.00000346	Kittitas County Fire District #3	Easton	Fire District	AIDV BLS	0	2	5	0	0
Kittitas	AIDV.ES.00000358	South Cle Elum Volunteer Fire Dept	South Cle Elum	City Fire Department	AIDV BLS	0	2	0	0	0
Kittitas	AIDV.ES.60119626	Kittitas County Fire District #6	Ronald	Fire District	AIDV BLS	0	4	11	0	0
Kittitas	AIDV.ES.61302355	Roslyn Fire Department	Roslyn	City Fire Department	AIDV BLS	0	4	4	0	0
Kittitas	AMBV.ES.00000345	Kittitas Valley Fire and Rescue	Ellensburg	Fire District	AMBV ALS	6	1	47	0	17
Kittitas	AMBV.ES.00000348	Kittitas County Fire District 7	Cle Elum	Fire District	AMBV BLS	2	4	22	0	0
Kittitas	AMBV.ES.00000354	Cle Elum Fire Department	Cle Elum	City Fire Department	AMBV BLS	2	1	7	0	0
Kittitas	AMBV.ES.00000359	Kittitas County Public Hospital District 2-Station 99	Cle Elum	Hospital District	AMBV ALS	4	0	8	0	10
Kittitas	AMBV.ES.60832495	Snoqualmie Pass Fire and Rescue	Snoqualmie Pass	Fire District	AMBV BLS	3	2	0	0	0
Kittitas	ESSO.ES.60285038	Cle Elum Police Department	Cle Elum	Law	ESSO	0	0	1	0	0
Kittitas	ESSO.ES.60432721	Kittitas County Sheriff's Office	Ellensburg	Law/SAR	ESSO	0	0	6	0	0

SOUTH CENTRAL REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Walla Walla	AIDV.ES.00000764	Walla Walla County Fire Protection District #1	Prescott	Fire District	AIDV BLS	0	1	0	0	0
Walla Walla	AIDV.ES.00000766	Walla Walla County Fire Protection District No. 3	Prescott	Fire District	AIDV BLS	0	1	5	0	0
Walla Walla	AIDV.ES.00000769	Walla Walla County Fire Protection District #6	Touchet	Fire District	AIDV BLS	0	4	7	0	0
Walla Walla	AIDV.ES.00000771	Walla Walla County Fire District #8	Dixie	Fire District	AIDV BLS	0	1	2	1	0
Walla Walla	AIDV.ES.60446434	Fire Protection Dist #7 Walla Walla County	Prescott	Fire District	AIDV BLS	0	2	3	0	0
Walla Walla	AIDV.ES.60937827	Columbia - Walla Walla Co. Fire District No. 2	Waitsburg	Fire District	AIDV BLS	0	2	3	0	0
Walla Walla	AMBV.ES.00000767	Walla Walla County Fire District #4	Walla Walla	Fire District	AMBV ALS	2	0	40	2	8
Walla Walla	AMBV.ES.00000777	City of Walla Walla Fire Department	Walla Walla	City Fire Department	AMBV ALS	5	5	19	0	30
Walla Walla	AMBV.ES.60444006	Fire Dist #5 Walla Walla County	Burbank	Fire District	AMBV ALS	2	1	8	1	4
Walla Walla	AMBV.ES.60779352	College Place Fire Department	College Place	City Fire Department	AMBV BLS	3	2	28	1	3
Yakima	AID.ES.60414426	Yakima Training Center FD	Yakima	Federal Fire Department	AID BLS	0	4	17	0	0
Yakima	AIDV.ES.00000855	Highland Fire Department	Cowiche	Fire District	AIDV BLS	0	3	10	0	0
Yakima	AIDV.ES.00000856	Selah Fire Department	Selah	City/Fire District	AIDV BLS	0	7	32	0	0
Yakima	AIDV.ES.00000857	Naches Fire Department	Naches	Fire District	AIDV BLS	0	6	13	0	0
Yakima	AIDV.ES.00000858	Yakima County Fire Dist #4	Yakima	Fire District	AIDV BLS	0	5	22	0	0

