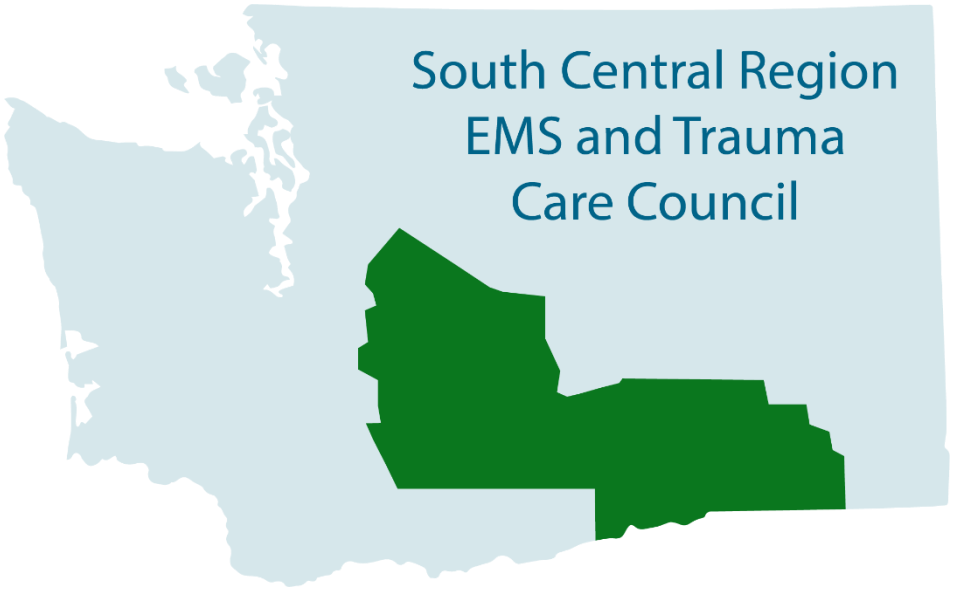
South Central Region
EMS and Trauma Care Council

System Plan

July 1, 2021 – June 30, 2023



Submitted By: South Central Region EMS and Trauma Care Council
Submitted: February 25, 2021
Approved by WA EMS and Trauma Steering Committee on May 19, 2021

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Introduction:

MISSION: Advance the Emergency Medical Service (EMS) and Trauma Care System.

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.

The South Central Region Emergency Medical Services (EMS) and Trauma Care Council (Region Council) sustains and advances the WA EMS & Trauma Care System within Columbia, Benton, Franklin, Kittitas, Walla Walla, and Yakima Counties. The Region Council was established in 1990 as a component of the WA 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). The RCW and WAC task the Region Council and County Councils 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 informs ongoing EMS & Trauma Care System development through the exchange of information. The Region Council provides a forum for EMS system stakeholders to meet on a regular basis to facilitate collaboration to accomplish the Council's work. The Region Council is comprised of twenty-five (25) volunteer stakeholder representative positions. Stakeholders represent; EMS agencies, fire districts, hospitals, Medical Program Directors (MPD), 911 dispatch centers, law enforcement, elected officials, injury prevention, air medical, preparedness, and community members. DOH appoints the Council Members with County Council recommendation. Region Council Members participate on their local County Councils, Quality Improvement Committees, EMS Steering Committee Technical Advisory Committees (TAC) and other interdisciplinary committees. This broad representation cultivates the development of a practical, system wide approach to the coordination and planning of the EMS system.

The Region Council is a private $501_{(c)}3$ nonprofit organization. The Region Council is primarily funded by contract with the DOH to complete the work in this plan. The Chair, Vice Chair, Treasurer, and Secretary make up the Executive Committee that oversees the routine business of the Council between Council meetings. Overall oversight remains the responsibility of the entire Council. All financial transactions are approved at meetings, and substantive business decisions are done by a vote of the Council. The South Central Region Council and Southwest Region Council have successfully consolidated administrative work via contract since July 2012. This consolidation has reduced the duplication of administrative tasks and expenses, which allows both regions to accomplish the work of the DOH contract independently while maximizing system program support funding.

The Region Council collaborates with County Councils to support and advance the local EMS. During the conduct of the County Council business system information is

exchanged amongst the County Councils, local EMS Agencies and county EMS Providers, Region Council and DOH. Region Council staff participate at County Council meetings whenever practical. The Region Council and County Councils work collaboratively. The following is a brief description of each county profile:

- **Benton County** has a land area of 1,700.38 square miles and a population of 204,390. The Hanford Nuclear site as well as many wineries and agricultural areas are located in Benton County. The Columbia River bisects Benton & Franklin Counties. Benton and Franklin Counties have joined together to form a joint local Council known as the Mid-Columbia EMS & Trauma Care Council. The Mid-Columbia Council usually meets the first Thursday of even months.

Benton County Resource Statistics					
EMS Providers	284 - BLS	28 - ILS	119 - ALS		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	11	2	0		
	Designated Trauma Level	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Kadlec Regional Medical Center, Richland WA	III	II	N/A	I	II
Trios Hospital, Kennewick	III	N/A	IIIP	I	II
Prosser Memorial Hospital, Prosser WA	IV	N/A	N/A	II	III
Training Program	Columbia Safety, Kennewick WA				
Training Program	Columbia Basin College Richland Health Science Center, Richland				

- **Columbia County** has a land area of 868.63 square miles and a population of 3,985. Making it the third least populous county in Washington. It is located in the southeast corner of Washington State It is a rural agricultural county.

Columbia County Resource Statistics					
EMS Providers	24 - BLS	0 - ILS	2 - ALS		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	2	1	0		
	Designated Trauma Level	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Dayton General Hospital, Dayton WA	V	N/A	N/A	II	III

Training Program	None

- Franklin County has a land area of 1,242.17 square miles and a population of 95,222. It is a mostly rural agricultural area. The Columbia River bisects both Benton & Franklin Counties. Benton and Franklin Counties have joined together to form a joint local Council known as the Mid -Columbia EMS & Trauma Care Council. The northern part of Franklin County surrounding Kahlotus WA and the state highway is unserved with no EMS service due to a lack of resources. Air medical services assist greatly reduces incident response and transport times. The Mid-Columbia Council usually meets the first Thursday of even months.

Franklin County Resource Statistics					
EMS Providers	110 - BLS	25 - ILS	34 - ALS		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	4	0	0		
	Designated Trauma Level	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Lourdes Medical Center, Pasco WA	IV	IIR	N/A	II	II
Training Program	None				

- Kittitas County has a land area of 2,297.27 square miles and a population of 47,935. The county is mostly rural/wilderness. Located in the Cascade Mountains, from the upper Yakima River Valley to the Columbia River. It is home to Central Washington University. Interstate 90 connects western and eastern WA over "the pass". At times I90 is closed for extended periods due to severe accidents and/or weather-related poor road conditions. The closures impede ground transport access from the whole of eastern WA to the only Level I Trauma Center Harborview.

Kittitas County Resource Statistics					
EMS Providers	113 - BLS	0 - ILS	24 - ALS		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	11	4	0		
	Designated Trauma Level	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Kittitas Valley Healthcare, Ellensburg WA	IV	N/A	N/A	II	II

Training Program	CWU EMS PM Program, Ellensburg WA
Training Program	Kittitas County EMS Division, Cle Elum WA

- Walla Walla County has a land area of 1,270.13 square miles and a population of 60,760. This rural agricultural County is situated along the Columbia River in southeastern WA.