SOUTH CENTRAL REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Yakima	AIDV.ES.00000859	Yakima County Fire Dist. 5	Zillah	Fire District	AIDV BLS	0	15	62	0	0
Yakima	AIDV.ES.00000860	Fire Protection Dist #6 Yakima County	Yakima	Fire District	AIDV BLS	0	2	9	0	0
Yakima	AIDV.ES.00000861	Naches Heights Fire Department	Cowiche	Fire District	AIDV BLS	0	4	8	0	0
Yakima	AIDV.ES.00000863	West Valley Fire Department	Yakima	Fire District	AIDV BLS	0	8	37	0	0
Yakima	AIDV.ES.00000864	Nile-Cliffdell Fire Department	Naches	Fire District	AIDV BLS	0	3	5	0	0
Yakima	AIDV.ES.00000873	Grandview Fire Department	Grandview	City Fire Department	AIDV BLS	0	1	15	2	0
Yakima	AIDV.ES.00000874	City of Granger Fire Department	Granger	City Fire Department	AIDV BLS	0	1	1	0	0
Yakima	AIDV.ES.00000879	Toppenish Fire Department	Toppenish	City Fire Department	AIDV BLS	0	1	5	0	0
Yakima	AIDV.ES.00000881	Wapato Fire Department	Wapato	City Fire Department	AIDV BLS	0	1	1	0	0
Yakima	AIDV.ES.00000882	Yakima Fire Department	Yakima	City Fire Department	AIDV BLS	0	16	88	0	0
Yakima	AIDV.ES.00000883	Zillah City Fire	Zillah	City Fire Department	AIDV BLS	0	1	1	0	0
Yakima	AIDV.ES.60440190	Mabton Fire Department	Mabton	City Fire Department	AIDV ALS	0	2	3	0	0
Yakima	AMBV.ES.00000877	City of Sunnyside Fire Department	Sunnyside	City Fire Department	AMBV ALS	5	10	13	7	8
Yakima	AMBV.ES.00000892	White Swan Ambulance	White Swan	Tribal EMS	AMBV ILS	5	0	3	1	0
Yakima	AMBV.ES.00000893	American Medical Response	Yakima	Private for Profit	AMBV ALS	28	2	58	1	28
Yakima	AMBV.ES.00000894	Advanced Life Systems	Yakima	Private for Profit	AMBV ALS	7	1	14	0	17
Yakima	ESSO.ES.60473298	Yakima County Search & Rescue	Yakima		ESSO	0	0	3	0	0
Yakima	ESSO.ES.61308212	Yakima County Dept of EMS	Union Gap		ESSO	0	0	5	2	0

Appendix 5B: Verified Services by County

Total Prehospital Verified Services by County						
COUNTY	AMBV - ALS	AMBV - ILS	AMBV - BLS	AIDV - ALS	AIDV -ILS	AIDV - BLS
Benton	6	2	2	0	0	1
Columbia	0	0	1	0	0	1
Franklin	2	1	1	0	0	0
Kittitas	2	0	3	0	0	5
Walla Walla	3	0	1	0	0	6
Yakima	3	1	0	0	0	16

Appendix 5C: Non-Verified Services by County

Total Prehospital Non-Verified Services by County							
COUNTY	AMB - ALS	AMB - ILS	AMB - BLS	AID - ALS	AID -ILS	AID - BLS	ESSO
Benton	0	0	0	0	0	2	0
Columbia	0	0	0	0	0	0	1
Franklin	0	0	0	0	0	0	0
Kittitas	0	0	0	0	0	0	2
Walla Walla	0	0	0	0	0	0	0
Yakima	0	0	0	0	0	1	2

Appendix 5D: South Central Region Personnel Paid and Volunteer by County

	# of EMR			# of EMT			# of AEMT			# of Paramedic		
COUNTY	**Paid**	**Volunteer**	**None**	**Paid**	**Volunteer**	**None**	**Paid**	**Volunteer**	**None**	**Paid**	**Volunteer**	**None**
Benton	1	2		296	91		36	7		128	3	
Columbia	0	2		11	9		2	0		0	1	
Franklin	1	11		68	39		16	16		43	1	
Kittitas	0	3		56	84		0	11 IV Tech		32	0	
Walla Walla	0	8		34	73		2	3		42	3	
Yakima	2	4		277	146		11	2		54	0	

APPENDIX 6

Approved MIN and MAX Numbers for Trauma Verified EMS Services

Approved Minimum and Maximum of Verified Prehospital Trauma Services by Level and Type by County					
COUNTY	**Verified Service Type**	**Care Level**	**State Approved Minimum #**	**State Approved Maximum #**	**Current Status (total # verified for each service type)**
BENTON	AIDV	BLS	4	4	1
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	0	2	2
		ILS	0	2	2
		ALS	4	6	6
COLUMBIA	AIDV	BLS	2	3	1
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	1	1	1
		ILS	0	0	0
		ALS	0	0	0
FRANKLIN	AIDV	BLS	1	3	0
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	2	2	1
		ILS	0	1	1
		ALS	1	2	2
KITTITAS	AIDV	BLS	5	8	5
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	1	3	3
		ILS	0	0	0
		ALS	2	2	2
WALLA WALLA	AIDV	BLS	8	8	6
		ILS	0	0	0
		ALS	0	0	0

Approved Minimum and Maximum of Verified Prehospital Trauma Services by Level and Type by County					
COUNTY	**Verified Service Type**	**Care Level**	**State Approved Minimum #**	**State Approved Maximum #**	**Current Status (total # verified for each service type)**
	AMBV	BLS	1	3	1
		ILS	0	1	0
		ALS	1	4	3
YAKIMA	AIDV	BLS	1	16	16
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	0	1	0
		ILS	0	1	1
		ALS	1	3	3

Link for approved WA air ambulance Strategic Plan

https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/530129.pdf

APPENDIX 7

Trauma Response Area and EMS Services

COUNTY	TRA #	Name of Verified Service(s) Responding in TRA	Type/Level of Verified Services in TRA
Benton	#1	Kennewick Fire Dept. Benton Fire District #1 Life Flight, AMR	AMBV BLS -1
Benton	#2	Richland Fire Dept. Benton Fire District #4 AMR	AMBV BLS -1 AMBV ALS -2
Benton	#3	Hanford Fire	AMBV ALS -1
Benton	#4	Benton Fire District #2, AMR	AIDV ILS - 1 AMBV ALS - 1
Benton	#5	West Benton Fire Authority, Prosser Memorial Health	AIDV BLS- 1 AMBV ALS - 1
Benton	#6	Benton County FD #6 AMR	AMBV ILS - 1 AMBV ALS -1
Columbia	#1	Columbia FD # 1, Columbia FD # 3	AIDV BLS- 1 AMBV BLS - 1
Franklin	#1	Pasco Fire Department, Franklin County FD #3, AMR	AIDV BLS – 1 AMBV ILS - 1 AMBV ALS - 2
Franklin	#2	Franklin PHD #1	AMBV BLS - 1
Franklin	#3		None
Kittitas	#1	Kittitas County FD#1, Kittitas County FD#7, Kittitas Valley Fire & Rescue, KCHD#2 – Medic One	AIDV BLS – 1 AMBV BLS – 1 ABMBV ALS -2
Kittitas	#2	Roslyn Fire Department, S. Cle Elum Fire Dept., Kittitas County FD #3, Kittitas County FD#6, Cle Elum Fire Depart. Kittitas County FD#7, Snoqualmie Pass FR KCHD#2 – Medic One	AIDV BLS – 4 AMBV BLS – 3 ABMBV ALS -1
Walla Walla	#1	Within the current city limits of Walla Walla and College Place, north and east boundary with trauma service area #2, west to county line, south to county line, except the area covered by service area #3.	AIDV BLS - 6 AMBV BLS - 1 AMBV ALS - 1
Walla Walla	#2	Within the current boundaries of Walla Walla Fire Protection District #5, north and east boundary with trauma service area #1, west boundaries the Snake River, south to the Oregon/Washington border, except the area covered by service area #2.	AIDV BLS – 2 AMBV ALS – 1
Walla Walla	#3	Within the current boundaries of Walla Walla County Fire Protection District #4.	AMBV ALS – 1
Yakima	#1	Highland Fire Dept., Selah Fire Dept. Yakima FD #4. Yakima Fire District #5,	AIDV BLS - 15 AMBV ILS - 1

		Yakima FD #6, Naches Fire Dept. West Valley Fire Dept. Nile-Cliffdell Fire Dept., Grandview Fire, Granger Fire Dept., Toppenish Fire Dept., Wapato Fire Dept., Yakima Fire Dept., Zillah City Fire Mabton Fire Dept., White Swan Ambulance, AMR, Advanced Life Service	AMBV ALS - 2
Yakima	#2	Yakima Fire District #5 Sunnyside Fire	AIDV BLS – 1
Yakima	#3	Grandview Fire, Yakima Fire District #5, City of Grandview, Sunnyside Fire	AIDV BLS - 3 AMBV ALS - 1