Walla Walla County Resource Statistics					
EMS Providers	117 - BLS	2 - ILS	39 - ALS		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	4	2	0		
	Designated Trauma Level	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Providence St Mary Medical Center, Walla Walla	III	II R	III P	I	II
Training Program	Walla Walla County EMS, Walla Walla WA				
Training Program	Walla Walla Community College, Walla Walla WA				

- Yakima County has a land area of 4,295.40 square miles and a population of 250,873. Within the County is the Yakima Indian Reservation, which is the 15th largest reservation in America, Mount Adams a popular recreational destination as well as agriculture.

Yakima County Resource Statistics					
EMS Providers	429 - BLS	9 - ILS	48 - ALS		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	20	1	2		
	Designated Trauma Level	**Designated Rehabilitation Level**	**Designated Pediatric Level**	**Categorized Cardiac Level**	**Categorized Stroke Level**
Sunnyside Community Hospital	IV	N/A	N/A	I	III
Astria Toppenish Community Hospital	IV	N/A	N/A	II	II
Yakima Valley Memorial	III	N/A	IIIP	I	II

Training Program	Yakima County Dept. of EMS, Yakima WA

Region EMS and Trauma Response Area Maps were developed as a tool for use in system planning. The maps describe geographic areas and the location of EMS and hospital resources providing services within each area. The area boundaries do not reflect any individual EMS agency jurisdiction, although some areas may appear to coincide with jurisdictions. DOH maintains an interactive Region EMS and Trauma Response Area Map within the EMS and Trauma Region and County Maps at: https://fortress.wa.gov/doh/ems/index.html

On an ongoing basis the Region Council and County Councils maintain and bolster system sustainability through routine Council work, such as min/max numbers, PCPs, reviewing applications for new EMS agencies, etc. The Council Members receive "just in time training" which serves to address the task at hand and allow all Members to better understand the components of the EMS and Trauma System.

The Region Council accomplished much during the 2019-2021 plan period. A few of the noteworthy successes are:

- In response to the Covid-19 pandemic the Region and County EMS Councils, EMS agencies, and MPDs have worked with local public health care coalitions, emergency management (DEM) and all hazards preparedness partners to coordinate plan and support the Covid-19 response. The entire EMS system is dedicated to continuing to aid in the Covid-19 response for the foreseeable future.

- The Region Council provides training grants to all County Councils. The training grants benefit 63 EMS agencies and the Region's approximately 1,300 EMS providers annually. The grants to County Councils reimburse direct EMS course expenses, OTEP, and training equipment. The grants also fund individual scholarships for initial EMS certification training. This has proved to be especially beneficial in rural counties which do not always have enough students or a local Training Program to host a full class. The Region Council scholarships allow students to attend EMS classes in neighboring counties allowing more opportunity to obtain EMS training where available.

- EMS Training Programs administer DOH approved EMS certification courses in the Region. The training programs coordinate and provide approved WA State EMS initial certification training for Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic (PM). Also provided are DOH approved EMS certification endorsement courses for supraglottic airway, adult and pediatric patient peripheral intravenous and intraosseous insertion and infusion, and venous blood sample. Senior EMS Instructors (SEIs) are affiliated with Training Programs. A list of current Training Programs can be found in appendix

#7. The Training Programs deliver high quality training. The result across the region is new well trained EMS providers eligible to test and apply for WA EMS certification.

- After King County EMS Online discontinued OTEP subscription service EMS providers, EMS Agencies, SEIs, and ESEs transitioned and adapted to new online OTEP platforms. Finding, comparing, then transitioning to a new online OTEP vendors was a time consuming and challenging process.

- The Region Council collaborated with the RAC TAC in the development of a statewide PCP template. It is better organized and prioritizes what belongs in the PCPs per statute and rule. The Region Council updated and reformatted the Region PCPs using the new template. The next step is collaboration of the Region Council, County Councils, and MPDs to develop a standardized template and revise the county operating procedures (COPs).

- The E, NE, SW, and SC Region Councils collaboratively developed data driven process to standardize and educate how County Councils conduct prehospital EMS min/max needs assessments. It identifies process steps, areas of inquiry, locally obtainable prehospital response data sources and how to use the data to come to an informed recommendation on min/max numbers. The Region Council formally adopted the standard process for all County Councils within the Region. The new process was successfully used in Benton County and Franklin County prehospital EMS min/max needs assessments. This process settled long standing questions about resource availability, the frequency of mutual aid responses out of primary response areas and actual response patterns. Everyone had the opportunity to provide impressions, historical anecdotes, and evidence-based input. Participants came away better educated on the overarching EMS System and the resources within their County.

- The Region Council and Region QI Committees meet on the same day. This coordination has increased attendance in-person and remotely, as a number of the members participate in both meetings. The Region Council continues to serve as the fiscal agent for the Region CQI Committee.

- The Region Council administered two Coverdell Cardiac and Stroke Grants to increase EMS transport to Categorized Cardiac and Stroke facilities and increase data submission of stroke key performance indicators to WEMSIS.

- The Region Council has promoted registration and obtained grant funds to provide rural agencies introduction to WEMSIS training to increase WEMSIS data submission. These efforts have increased agency registration, participation and data submission.

The Region Council and County Councils identified a number of challenges:

- The Covid-19 pandemic social distancing restrictions disrupted initial and ongoing EMS training. To ensure County Councils did not lose grant award funds for activities that were not able to be completed during 2020, the Region Council carried forward the unused program grants funding from FY19-20 into the FY20-21 grant period. In order to safely resume EMS training and protect instructors and providers training methods were modified to a hybrid combination of remote and in person sessions. There are concerns about learning in the environment of social distancing, as there has been a loss of individual and group interactive skills maintenance practice, patient contact in clinical rotation, as well as the collegial crew development that is gained during in person training. Compensating for the impact on providers, especially new providers, will need to be addressed to maintain an adequately trained workforce.

- The Region Council has not had a means to adequately assess the need and distribution of designated trauma and rehabilitation facilities to develop hospital min/max number recommendations. In the past, the Region Councils turned to enlisting help form the Region Quality Improvement Committees as subject matter experts to review and make recommendations on Trauma Designation min/max. In short, hospital min/max recommendations have been roughly based on what level of trauma service the designated facilities indicated they were capable of maintaining and seeking designation for rather than what the community need is. The Region Council and Region Quality Improvement Committees await guidance from the newly formed DOH led workgroup developing an effective method to conduct an assessment and develop recommendations on the distribution of lower levels of designated trauma facilities that can be adapted to use locally.

- The Region Council completed the revision and reformatting of the Region Patient Care Procedures (PCPs) to a standardized template. There is a need for local County Operating Procedures (COPs) to be reformatted in a similar standardized template for consistency with the Region PCPs. This is an opportunity to identify what should be a COP versus a protocol and educate County Councils and MPDs. Like the new statewide PCP format, the development of a master standardized COPs template and clear definition of the scope of the COPs will eliminate inconsistencies among the County EMS field operations and improve operational cohesion between counties. Furthermore, there is not a mechanism in place to notify Region Councils when changes to COPs are submitted and approved by DOH when embedded within the MPD Protocols. Adding a formalized step in the DOH protocol approval process for the Region Council to review and confirmation (similar to the Region Council review

and comment page of agency license/verification application) as revised COPs are consistent with Region PCPs would resolve the current gap.

- Local rural and suburban volunteer EMS agencies continually to struggle with finding enough volunteer EMS providers. This continues to be a critical need for all counties because volunteers staff the majority of the EMS agencies in the region. The Region Council training grants have assisted with new and ongoing OTEP volunteer education. No SC agencies are included in the DOH Rural EMS Assessment Project. Recruitment and retention are further challenged during the pandemic. The current Region Council focus is on how we can support the County Councils and agencies without adding to their workload.