APPENDIX 8: Education and Training Programs, Educators, and Testing Sites

Appendix 8A: Approved Training Programs

SC REGION TRAINING PROGRAMS APPROVED BY WASHINGTON STATE DEPARTMENT OF HEALTH					
Credential #	**Status**	**Expiration Date**	**Facility Name**	**Site City**	**Site County**
TRNG.ES.60124026-PRO	Approved	9/30/2027	Columbia Basin College	Richland	Benton
TRNG.ES.60866234-PRO	Approved	9/30/2028	Columbia Safety Training Center	Pasco	Franklin
TRNG.ES.60136659-PRO	Approved	9/30/2027	Mid Columbia EMS & TCC	Kennewick	Benton
TRNG.ES.60124931-PRO	Approved	9/30/2028	CWU EMS Paramedicine Program	Ellensburg	Kittitas
TRNG.ES.60124934-PRO	Approved	9/30/2027	Kittitas County EMS Division	Cle Elum	Kittitas
TRNG.ES.60265035-PRO	Approved	9/30/2027	Walla Walla County EMS	Walla Walla	Walla Walla
TRNG.ES.60136616-PRO	Approved	9/30/2028	Yakima County Dept of EMS	Union Gap	Yakima

Appendix 8B: Approved EMS Educators by County

ESE			
County		2024	
Benton		126	
Columbia		3	
Franklin		33	
Kittitas		20	
Walla Walla		36	
Yakima		86	
TOTALS:		304	

SEIC			
County		2024	
Benton		1	
Columbia		0	
Franklin		0	
Kittitas		2	
Walla Walla		0	
Yakima		1	
TOTALS:		4	

SEI			
County		2024	
Benton		9	
Columbia		0	
Franklin		0	
Kittitas		5	
Walla Walla		1	
Yakima		3	
TOTALS:		18	

Total EMS educators in the South Central Region = 326

Appendix 8C: Approved NREMT Testing Sites

NATIONAL REGISTRY EMERGENCY MEDICAL TECHNICIAN TESTING SITES		
Facility Name	**Site City**	**Site County**
Central Washington University	Ellensburg	Kittitas
Charter College	Pasco	Franklin
Walla Walla Community College	Walla Walla	Walla Walla
Pearson Vue Professional Center	Yakima	Yakima

Appendix 9:

Local Health Jurisdictions

LOCAL HEALTH JURISDICTIONS		
Agency/Organization Name	**City**	**County**
Benton-Franklin Health District	Kennewick	Benton
Columbia County Public Health	Dayton	Columbia
Benton-Franklin Health District	Pasco	Franklin
Kittitas County Public Health	Ellensburg	Kittitas
Walla Walla County Department of Community Health	Walla Walla	Walla Walla
Yakima County Health District	Union Gap	Yakima

Appendix 10:

Local Department of Emergency Management Offices

LOCAL DEPARTMENT OF EMERGENCY MANAGEMENT OFFICES		
Agency/Organization Name	**City**	**County**
Benton County Emergency Management	Richland	Benton
Columbia County Emergency Management	Dayton	Columbia
Franklin County Emergency Management	Pasco	Franklin
Kittitas County (Sheriff's) Emergency Management	Ellensburg	Kittitas
Walla Walla County Emergency Management	Walla Walla	Walla Walla
Yakima County Emergency Management	Union Gap	Yakima

Appendix 11:

Regional Preparedness Coalitions

REGIONAL PREPAREDNESS COALITIONS		
Agency/Organization Name	**City**	**County**
Northwest Healthcare Response Network (this organization is slated to take over preparedness work in the SC Region soon).		

SOUTH CENTRAL REGION: PATIENT CARE PROCEDURES

The South Central Region Patient Care Procedures (PCPs) are included in the Regional Plan per regulations. The following PCPs are approved with the South Central Region 2025-2027 Strategic Plan. Future updates or amendments to these PCPs will be submitted to the department for review; approved PCP updates and/or amendments will require approval of the entire South Central Region 2025-2027 Strategic Plan. The South Central Region will continue to follow the website posting and distribution requirements for the regional plan.

South Central Region Patient Care Procedures (PCPs)

Approved: _____

Table of Contents

A. Contacts

See website (www.screms) for current contacts.

B. Regulations

The following regulations provide guidance on the subject matter contained in this document. Please note that this is not an inclusive list. For more information, please contact a Department of Health Emergency Care System representative.

C. Revised Code of Washington (RCW)
   1. RCW 18.73 – Emergency medical care and transportation services
      a. RCW 18.73.030 - Definitions
   2. RCW 70.168 – Statewide Trauma Care System
      a. RCW 70.168.015 – Definitions
      b. RCW 70.168.100 – Regional Emergency Medical Services and Trauma Care Councils
      c. RCW 70.168.170 – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

D. Washington Administrative Code (WAC)
   1. WAC 246-976 – Emergency Medical Services and Trauma Care
      a. WAC 246-976-920 – Medical Program Director
      b. WAC 246-976-960 – Regional Emergency Medical Services and Trauma Care Councils
      c. WAC 246-976-970 – Local Emergency Medical Services and Trauma Care Councils
      d. WAC 246-976-910 – Regional Quality Assurance and Improvement Program

1. Level of Medical Care Personnel to Be Dispatched to An Emergency Scene

A. PURPOSE:

The appropriate level of emergency, BLS, ILS, ALS personnel, aid or ambulance services will be dispatched to the emergency incident scene to provide timely patient care.

B. SCOPE:

Appropriate licensed and trauma verified aid and ambulance services are dispatched to all emergency medical and trauma incidents within an identified service area.

C. GENERAL PROCEDURES:

1) Dispatch
   a. Local EMS and Trauma Care Councils should identify primary and secondary Public Safety Answering Point (PSAP)/dispatch in each county and provide information to the Region Council of any changes.
   b. Dispatchers should be trained in and use an Emergency Medical Dispatch (EMD) Guidelines Program to include pre-arrival instructions.
   c. The appropriate level of service will be dispatched to the incident.
   d. EMS services are responsible to update PSAP/dispatch, DOH, Local and Region Councils of any response area changes as soon as possible.
   e. In the event a patient approaches a service seeking help or a unit happens upon an incident, PSAP/dispatch must be contacted to activate the EMS system.
2) Response Times

   Response times are measured from the time the call is received by the responding agency until the time the agency arrives on scene.
3) Cancellation of Response Criteria

   For all level EMS Agencies:
   a. The responsible party for patient care decisions is the highest-level EMS provider on scene with the patient.
   b. Communicate with PSAP/dispatch if no patient is found or non-injury or the following conditions are confirmed; (Proceed if requested by law enforcement.)
      i. Decapitation
      ii. Decomposition
      iii. Incineration
      iv. Lividity and Rigor Mortis
4) Slow Down
   a. The first on-scene unit should convey available patient information to responding transport units that may be used to slow response.

5) Diversion to Another Emergency Call

An EMS transport unit may be diverted to another call when:

a. It is obvious the second call is a life-threatening emergency and first-in EMTs and/or paramedics report that the first call can await a second unit.
b. A second ambulance is requested to the first call.
c. The highest-level transport responding unit is closer to the second call and may be vital to the patient's outcome.
d. If Priority Dispatch System used, follow local county operating procedures (COPs) for diversion to another call.

6) Staging/Standby

Dispatch should provide ALL pertinent information to the responding units so they can make a determination as to whether to stage. Units will advise Dispatch of intent to stage and request Law Enforcement response if appropriate.

D. APPENDICES:

None

2. Guidelines for Rendezvous With Agencies That Offer Higher Level Of Care

A. PURPOSE:

To guide EMS providers to initiate rendezvous with a higher level of care while en route to a receiving hospital based on patient needs and resource availability.

B. SCOPE:

BLS or ILS units may rendezvous with a higher level of care. Rendezvous is appropriate when:

1) Patient may benefit from a higher level of care.
2) Resources may be limited or not available.

C. GENERAL PROCEDURES:

1) The BLS/ILS ambulance should request ALS ambulance rendezvous by contacting dispatch.
2) Ground ambulance should rendezvous with a higher level of care based on patient illness or injury.
3) Benefit to patient should outweigh increase to out of hospital time.
4) Based on updated information, requesting units may cancel the rendezvous by contacting dispatch.
5) EMS providers should use effective communication with all incoming and on scene emergency responders, with responder safety and patient care as their highest priority.
6) Communication should include patient report when appropriate.

D. APPENDICES:

None

3. Air Medical Services - Activation and Utilization

A. PURPOSE:

Air Medical Service activation and utilization provides expeditious transport of critically ill or injured patients to the appropriate hospital including designated/categorized receiving facilities.

B. SCOPE:

Licensed and trauma verified aid and/or ambulance services utilize county protocols and county operating procedures (COPs) consistent with current "WA Statewide Recommendations for EMS Use of Air Medical" (within the WA State Air Medical Plan) to identify and direct activation and utilization of air medical services.