- There are areas within the region without local EMS agency transport capability. The burden of response often falls on neighboring agencies on a "mutual" aid basis which can deplete the responding agency's resources and impair their ability to respond to their primary area.

- Despite efforts, representative position vacancies continue on the Region Council and County Council. Inconsistent participation of hospitals, EMS leaders, injury prevention, public health and other system partners at the Region Council and County Councils meetings create gaps in information sharing and system building. The MPDs do not attend or participate the Region Council and Region QI Committee meetings. The MPDs have the ability to bring valuable insight to the Region meetings and communicate information directly back to EMS agencies and all EMS providers to improve the system is. There is work planned to increase membership and attendance.

- The Regional Quality Improvement Committee is a separate committee from the Region Council. The Region QI Committee is coordinated and led by designated hospitals per their designation requirements and WAC 246-976-910. Because the Region QI Committee is a function of designation regulations the QI Committee meetings are attended by mostly hospital representatives, some prehospital EMS representatives attend while none of the Region's MPDs do. As such the Region QI Committee work is generally hospital centric. Therefore, the state EMS data reviews, QI information, and resolutions identified in QI meetings may not getting disseminated to all MPDs and prehospital EMS agencies/providers.

- WEMSIS data continues to be unavailable for system assessment and planning to the Region Council and County Councils, MPDs, prehospital EMS agencies, and hospitals. Legislation was enacted that now require agency data submission to WEMSIS. This legislation is a tremendous burden on non-electronic reporting agencies especially rural volunteer agencies both financially and additional workload. In many areas there is no internet access available to purchase. Other rural agencies will strain to afford to continue to provide EMS service with the

high cost of satellite or other rural internet carriers. There is concern the additional workload may accelerate the loss of volunteer workforce. While usable WEMSIS data remains unavailable for prehospital EMS sustainability planning.

- Adequate sustainable funding remains a challenge for the region. The Region Council seeks grants in order to support the EMS providers and system improvements beyond the state contract.

The work set forth in this plan is designed to enhance the South Central Region EMS and Trauma Care System. As directed by the RCW and WAC, are tasked to provide an objective system-level analysis and make recommendations for system quality improvements to support and advance the system, the Region Council and County Councils will accomplish the work as outlined. The goals, objectives, and strategies section of this plan provide detail on how work will be completed. Each objective in this plan is crafted to build upon previous work so time is spent as efficiently as possible. The plan objectives and strategies are accomplished either by the Council Members during council meetings, in conjunction with County Councils, ad hoc committees or with a mix of approaches. In the past, the Region Council maintained a number of standing sub-committees. However, this created an environment where the same small number of people shouldered the majority of the work. Now ad-hoc work groups are appointed as needed and have replaced standing subcommittees. This change has fostered a more inclusive “all hands” participation approach.

This work is made possible by the DOH contract to maintain a forum, at Region Council and County Council meetings for County Council Members, MPDs, local EMS agencies, MPDs, hospitals, dispatch centers and other stakeholders to report what is working, what is not, and to collaborate on practical solutions. The information drawn will create a better understanding of standing practices and the ability to implement practical solutions to fine-tune the system. Region Council and County Councils will continue to engage partners to collaborate on solutions to system challenges, and most importantly give them a voice in the future direction of the WA EMS and Trauma System.

GOAL 1 **Maintain, assess and increase emergency care resources.**
Prehospital trauma verified services minimum/maximum (min/max) numbers are in place to reduce inefficient duplication of resources and provide service to underserved and unserved areas. Hospital min/max numbers outline the levels of designated trauma, pediatric, rehabilitation services, and prehospital trauma verified services within the region. The WA Emergency Cardiac and Stroke System is a voluntary self-categorizing system of participating hospital that meet the care requirements of levels of service. There is not an established systemic method to notify prehospital agencies, County MPDs, and County/Region Councils when changes in the categorized Cardiac and Stroke facility level of services occur. Therefore, the prehospital agencies, County MPDs, County Councils, and Region Council will request the categorized Cardiac and Stroke facilities notify them of any changes of level of services in a timely manner. An in-depth analysis of the distribution of services, coordinated by the Region Council and the County Councils, will identify unserved and underserved areas and specific unmet system needs related to hospital designation and prehospital verification. The Region Council and the County Councils will use the information gained for future system planning. The Region Council reviews and updates as needed the Patient Care Procedures (PCPs) every two years and revises as needed. The Region PCPs are system operational procedures, developed by the Region Council with County Council and MPD input, based on the guidance and approval from the state DOH. A thorough review and update of each County COPs is needed to ensure consistency with the Region PCPs. Reformatting the COPs to a standardized template consistent with the new PCP format is needed.

Objective 1 By June 2023, the Region Council will review prehospital trauma verified min/max numbers.	Strategy 1 By July 2022, the Region Council will request each County Council review the prehospital verified min/max numbers.
	Strategy 2 By January 2023, the County Councils will coordinate with the County Councils to review the prehospital verified min/max and the Regional Trauma Response Area Maps then update as needed.

	Strategy 3 By June 2023, the Region Council will consider any recommended changes from County Councils.
Objective 2 By June 2023, the Region Council will review the Designated Trauma and Rehabilitation Services min/max numbers.	Strategy 1 By November 2022, the Region Council will request the Region QI committee (as subject matter experts) review Designated Trauma and Rehabilitation services min/max numbers.
	Strategy 2 By January 2023, the Region Council will collaborate with the QI committee through the process of evaluating and/or recommending changes by providing information, and training as needed.
	Strategy 3 By June 2023, the Region Council will consider any recommendation to change to the min/max numbers at a Region Council meeting.
Objective 3 By December 2021, the Region Council will review, and document categorized Cardiac and Stroke facilities.	Strategy 1 By December 2021, the participating cardiac and stroke categorized facilities will be asked to inform the County Councils, Region Council, MPD, prehospital transport agencies, and the Region QI Committee, when there is a change in level of service facility (closure, addition, change of level of service) as soon as possible.
	Strategy 2 By December 2021, the Region Council will review the current system plan list of categorized cardiac and stroke facilities in the region plan for accuracy.
Objective 4 By April 2023, the Region Council will collaborate with DOH to support system sustainability.	Strategy 1 By January 2023, as directed by DOH, the Region Council will collaborate with DOH and the RAC TAC in developing an effective method to support and advance the EMS system.
Objective 5 By June 2023, the Region Council and County Councils will collaboratively review the County	Strategy 1 By September 2021, the Region Council will request the County Council review the COPs.

Operating Procedures (COPs) and the Region Patient Care Procedures (PCPs).	Strategy 2 By June 2022, the Region Council will coordinate with the County Councils to review, update and reformat the COPs to a standardized template.
	Strategy 3 By September 2022, the Region Council will collaborate with County Councils and MPDs to create a method of sending notices and following up on future changes to COPs.
	Strategy 4 By September 2022, the Region Council will collaborate with County Councils and MPDs to review the PCPs and update as needed.
	Strategy 5 By June 2023, the Region Council will maintain the Regional PCPs on the region's website.

<table>
<tr><td colspan="2">GOAL 2

Support emergency preparedness activities.</td></tr>
<tr><td colspan="2">The Region Council serves as a forum for collaboration with the system partners to enhance EMS system readiness. Emergency Preparedness/Public Health participates on Region Council to engage the multidisciplinary system partners. Emergency preparedness planning led by local health jurisdictions, regional coalitions, and federal preparedness organizations overlap the daily preparedness and response of the EMS and traumas system. Over recent years, the structure and roles of the various preparedness organizations have changed. It is necessary to identify the current organizations and roles to determine how the Region Council can effectively integrate the preparedness planning, exercise/drills and quality improvement.