C. GENERAL PROCEDURES (Content based on State Air Medical Plan):

1) Air medical response should take significantly less time than it takes to travel by ground to the closest appropriate facility. Consideration should be given to activating the helicopter prior to arrival based on scene location, available system resources, or time savings by rendezvous enroute to a local hospital. This decision should be made as per local COPS in conjunction with local medical control.
2) Responders should involve dispatch to contact and activate air medical response to maintain system safety and integrity. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units.
3) Responding EMS service may activate air medical service prior to arrival on scene based on dispatch information or upon arrival on scene based on initial assessment.
4) Air medical service will provide ETA of available, fully-staffed, closest air ambulance.
5) The final patient transport and destination decisions will be made on the scene by lead ground provider and air medical in conjunction with triage destination procedures.
6) Air medical service will notify PSAP/dispatch when activated by a mechanism outside the emergency dispatch system.
7) Air Medical transport is recommended for the following:
    a. Trauma: Patient condition identified as a major trauma per the Trauma Triage Tool (see link to the WA Trauma Triage Destination Procedure in the appendix).
    b. Non Trauma:
        i. Any patient airway that cannot be maintained.
        ii. Patient with cardiac disease and is experiencing a progressively deteriorating course, is unstable, and/or requires measures not available en route (e.g. ALS level care, cardiac catheterization, thrombolytic therapy).
        iii. Patient is experiencing a severe neurological illness requiring neurosurgical or other intervention that is not available en route. (CVA, uncontrolled seizures, etc.).

8) Exceptions

Some patients that do not meet the above indications for air transport may still be candidates for air transport under the following circumstances:

a. Long distance transport of critical patients (more than 2 hours by ground).
b. Remote locations with isolated injury patients that could create a prolonged painful transport (i.e. logging injury).
c. Situations where a ground CCT unit will not be available for an extended time period.
d. Situations where resources at the sending facility and/or scene are severely limited.
e. Mass casualty situations.
f. Lack of availability of ground transport.
g. Lack of availability of specialty care personnel (with a minimum of one registered nurse) to accompany patient.
h. Road conditions which may extend ground transport times (e.g. icy roads, flooding, remote locations, bridge openings, heavy traffic, etc.).
i. Land transport would deplete the local community of vital EMS services for an extended period of time.
j. EMS regional or state-approved protocol identifies need for on-scene air transport.

9) Exclusions

Patients for whom air medical transport is contraindicated include:

a. Patients who have been pronounced dead (the need for or potential for cardiopulmonary resuscitation is not a contraindication for air transport).
b. Obstetrical patients in advanced active labor and in whom an imminent and /or precipitous delivery can be expected.
c. Patients with actual or potential for violent or self-destructive behavior that cannot be adequately and safely restrained or controlled using chemical or physical restraints.
d. A patient in traumatic full arrest if another critically injured patient requires air transport and is determined to have a greater chance of surviving with rapid transport by air.

D. APPENDICES:

1) Link to DOH website WA State Air Medical Plan
https://www.doh.wa.gov/portals/1/Documents/Pubs/530129.pdf
2) WA Trauma Triage Destination Procedure:
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf

4. On Scene Command

A. PURPOSE:

Provide coordinated and systematic delivery of patient-centric emergency medical care and transport services at all incidents, to include single EMS agency, multi-agency, and multi-jurisdictional responses.

B. SCOPE:

The National Incident Management System (NIMS) Incident Command System (ICS) will be used when establishing on scene command.

C. GENERAL PROCEDURES:

1) Agencies are responsible for ensuring responders are trained in NIMS ICS per FEMA guidelines at the appropriate level.
2) ICS guidelines will be followed when establishing command and assigning other roles based on incident needs.
3) The Medical Group Supervisor should be an individual trained in the ICS, familiar with both the local EMS resources and the county Mass Casualty Incident and Disaster Plan, and capable of coordinating the medical component of a multiple patient incident.
4) Unified Command: An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the Unified Command, often the senior person from agencies and/or disciplines participating in the Unified Command, to establish a common set of objectives and strategies and a single Incident Action Plan.

D. APPENDICES:

None

5. Prehospital Triage and Destination Procedure

A. PURPOSE:

Provide guidance for transport destination decisions for Trauma, Cardiac, Stroke, Mental Health and Chemical Dependence patients from the emergency medical scene to the appropriate receiving facility.

B. SCOPE:

A coordinated system of care which identifies hospital levels of services available for specific categories of patient need. The triage destination procedures inform EMS providers of patient triage criteria algorithms to identify the transport destination to the appropriate designated/categorized hospital receiving facilities.

C. GENERAL PROCEDURES:

Prehospital providers will utilize the most current State of Washington Destination Procedure, local COPs, and Medical Program Director (MPD) protocols to transport critically ill or injured patients to an appropriate receiving facility.

D. APPENDICES:

None

5.1 Trauma Triage and Destination Procedure

A. PURPOSE:
Trauma patients are identified and transported to the most appropriate trauma designated hospital receiving facility to reduce death and disability.

B. SCOPE:
Licensed and trauma verified aid and/or ambulance services utilize the most current State of Washington Prehospital Trauma Triage Destination Procedure to identify and direct transport of patients to the appropriate trauma designated hospital.

C. GENERAL PROCEDURES:
Prehospital providers will utilize the most current State of Washington Prehospital Trauma Triage Destination Procedure, local COPs, and Medical Program Director (MPD) protocols to direct prehospital providers to transport patients to an appropriate Washington State trauma designated hospital receiving facility.

D. APPENDICES:
Link to DOH website: Washington Prehospital Trauma Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf
Link to DOH list of trauma designated hospitals:
https://doh.wa.gov/sites/default/files/2022-02/530101.pdf

5.2 Cardiac Triage and Destination Procedure

A. PURPOSE:

Patients presenting with signs and symptoms of acute cardiac distress are identified and transported to an appropriate categorized Washington State Emergency Cardiac System participating hospital to reduce death and disability.

B. SCOPE:

Licensed and trauma verified aid and/or ambulance services utilize the most current State of Washington Prehospital Cardiac Triage Destination Procedure to identify patients with signs or symptoms of acute cardiac distress and transport to the appropriate categorized cardiac hospital.

C. GENERAL PROCEDURES:

Prehospital providers will utilize the most current State of Washington Prehospital Cardiac Triage Destination Procedure, local COPs, and MPD protocols to direct prehospital providers to transport patients to an appropriate categorized Washington State Emergency Cardiac System participating hospital.

D. APPENDICES:

1) Link to DOH website: Washington Prehospital Cardiac Triage Destination Procedure https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf
2) Link to DOH website: List of WA State Emergency Cardiac and Stroke System Participating Hospitals https://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf

5.3 Stroke Triage and Destination Procedure

A. PURPOSE:

Patients presenting with signs and symptoms of acute stroke are identified and transported to the appropriate categorized Washington State Emergency Stroke System participating hospital to reduce death and disability.

B. SCOPE:

Licensed and trauma verified aid and/or ambulance services utilize the most current State of Washington Prehospital Stroke Triage Destination Procedure to identify patients with signs or symptoms of acute stroke and transport to the appropriate categorized stroke hospital.

C. GENERAL PROCEDURES:

Prehospital providers will utilize the most current State of Washington Prehospital Stroke Triage Destination Procedure, local COPs, and MPD protocols to direct prehospital providers to transport patients to an appropriate categorized Washington State Emergency Stroke System participating hospital.

D. APPENDICES:

1) Link to DOH website: Washington Prehospital Stroke Triage Destination Procedure
https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/530182.pdf
2) Link to DOH website: List of WA State Emergency Cardiac and Stroke System Participating Hospitals
https://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf

5.4 Behavioral Health Destination Procedure

A. PURPOSE:

Operationalize licensed and verified ambulance services to transport patients from the field to alternate facilities for behavioral health services.

B. SCOPE:

Licensed and verified ambulances may transport patients from the field to behavioral health services in accordance with RCW 70.168.170.

C. GENERAL PROCEDURES:

1) Prehospital EMS agencies and receiving behavioral health facility participation is voluntary.
2) Participating agencies and facilities will adhere to the WA State Department of Health Guidelines in accordance with RCW 70.168.170.
3) Facilities that participate will work with the MPD and EMS agencies to establish criteria for accepting patients.
4) MPDs and Local EMS and Trauma Care Councils will develop county operating procedures.
5) Upon implementation and during ongoing operation of transport to alternate receiving facilities the following will be in place with DOH approval:
    a. County Operating Procedure (COPs)
    b. MPD patient care protocols
    c. EMS provider education

D. APPENDICES:

Link to DOH website: EMS Guideline Transport to Behavioral Health Services https://doh.wa.gov/sites/default/files/2024-06/530262-EMSGuidelineTransportToBehavioralHealthFacilities.pdf

6. EMS/Medical Control Communications

A. PURPOSE:
Communications between prehospital personnel, base station hospital (online medical control), and all receiving healthcare facilities are interoperable to meet system needs.

B. SCOPE:
Communication between prehospital personnel, base station hospital (online medical control), and all receiving health care facilities (to include designated trauma services and categorized cardiac and stroke services) utilize effective communication to expedite the exchange of patient care information.

C. GENERAL PROCEDURES:
1) Communication between EMS providers and healthcare facilities may be done directly or indirectly via local PSAP/dispatch.
2) Based on geographic area, communication via radio, cell phone and/or telephone may be used to expedite the exchange of information as needed.
3) EMS agencies and receiving healthcare facilities will maintain communication equipment and training to communicate effectively.