Throughout the declared emergency the Region Council will collaborate to support REDi HCC and public health emergency preparedness partners response efforts to the Covid-19 pandemic.</td></tr>
<tr><td rowspan="2">Objective 1 By January 2023, the Region Council will collaborate with Emergency preparedness and EMS to support emergency preparedness partners to support response to incidents and planning.</td><td>Strategy 1 By September 2022 the Region Council will evaluate the structure and roles of the Regional Emergency and Disaster Health Care Coalition (REDi HCC), Homeland Security Region 8 Emergency Management, Public Health Emergency Preparedness Region 8.</td></tr>
<tr><td>Strategy 2 On an ongoing basis, the Region Council will collaborate with Emergency preparedness and EMS to support and participate in public health emergency response preparedness planning.

(DOH, Public Health Emergency Preparedness Region 8, WA REDi HCC, Homeland Security Region 8 Emergency Management)</td></tr>
<tr><td></td><td>Strategy 3 Throughout the declared emergency the Region Council will collaborate to support REDi HCC and public health emergency preparedness partners response efforts to the Covid-19 pandemic.</td></tr>
</table>

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 importance of injury, illness, and violence prevention cannot be overstated. The Region Council has historically supported local prevention initiatives, and continues to do so to the extent possible, amid diminishing resources. Area hospitals and EMS agencies host a multitude of prevention activities that specifically address local issues as well as initiatives to reduce the leading causes of injuries. Gathering and compiling lists of injury prevention activities being done by IVP partners has not resulted in usable information. Falls is the leading cause of preventable morbidity and mortality. There is no statewide falls prevention initiative while locally driven projects have limited capabilities. The Region Council participates on the IVP TAC to develop a statewide evidenced-based injury prevention initiative. The Region supports the reduction of injury and violence morbidity and mortality by continuing to maintain prevention resource links on the regional website.	
Objective 1 By July 20212023, the Region Council will promote best available or promising practices and programs.	Strategy 1 By July 2021, the Region Council will disseminate and maintain IVP best practices information/links on the region website.
	Strategy 2 By July 2023 the Region Council will assist in promoting and implementing a statewide falls initiative.
Objective 2 By June 2023, the Region Council will build sustainable prevention partnerships.	Strategy 1 By January 2022, the Region Council will invite hospital and EMS agency IVP personnel to increase attendance and participation in County and Region Council meetings.
	Strategy 2 By March 2022, the Region Council will participate in IVP TAC meetings and webinars as available to build sustainable prevention partnerships.
	Strategy 3 By June 2023, the Region Council will support and participate in state IVP initiatives as resources permit.

GOAL 4 **Assess weaknesses and strengths of quality improvement programs in the region.**	
The Region Council is continuously striving for systemic quality improvement. The quality improvement (QI) committee reviews the EMS and trauma system to ensure the EMS system continues to evolve to meet the needs of the residents and visitors in our region. The quality improvement focus is the best care for the patient. EMS system components must be in place and operational to get the right patient, to the right care destination, in the right amount of time, thus improving the patient outcome by reducing morbidity and mortality.	
Objective 1 By September 2023, the Region Council will collaborate and support the Regional Quality Improvement Committee.	Strategy 1 February 2022, the Region and County Councils will participate on the Regional Quality Improvement Committee.
	Strategy 2 By June 2023, the Region Council will serve as the fiscal agent for the Regional Quality Improvement Committee and provide other assistance as requested.
Objective 2 By May 2022, the Region Council will support EMS agency participation in WEMSIS.	Strategy 1 Throughout the plan period, the Region will participate on the DOH WEMSIS Workgroup.
	Strategy 2 By May 2022, the Region Council will request and host WEMSIS Data Training, to assist the prehospital EMS agencies. .

GOAL 5 **Promote regional system sustainability.**	
The sustainability of the Region Council includes the overarching Region Council operations and ongoing system support to sustain and enhance the EMS and trauma system. Local and regional input that enhances the planning and operations of this system. The Region Council is composed of volunteer multidisciplinary system partner representatives from throughout the region. These dedicated professionals are subject matter experts within the EMS system who devote their time and effort to ensure the mission of the council is completed. Combined, the Council Members contribute hundreds of hours of time and effort each year. In an effort to improve long-term Region Council sustainability and maximize funds, the Southwest and South Central Regions contracted with each other to consolidate business administration in 2012. By contract, the Southwest Region Council provides administrative services for the South Central Region Council. Each Region remains legally independent organizations therefore operate and contract with DOH separately. EMS agencies continually strive to meet increasing operational requirements. Providing EMS services comes at the cost of time, effort, and money for essential EMS Provider Training. To bridge the gap of resources, the Region Council provides training grant funding to each County Council to supplement the unique needs of each county. Volunteers remain the backbone of the rural EMS and Trauma System, therefore the region emphasizes support to encourage volunteers directly by offsetting training costs. Overall, the Region Council works toward a long-term sustainable future for all EMS system components in the region.	
Objective 1 Throughout the plan period, the Region Council will manage the business of the Council in a manner consistent with our WA nonprofit & 501(c)3 status and DOH contract.	Strategy 1 By July annually, the Region Council will develop a fiscal year annual budget for administration and programs as outlined in the DOH contract and submit a copy to DOH.
	Strategy 2 Throughout the plan period, the Region Council will review and approve contracts, deliverables, and financial reports in accordance with the council fiscal control policies.
	Strategy 3 By November annually, the Region Council will submit the BARS report to the State Auditor's Office (SAO) as required in accordance with the council fiscal control policies.

Objective 2 By July biennially, the Region Council will maintain business contracts.	Strategy 1 Biennially per the DOH timeline, the Region Council will renew the contract with DOH for implementation of the Region System Plan and maintain ongoing contractual compliance oversight.
	Strategy 2 By July biennially, the Southwest and South Central Region Councils will renew the contract for administrative services and maintain ongoing contractual compliance oversight.
Objective 3 Throughout the plan period, the Region Council will manage Region Council membership to ensure EMS system stakeholders are represented.	Strategy 1 Throughout the plan period, the Region Council will maintain current roster membership positions, new appointments, appointment expirations, and reappointments.
	Strategy 2 Throughout the plan period, the Region Council will invite hospital, EMS agency, IVP representatives and other system partners to increase attendance and participation in County and Region Council meetings.
	Strategy 3 Throughout the plan period, the Region Council will coordinate Council/Committee meetings and communications with region partners.
	Strategy 4 Throughout the plan period, the Region Council will maintain information including the Region Council handbook (etc.) on the region website.
Objective 4 Throughout the plan period, the Region Council will support EMS training for prehospital providers to enhance workforce development.	Strategy 1 By May annually, the Region Council will initiate the grant award process by notifying each County Council of the training needs assessment and application to be eligible for the grant.
	Strategy 2 June annually, the County Councils will submit a completed training needs assessment and grant application for the following fiscal year.

	Strategy 3 By August annually, the region will allocate program grant funds to County Council grants and establish prehospital training grant contracts.
	Strategy 4 Throughout the plan period, the Region Council will assist the County Councils with course coordination/equipment purchases.
	Strategy 5 Throughout the grant period, the Region Council will distribute grant funds as completed reimbursement request documentation is received at the Region Council office.