D. APPENDICES:
None

7. Hospital Diversion

A. PURPOSE:

Hospitals have diversion policies to divert trauma, cardiac, or stroke patients to other appropriate facilities based on that facility's inability to provide care and intervention.

B. SCOPE:

All designated trauma services and categorized cardiac and stroke hospitals within the Region have written policies to divert patients to other appropriate designated or categorized facilities.

C. GENERAL PROCEDURES:

1) Hospitals identify communication procedures for redirection/diversion of trauma, cardiac and stroke patients to another facility when resources are unavailable. The hospital must notify the EMS transport agencies and other designated services in their area.
2) Exceptions to redirection/diversion:
    a. Airway compromise
    b. Cardiac arrest
    c. Active seizing
    d. Persistent shock
    e. Uncontrolled hemorrhage
    f. Urgent need for IV access, chest tube, etc.
    g. Disaster declaration
    h. Paramedic discretion

D. APPENDICES:

WATrac Tracking and Alert System link: https://doh.wa.gov/public-health-healthcare-providers/emergency-preparedness/watrac

8. Cross Border Transport

This section is intentionally left blank.

9. Inter-Facility Transport Procedure

A. PURPOSE:

To provide guidance on transferring high-risk trauma and medical patients without adverse impact to clinical outcomes.

B. SCOPE:

All interfacility patient transfers via ground or air shall be provided by appropriate licensed or verified service with appropriate certified personnel and equipment to meet the patient's needs.

C. GENERAL PROCEDURES:

1) Medical responsibility during transport should be arranged at the time of the initial contact between referring and receiving physicians, and transfer orders should be written after consultation between them.
2) Immediately upon determination that a patient’s needs exceed the scope of practice and/or protocols, prehospital personnel shall advise the facility that they do not have the resources to do the transfer.
3) When on line medical control is not available, prehospital protocols shall be followed during an EMS transport in the event that an emergency situation occurs while en route that is not anticipated prior to transport.
4) While en route, the transporting agency should communicate patient status and estimated time of arrival to the receiving health care service per MPD local protocols and COPs.

D. APPENDICES:

None

10. Procedures to Handle Types and Volumes of Patients That Exceed Regional Resources

A. PURPOSE:
To provide for the standardization and integration of Mass Casualty Incident (MCI) Plans between counties throughout the region.

B. SCOPE:
Major incidents/emergencies that create hazardous conditions that threaten public health, that exceed local resources, and may involve multiple counties and states.

C. GENERAL PROCEDURES:
1) All EMS agencies and Incident Commanders working during an MCI event shall operate within the National Incident Management System (NIMS).
2) Based on available local resources, prehospital EMS responders will use appropriate protocols and procedures consistent with the Washington State DOH "Mass Casualty-All Hazard Field Protocols" during an All-Hazards-MCI incident. Prehospital EMS responders will additionally follow any other All-Hazards-MCI protocols/county operating procedures (COPs) set forth by the County MPD and County EMS & Trauma Care Council.
3) The appropriate local Public Health Department will be notified when a public health threat exists. County Local Governing Officials with authority will proclaim a "state of emergency" for incidents/emergencies with health implications that threaten to overwhelm the emergency response resources and healthcare system.

D. APPENDICES:
None

10.1 MCI/ALL HAZARDS

A. PURPOSE:

To provide for the standardization and integration of Mass Casualty Incident (MCI) Plans between stakeholder agencies throughout the region.

B. SCOPE:

The following material represents a broad guideline for the common practice of our EMS providers when dealing with a mass casualty event.

C. GENERAL PROCEDURES:

1) Triage System:
   a. Initial triage should be rapid with an emphasis on identifying severe but survivable injuries.
   b. A single system should be used throughout the EMS system. For example, START and Jump/START are simple and effective tools for initial triage.
   c. A triage tag or identifier should be applied at the time of initial EMS contact.
   d. Secondary triage should be applied at the scene (treatment area) with a focus on identifying patients whose outcome will depend primarily on time critical hospital based interventions (surgery/critical care).
2) Transport:
   a. Critical patients should be the priority for earliest transport to receiving hospitals with an emphasis on those that need immediate surgical interventions.
   b. EMS staffed transport vehicles should be loaded to full capacity and provide ALS level EMS during transport, if possible.
   c. When ambulance capacity is exceeded, alternate transport vehicles (buses, etc.) should be considered to move the less severely injured. EMS personnel should be assigned to the vehicles.

D. APPENDICES:

None