Appendix 1

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

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

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

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

Appendix 2

Categorized Cardiac and Stroke Facilities

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

Cardiac Level I	Cardiac Level II	Cardiac Uncategorized	Stroke Level I	Stroke Level II	Stroke Level III	Stroke Uncategorized
5	5			7	3	

Cardiac	Stroke	Name	City	County

Level	Level			
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's Medical Center	Walla Walla	Walla Walla
I	III	Sunnyside Community Hospital	Sunnyside	Yakima
II	II	Toppenish Community Hospital	Toppenish	Yakima
I	II	Yakima Valley Memorial Hospital	Yakima	Yakima

Appendix 3

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

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

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

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

Appendix 4

EMS Resources, Prehospital Verified Services, Prehospital Non-Verified Services

									Ground Vehicles		Personnel		
EMS County UDL	Credential #	Credential Status	Agency Name	Mailing City	Expiration Date	Organization Type	Agency Type	Care Level	# AMB	# AID	# BLS	# ILS	# ALS
Benton	AID.ES.60013634	ACTIVE	Horn Rapids Motorsports Complex	Spokane Valley	04/30/2022	Private for Profit	AID	BLS	0	1	0	0	0
Benton	AID.ES.60355652	ACTIVE	Mid Columbia Pre Hospital Care Association	Kennewick	10/31/2021	Private Volunteer Association	AID	BLS	0	1	24	0	1
Benton	AIDV.ES.60583166	ACTIVE	West Benton Regional Fire Authority	Prosser	09/30/2021	Fire District	AIDV	BLS	0	1	8	1	0
Benton	AMBV.ES.00000008	ACTIVE	Benton County Fire Protection District #2	Benton City	11/30/2021	Fire District	AMBV	ILS	3	4	17	10	5
Benton	AMBV.ES.00000011	ACTIVE	Benton County Fire District 6	Paterson	11/30/2022	Fire District	AMBV	ILS	2	0	7	0	2

Benton	AMBV.ES.00000017	ACTIVE	Kennewick Fire Department	Kennewick	04/30/2022	City Fire Department	AMBV	ALS	8	0	55	5	32
Benton	AMBV.ES.00000018	ACTIVE	Richland Fire and Emergency Services	Richland	04/30/2022	City Fire Department	AMBV	ALS	8	11	25	5	39
Benton	AMBV.ES.00000026	ACTIVE	Prosser Memorial Health	Prosser	01/31/2022	Hospital District	AMBV	ALS	5	2	5	3	7
Benton	AMBV.ES.60202198	ACTIVE	Benton County Fire Protection District #4	West Richland	11/30/2021	Fire District	AMBV	BLS	3	2	11	1	12
Benton	AMBV.ES.60473490	ACTIVE	Hanford Fire Department	Richland	05/31/2022	Federal Fire Department	AMBV	ALS	6	0	83	3	15
Benton	AMBV.ES.60661332	ACTIVE	Life Flight Network	Aurora	08/31/2022	Private Non-Profit	AMBV	ALS	3	0	4	0	4
Benton	AMBV.ES.60789012	ACTIVE	American Medical Response	Yakima	06/30/2022	Private for Profit	AMBV	ALS	6	1	5	0	1
Benton	AMBV.ES.61044713	ACTIVE	Benton County Fire District #1	Kennewick	11/30/2022	Fire District	AMBV	BLS	2	14	40	0	1
Columbia	AIDV.ES.00000092	ACTIVE	Columbia County Fire District #1	Starbuck	11/30/2022	Fire District	AIDV	BLS	0	1	2	0	0
Columbia	AMBV.ES.00000093	ACTIVE	Columbia County Fire District #3	Dayton	10/31/2021	Fire District	AMBV	BLS	3	1	16	0	0
Columbia	ESSO.ES.60281391	ACTIVE	Bluewood Ski Patrol	Dayton	10/31/2022		ESSO		0	0	2	0	2
Franklin	AMBV.ES.00000024	ACTIVE	American Medical Response	Yakima	09/30/2021	Private for Profit	AMBV	ALS	8	0	18	0	3
Franklin	AMBV.ES.00000132	ACTIVE	Pasco Fire Department	Pasco	07/31/2022	City Fire Department	AMBV	ALS	6	6	43	8	30
Franklin	AMBV.ES.00000133	ACTIVE	Franklin County Public Hospital District #1	Mesa	07/31/2021	Municipality (city/county)	AMBV	BLS	7	2	29	13	0
Franklin	AMBV.ES.60334626	ACTIVE	Franklin County Fire District 3	Pasco	08/31/2021	Fire District	AMBV	ILS	2	2	20	4	1
Kittitas	AID.ES.00000356	ACTIVE	Roslyn Fire Department	Roslyn	05/31/2022	City Fire Department	AID	BLS	0	3	5	0	0
Kittitas	AIDV.ES.0	ACTIVE	Kittitas County Fire District #1	Thorp	08/31/2021	Fire District	AIDV	BLS	0	7	9	0	0

	0000344												
Kittitas	AIDV.ES.00000346	ACTIVE	Kittitas County Fire Dist #3	Easton	02/28/2021	Municipality (city/county)	AIDV	BLS	0	1	6	0	0
Kittitas	AIDV.ES.00000347	ACTIVE	Vantage Fire Dept	Vantage	02/28/2022	Fire District	AIDV	BLS	0	1	3	0	0
Kittitas	AIDV.ES.00000358	ACTIVE	South Cle Elum Volunteer Fire Department	Cle Elum	11/30/2022	City Fire Department	AIDV	BLS	0	2	2	0	0
Kittitas	AIDV.ES.60119626	ACTIVE IN	Kittitas County Fire District #6	Ronald	02/28/2021	Fire District	AIDV	BLS	0	4	9	0	0
Kittitas	AMBV.ES.00000345	ACTIVE	Kittitas Valley Fire and Rescue	Ellensburg	02/28/2021	Fire District	AMBV	ALS	6	0	46	0	16
Kittitas	AMBV.ES.00000348	ACTIVE	Kittitas County Fire District 7	Cle Elum	08/31/2022	Fire District	AMBV	BLS	4	6	13	0	0
Kittitas	AMBV.ES.00000354	ACTIVE	Cle Elum Fire Department	Cle Elum	11/30/2021	City Fire Department	AMBV	BLS	2	3	9	0	0
Kittitas	AMBV.ES.00000359	ACTIVE	Upper Kittitas County Medic One	Cle Elum	11/30/2022	Hospital District	AMBV	ALS	4	0	4	0	8
Kittitas	AMBV.ES.60832495	ACTIVE	Snoqualmie Pass Fire and Rescue	Snoqualmie Pass	05/31/2022	Fire District	AMBV	BLS	1	0	1	0	0
Kittitas	ESSO.ES.60285038	ACTIVE	Cle Elum Police Department	Cle Elum	08/31/2022		ESSO		0	0	1	0	0
Kittitas	ESSO.ES.60432721	ACTIVE	Kittitas County Sheriff's Office	Ellensburg	12/31/2021		ESSO		0	0	5	0	0
Walla Walla	AIDV.ES.00000764	ACTIVE	Walla Walla County Fire Protection District #1	Prescott	01/31/2022	Fire District	AIDV	BLS	0	1	1	0	0
Walla Walla	AIDV.ES.00000766	ACTIVE	Walla Walla Fire Protection District No. 3	Prescott	01/31/2021	Fire District	AIDV	BLS	0	1	6	0	0
Walla Walla	AIDV.ES.00000769	ACTIVE	Walla Walla FPD #6	Touchet	01/31/2022	Fire District	AIDV	BLS	0	4	9	0	0
Walla Walla	AIDV.ES.00000771	ACTIVE	Walla Walla County Fire District #8	Dixie	01/31/2022	Fire District	AIDV	BLS	0	1	4	2	0
Walla Walla	AIDV.ES.60446434	ACTIVE	Walla Walla County Fire Protection District # 7	Prescott	01/31/2022	Fire District	AIDV	BLS	0	2	3	0	0

Walla Walla	AIDV.ES.60937827	ACTIVE	Columbia - Walla Walla Co. Fire District No. 2	Waitsburg	01/31/2022	Fire District	AIDV	BLS	0	2	4	0	1
Walla Walla	AMBV.ES.00000767	ACTIVE	Walla Walla County Fire District #4	Walla Walla	01/31/2021	Fire District	AMBV	ALS	2	0	39	0	6
Walla Walla	AMBV.ES.00000777	ACTIVE	City of Walla Walla Fire Department	Walla Walla	07/31/2022	City Fire Department	AMBV	ALS	5	5	17	0	30
Walla Walla	AMBV.ES.60444006	ACTIVE	Walla Walla County Fire District 5	Burbank	01/31/2022	Fire District	AMBV	ALS	2	1	14	0	2
Walla Walla	AMBV.ES.60779352	ACTIVE	College Place Fire Department	College Place	07/31/2022	City Fire Department	AMBV	BLS	2	2	20	0	0
Yakima	AID.ES.60414426	ACTIVE	Yakima Training Center FD	Yakima	09/30/2022	Federal Fire Department	AID	BLS	0	4	21	0	0
Yakima	AIDV.ES.00000855	ACTIVE	Highland Fire Department	Cowiche	03/31/2022	Fire District	AIDV	BLS	0	2	8	0	0
Yakima	AIDV.ES.00000856	ACTIVE	Selah Fire Department	Selah	03/31/2022	City/Fire District Combination	AIDV	BLS	0	7	25	0	0
Yakima	AIDV.ES.00000857	ACTIVE	Naches Fire Department	Naches	03/31/2021	Fire District	AIDV	BLS	0	6	13	0	0
Yakima	AIDV.ES.00000858	ACTIVE	Yakima County Fire Dist #4	Yakima	03/31/2021	Fire District	AIDV	BLS	0	5	22	0	0
Yakima	AIDV.ES.00000859	ACTIVE	Yakima County Fire Dist. 5	Zillah	12/31/2022	Fire District	AIDV	BLS	0	14	77	0	0
Yakima	AIDV.ES.00000860	ACTIVE	Fire Protection Dist #6 Yakima County	Yakima	03/31/2022	Fire District	AIDV	BLS	0	2	9	0	0
Yakima	AIDV.ES.00000861	ACTIVE	Naches Heights Fire Department	Cowiche	03/31/2022	Fire District	AIDV	BLS	0	4	6	0	0
Yakima	AIDV.ES.00000863	ACTIVE	West Valley Fire Department	Yakima	06/30/2022	Fire District	AIDV	BLS	0	5	38	1	0
Yakima	AIDV.ES.00000864	ACTIVE	Nile-Cliffdell Fire Department	Naches	06/30/2022	Fire District	AIDV	BLS	0	2	11	1	0
Yakima	AIDV.ES.00000873	ACTIVE	Grandview Fire Department	Grandview	12/31/2022	City Fire Department	AIDV	BLS	0	1	11	0	0

Yakima	AIDV.ES.00000874	ACTIVE	City of Granger Fire Department	Granger	12/31/2022	City Fire Department	AIDV	BLS	0	1	0	0	0
Yakima	AIDV.ES.00000879	ACTIVE	Toppenish Fire Department	Toppenish	12/31/2021	City Fire Department	AIDV	BLS	0	1	3	0	0
Yakima	AIDV.ES.00000881	ACTIVE	Wapato Fire Department	Wapato	12/31/2021	City Fire Department	AIDV	BLS	0	1	1	0	0
Yakima	AIDV.ES.00000882	ACTIVE	Yakima Fire Department	Yakima	02/28/2022	City Fire Department	AIDV	BLS	0	15	96	0	1
Yakima	AIDV.ES.00000883	ACTIVE	Zillah City Fire	Zillah	12/31/2022	City Fire Department	AIDV	BLS	0	1	1	0	0
Yakima	AIDV.ES.60440190	ACTIVE	Mabton Fire Department	Mabton	12/31/2021	City Fire Department	AIDV	BLS	0	2	4	0	0
Yakima	AMBV.ES.00000877	ACTIVE	City of Sunnyside Fire Department	Sunnyside	06/30/2022	City Fire Department	AMBV	ALS	4	6	18	1	12
Yakima	AMBV.ES.00000892	ACTIVE	White Swan Ambulance	White Swan	09/30/2021	Tribal EMS	AMBV	ILS	4	0	2	1	1
Yakima	AMBV.ES.00000893	ACTIVE	American Medical Response	Yakima	09/30/2021	Private for Profit	AMBV	ALS	19	2	37	1	21
Yakima	AMBV.ES.00000894	ACTIVE	Advanced Life Systems	Yakima	09/30/2022	Private for Profit	AMBV	ALS	16	1	19	4	13
Yakima	ESSO.ES.60322342	ACTIVE	Yakima Police Department	Yakima	09/30/2021		ESSO		0	0	1	0	0
Yakima	ESSO.ES.60473298	ACTIVE	Yakima County Search & Rescue	Yakima	03/31/2021		ESSO		0	0	6	0	0

Appendix 5

Approved Min/Max numbers of Verified Trauma Services by Level and Type by

County

County	**Verified Service Type**	**State Approved - *Minimum number***	**State Approved *Maximum number***	**Current Status (# Verified for each Service Type)**
Benton County	AID – BLS	4	4	1
	AID –ILS	0	0	0
	AID – ALS	0	0	0
	AMB –BLS	0	2	21
	AMB – ILS	0	2	2
	AMB - ALS	4	7	6
Columbia County	AID – BLS	2	3	1
	AID –ILS	0	0	0
	AID – ALS	0	0	0
	AMB –BLS	1	1	1
	AMB – ILS	0	0	0
	AMB - ALS	0	0	0
Franklin County	AID – BLS	1	3	0
	AID –ILS	0	0	0
	AID – ALS	0	0	0
	AMB –BLS	2	2	1
	AMB – ILS	0	1	1
	AMB - ALS	1	2	2
Kittitas County	AID – BLS	5	8	5
	AID –ILS	0	0	0
	AID – ALS	0	0	0
	AMB –BLS	1	3	3
	AMB – ILS	0	0	0
	AMB - ALS	2	2	2
Walla Walla	AID – BLS	8	8	6

County	AID –ILS	0	0	0
	AID – ALS	0	0	0
	AMB –BLS	1	3	3
	AMB – ILS	0	1	0
	AMB - ALS	1	4	3
Yakima County	AID – BLS	18	20	16
	AID –ILS	0	1	0
	AID – ALS	0	1	0
	AMB –BLS	2	9	0
	AMB – ILS	0	1	1
	AMB - ALS	3	3	3

Appendix 6

Trauma Response Areas

DOH Map Link to Trauma Response Areas

https://fortress.wa.gov/doh/eh/maps/EMS/index.html

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

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

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

Explanation: The *type and number* column of this table accounts for the level of care available in a specific trauma response area that is provided by verified services. Some verified services (agencies) may provide a level of care in multiple trauma response areas therefore the **total type and number of verified services depicted in the table may not represent the actual number of State verified services available in a county; it may be a larger number in Trauma Response Area table. The verified service minimum/maximum table will provide accurate verified service numbers for counties.

Benton	**Trauma**	**Description of Trauma Response Area's**	**Type and # of**

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

	Number		**each Response Areas**
	#1	Within the current City limits of Pasco, Franklin County FD #3 boundaries, and north to Sagemore Road.	A-1 F-1
	#2	Within the boundaries of Franklin County Hospital District #1 that includes the communities of Connell, Mesa, Basin City and Merrill's Corner, west to the Columbia River and south to Sagemore Road.	D-1
	#3	Within the current city limits of Kahlotus and the boundaries of Franklin County Fire District #2	None
Kittitas County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	#1	From the southern county boundary to the east and west county boundaries encompassing the boundaries of Kittitas County Public Hospital District #1 to Exit 93 (Elk Heights and including Sunlight Waters to the development, *south* on 182 to milepost 18.5 (N. Umptanum turnaround), *south* on SR 821 to mile post 14 (Weimer Cut), *west* on State Route 10 to mile post 93 (east end of Bristol Flats), *west* of Lauderdale on State Route 97, *north* to mile post 163.7 (Blewett Pass Summit). This trauma area also includes the cities of Ellensburg and Kittitas, the rural communities of Vantage and Thorp, and boundaries of FD#1, FD#2, and FD#4 and surrounding rural and wilderness areas.	A-2 D-1 F-1
	#2	From the northern county boarder and within the current boundaries of Kittitas County Public Hospital District #2, I90 east to MP 93.5 (Elk Heights OP, Exit 93). I90 west to MP 54.5 (exit 53/E. Summit), SR 10 to MP 93 (E. end of Bristol Flats-HD #1), SR 970 north to MP 149.5 (Lauderdale Junction/SR 97, MP 10.3, West of Lauderdale Junction on SR 97 (including area around junction and residences accessed from SR 97, SR 970 from Teanaway Junction (MP 2.6) east to Lauderdale Junction (end of SR 970, MP 10.3),	A-3 D-3 F-1

		the Cities of Cle Elum and Roslyn, Town of S. Cle Elum, the rural community of Ronald, Easton, and Snoqualmie Pass, to the eastern and western county boundaries encompassing the surrounding rural and wilderness areas within HD #2.	
Walla Walla County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	#1	Within the current boundaries of Walla Walla County	A-6 D-3 F-1
Yakima County	**EMS & Trauma Response Area #**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	#1	North county line to west county line; south to south county line; east to Boundary Road; along Boundary Road to Newland Road and north on Newland Road to Yakima River; north along the Yakima River to Beam Road; north on Beam Road to end of the road and directly east to County line.	A-16 E-1 F-2
	#2	North Beam Road east to county line; county line south to Alexander Extension; southwest on Alexander Extension to Yakima River; and Yakima River north to Beam Road.	A-1 F-1
	#3	Alexander Extension south west to Yakima River; north from Yakima River on Newland Road; south to county line, east on county line; and north to Alexander Extension,	A-3 F-1

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

Appendix 8
Patient Care Procedures

Table of Contents

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.

Regulations

1.1 Revised Code of Washington (RCW):

A. **RCW 18.73** – Emergency medical care and transportation services
   1. RCW 18.73.030 - Definitions

B. **RCW Chapter 70.168** – Statewide Trauma Care System
   1. RCW 70.168.015 – Definitions
   2. RCW 70.168.100 – Regional Emergency Medical Services and Trauma Care Councils
   3. RCW 70.168.170 – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

1.2 Washington Administrative Code (WAC):

A. **WAC Chapter 246-976** – Emergency Medical Services and Trauma Care Systems
   1. WAC 246-976-920 – Medical Program Director
   2. WAC 246-976-960 – Regional Emergency Medical Services and Trauma Care Councils
   3. WAC 246-976-970 – Local Emergency Medical Services and Trauma Care Councils

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

1. **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.

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

3. **GENERAL PROCEDURES:**
   a. **Dispatch**
      i. Local EMS and Trauma Care Council's should identify primary and secondary Public Safety Answering Point (PSAP)/dispatch in each county and provide information to the Region Council of any changes.
      ii. Dispatchers should be trained in and use an Emergency Medical Dispatch (EMD) Guidelines Program to include pre-arrival instructions.
      iii. The appropriate level of service will be dispatched to the incident.
      iv. EMS services should proceed in an emergency response mode until they have been advised of non-emergent status unless advised of non-emergent status by dispatch.
      v. EMS services are responsible to update; PSAP/dispatch Center, DOH, Local and Region Councils, of any response area changes as soon as possible.
      vi. 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.

   b. **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.

   c. **Cancellation of Response Criteria**
      In coming units and on-scene EMS providers will communicate patient status report before cancelling response when practical.

      For all level EMS Agencies:

i. The responsible party for patient care decisions is the highest-level EMS provider on scene with the patient.
ii. Communication with PSAP/dispatch that no patient is found or non-injury or the following conditions are confirmed. (Proceed if requested by law enforcement.)
    a. Decapitation
    b. Decomposition
    c. Incineration
    d. Lividity and Rigor Mortis

d. **Slow Down**
i. Transport units may be slowed by first in on scene emergency responder.
ii. The first in on scene unit may convey available patient information to responding transport units.

e. **Diversion to another emergency call**

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

f. **Staging/Standby**

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

4. **APPENDICES: None**

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved	5/28/20	X Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

2. Guidelines for Rendezvous with Agencies That Offer Higher Level of Care

1. **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.

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

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

3. **GENERAL PROCEDURES:**
   a. The BLS/ILS ambulance may request ALS ambulance rendezvous by contacting dispatch.
   b. Ground ambulance should rendezvous with a higher level of care based on patient illness or injury,
   c. Benefit to patient should outweigh increase to out of hospital time.
   d. Based on updated information, requesting units may cancel the rendezvous by contacting dispatch.
   e. EMS providers should use effective communication with all incoming and on scene emergency responders at all times with patient care as their highest priority.
   f. Communication should include patient report when appropriate.

4. **APPENDICES: None**

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved	5/28/20	X Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

3. Air Medical Services - Activation and Utilization

1. **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.

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

3. **GENERAL PROCEDURES:**
   a. For scene transport to be efficacious and optimize patient outcome, the air medical response should take significantly less time (greater than 20 minutes time savings) than it takes to travel by ground to the closest appropriate facility. If this is not the case, strong consideration should be given to activating the helicopter from the scene, and meeting at the local hospital. This decision should be made in conjunction with local medical control. This is particularly important for head injured and hypotensive patients.
   b. 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.
   c. 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.
   d. Air medical Service will provide ETA of available fully staffed closest air ambulance.
   e. The final patient transport and destination decisions will be made on the scene.
   f. Air medical service will notify PSAP/dispatch when activated by a mechanism outside the emergency dispatch system.

Air Medical transport is recommended for the following:

Trauma:

a. Head injured patients with one of the following:
    i. Revised Trauma score <12 or deteriorating
    ii. Pediatric Revised Trauma score <10 or deteriorating
    iii. Change in LOC and/or neurological deficits
    iv. Significant penetrating injury above mid-thigh, torso, or head.
b. Patients with the following chest injuries:
    i. Possible tension pneumothorax
    j. Major chest wall injury
    k. Potential cardiac injury
    l. Penetrating chest wound
c. Patients with unstable vital signs including hypotension, tachypnea, severe respiratory failure.
d. Patient with burns of greater than 10% BSA or major burns of face, hands, feet, or perineum.
e. Major electrical or chemical burns.
f. Patients with spine injuries with neurologic involvement and potential airway/breathing compromise.
g. Amputation or near amputation.
h. Two or more long bone fractures or a major pelvic fracture.
i. Patients with scalping injury or “degloving” injury.
j. Patients with a significant mechanism of injury, hemodynamic instability, and associated signs and symptoms including:
    i. MVA with significant structural intrusion into victim’s space.
    ii. Speed of vehicle >55 mph.
    iii. MVA with extrication time >15 minutes or prolonged entrapment time.
    iv. MVA with patient ejected.
    v. MVA with associated fatalities.
    vi. Motorcycle victim ejected at >20 mph.
    vii. Pedestrian struck and thrown >15 feet.
    viii. Fall from a height of 20 feet or greater.
    ix. Crushing injuries to the abdomen, chest, or head.
    x. Near-drowning injuries, with or without existing hypothermia.
    xi. Trauma patients <12 or >55 years old.

Non-trauma:

a. Any patient airway that cannot be maintained.

b. 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.)
c. Patient is experiencing a severe neurological illness requiring neurosurgical or other intervention that is not available en route. (CVA, uncontrolled seizures, etc.)

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.

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.
e. HAZMAT victims not appropriately decontaminated that pose a risk to the crew or could potentially contaminate the aircraft.

4. **APPENDICES:**

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

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4. On Scene Command

1. **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.

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

3. **GENERAL PROCEDURES:**
   a. Agencies are responsible for ensuring responders are trained in NIMS ICS per FEMA guidelines at the appropriate level.
   b. ICS guidelines will be followed when establishing command and assigning other roles based on incident needs.
   c. 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.
   d. 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.

4. **APPENDICES: None**

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5. Prehospital Triage and Destination Procedure

1. **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.

2. **SCOPE**:
   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 algorithm to identify the transport destination to the appropriate designated/categorized hospital receiving facilities.

3. **GENERAL PROCEDURES:**
   EMS providers use the statewide triage destination procedures to identify transport of critically ill or injured patients to the appropriate designated/categorized hospital receiving facilities for definitive care.

4. **APPENDICES: None**

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5.1 Trauma Triage and Destination Procedure

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

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

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

4. **APPENDICES:**
   Link to DOH website: WA Trauma Triage Destination Procedure:

   https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf

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5.2 Cardiac Triage and Destination Procedure

1. **PURPOSE:**
   Patients presenting with signs and symptoms of acute cardiac distress are identified and transported to appropriate categorized WA State Emergency Cardiac System participating hospital to reduce death and disability.

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

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

4. **APPENDICES:**
   Link to DOH website: WA Cardiac Triage Destination Procedure:

   https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf

   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

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5.3 Stroke Triage and Destination Procedure

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

2. **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.

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

4. **APPENDICES:**
   Link to DOH website: WA Stroke Triage Destination Procedure:

   https://www.doh.wa.gov/Portals/1/Documents/Pubs/346049.pdf

   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

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5.4 Mental Health and Chemical Dependency Destination Procedure

1. **PURPOSE:**
   Operationalize licensed ambulance services transport of patients from the field to alternate facilities for mental health or chemical dependency services.

2. **SCOPE**:
   Licensed ambulances may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170.

3. **GENERAL PROCEDURES:**
   a. Prehospital EMS agencies and receiving mental health and/or chemical dependency facility participation is voluntary.
   b. Participating agencies and facilities will adhere to the WA State Department of Health Guidelines in accordance with RCW 70.168.170.
   c. Facilities that participate will work with the MPD and EMS agencies to establish criteria for accepting patients.
   d. MPD and Local EMS and Trauma Care Council will develop county operating procedures.
   e. Upon implementation and during ongoing operation of transport to alternate receiving facilities the following will be in place with DOH approval;
      i. County Operating Procedure (COPs)
      ii. MPD patient care protocols
      iii. EMS provider education

4. **APPENDICES: none**

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Regional Council	Approved	5/28/20	X Major ☐ Minor
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6. EMS/Medical Control Communications

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

2. **SCOPE**:
   Communications 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 patient care information exchange.

3. **GENERAL PROCEDURES:**
   a. Communication between EMS providers and healthcare facilities may be done directly or indirectly via local PSAP/dispatch.
   b. Based on geographic area communication via radio and cell phone and telephone may be used to expedite the exchange of information as needed.
   c. EMS agencies and receiving healthcare facilities will maintain communication equipment and training to communicate effectively.
4. **APPENDICES: none**

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Regional Council	Approved	5/28/20	X Major ☐ Minor
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7. Hospital Diversion

1. **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.

2. **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.

3. **GENERAL PROCEDURES:**
   a. 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.
   b. Exceptions to redirection/diversion:
      i. Airway compromise
      ii. Cardiac arrest
      iii. Active seizing
      iv. Persistent shock
      v. Uncontrolled hemorrhage
      vi. Urgent need for IV access, chest tube, etc.
      vii. Disaster Declaration
      viii. Paramedic Discretion

4. **APPENDICES: None**

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Regional Council	Approved	5/28/20	X Major ☐ Minor
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8. Cross International Border Transport

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1. PURPOSE:

2. **SCOPE**:

3. **GENERAL PROCEDURES:**

4. **APPENDICES:**

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9. Inter-Facility Transport Procedure

1. **PURPOSE:**
   Guidance on transferring high-risk trauma and medical patients without adverse impact to clinical outcomes.

2. **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.

3. **GENERAL PROCEDURES:**
   a. 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.
   b. 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.
   c. When online medical control is not available, prehospital protocols shall be followed during an EMS transport in the event that an emergency situation occurs while in route that is not anticipated prior to transport.
   d. While 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.

4. **APPENDICES: none**

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

1. PURPOSE:

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

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

All EMS agencies and Incident Commanders working during an MCI event shall operate within the National Incident Management System (NIMS).

Based on available local resources, prehospital EMS responders will use appropriate protocols and procedures consistent with the WA 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 Medical Program Director (MPD) and County EMS & Trauma Care Council.

The appropriate local Public Health Department will be notified where 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.

4. **APPENDICES: None**

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10.1 MCI

1. PURPOSE:

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

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

a. Triage System:
    i. Initial triage should be rapid with an emphasis on identifying severe but survivable injuries.
    ii. A single system should be used throughout our EMS system. START and Jump/START are simple and effective tools for initial triage.
    iii. A triage tag or identifier should be applied at the time of initial EMS contact.
    iv. 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).
b. Initial Treatment after triage may include:
    i. Immediate lifesaving treatments should be done as soon as possible at the time of initial EMS contact based on available resources.
        a. Maintain open airway.
        b. Control severe bleeding.
        c. Treat open (sucking) chest wounds.
        d. Treat for shock.
    ii. Secondary treatment
        a. Spinal restriction (prior to moving the patient).
        b. Definitive airway placement and oxygen administration.
        c. Needle decompression of tension pneumothorax.
c. Transport:
    i. RED (critical) patients should be the priority for earliest transport to receiving hospitals with an emphasis on those that need immediate surgical interventions.
    ii. EMS staffed transport vehicles should be loaded to full capacity and provide ALS level EMS during transport, if possible.
    iii. 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.

4. APPENDICES:

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10.2 All Hazards

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1. PURPOSE:

2. **SCOPE**:

3. **GENERAL PROCEDURES:**

4. **APPENDICES:**

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10.3 Highly Infectious Disease

1. PURPOSE:

To provide guidance to Medical Program Directors and EMS agencies regarding the identification, triage, treatment, transport, and post incident management of patients with suspected highly infectious diseases.

2. **SCOPE**:

The incidence and risk associated with highly infectious diseases and requires a modified level of response from Emergency Medical Services.

3. **GENERAL PROCEDURES:**

Use of the Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients under Investigation (PUIs) for in the United States as published by the Centers for Disease Control and Prevention (CDC) is endorsed by the Washington State Department of Health for inclusion in policies, procedures, and protocols.

EMS agencies that have self-identified as being capable of transporting patients with highly infectious diseases can be found on the WA State DOH website: EMS & Trauma GIS Resource Map. This map also identifies the hospitals capable of assessing and/or treating HID's.

4. **APPENDICES:**

Link to DOH EMS & Trauma GIS Resource Map
https://fortress.wa.gov/doh/ems/index.html

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