

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

S T R A T E G I C P L A N

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Submitted by the West Region EMS & Trauma Care Council
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EXECUTIVE SUMMARY

Introduction

The purpose of the 2009-2012 West Region Emergency Medical Services (EMS) and Trauma System Plan is to create and sustain a robust continuum of care that effectively reduces injuries and fatalities as well as treats and rehabilitates victims of trauma and medical emergencies within the five-county area of Grays Harbor, Lewis, North Pacific, Pierce and Thurston Counties.

The goals contained within the West Region 2009-2012 Strategic Plan are aligned with the State of Washington's EMS and Trauma System Strategic Plan of 2007-2012. The objectives and strategies were developed by members of the West Region EMS and Trauma Care Council as well as other regional stakeholders who collaborated to identify the region's specific needs.

To guarantee all citizens and visitors appropriate and timely EMS and trauma care, the West Region EMS & Trauma Care Council focuses its efforts toward prevention education and medical training of EMS and trauma personnel, trauma level designations of hospitals, trauma verification of prehospital agencies, all-hazards preparedness, improved data collection, and regional quality evaluation and improvement. The Vision Statement of the West Region EMS and Trauma System captures those efforts:

Vision Statement: We envision a tenable regional EMS and Trauma System with a plan that:

- Keeps patient care and interest the number one priority
- Recognizes the value of prevention and public education to decrease trauma-related morbidity and mortality
- Preserves local integrity and authority in coordination with inter/intra-regional agreements

Through this strategic plan, the West Region EMS and Trauma Care Council will work as a non-partisan facilitator, coordinator, and resource for regional EMS issues to achieve the Council mission:

Mission Statement: To assist and guide local EMS and trauma care providers in the coordination and improvement of emergency medical services and injury prevention/public education in the West Region.

Ten major system components of the continuum of care are addressed in this plan and are briefly outlined below:

System Leadership

The West Region EMS & Trauma Care Council has a diverse representation of dedicated members. Fifty-eight Council positions represent local healthcare providers, local government agencies, and consumers. Coordination of local EMS and trauma care planning is accomplished through county EMS & trauma care councils. The 2009-2012 West Region Plan addresses the following needs:

- Membership outreach for local and regional councils
- Optimal engagement with other groups involved in healthcare industry

- Development of leadership resources and training programs

System Development

The West Region Council accomplishes its role in system development through the review of regional patient care procedures, trauma designation of hospitals, trauma verification of prehospital agencies, and all-hazards preparedness planning. The 2009-2012 West Region Plan addresses the following needs:

- Evaluation of distribution of EMS and trauma services
- Implementation of evidence-based county EMS protocols
- Production of 2012-2017 WREMS Trauma Care System Plan
- Annual review of West Region Patient Care Procedures
- Distribution of state information to appropriate stakeholders
- All-hazards preparedness planning between the Regional Council, public health, hospitals and EMS in Public Health Regions 3 and 5
- Continued development of interoperable communications

System Public Information and Education

The 2009-2012 West Region Plan identifies the need for a regional Public Information Plan for distribution and education to the public and will collaborate with DOH to make it consistent with the state Public Information Plan.

System Finance

The West Region Council is a fiscally responsible steward of state funds and uses them to fulfill its mission to assist local providers in coordination and improvement of emergency medical and trauma care. The 2009-2012 West Region Plan addresses the following needs:

- Regional Council budget updated according to the current economic climate
- Resources available to regional EMS agencies for grant writing and research

Injury Prevention and Control

The West Region EMS & Trauma Care Council's Injury Prevention Program funds data-driven projects targeting the leading causes of injury. The 2009-2012 West Region Plan addresses the following needs:

- Fall related injuries in seniors 55 and older
- Injuries from motor vehicle crashes
- Unintentional poisoning & suicide related injuries
- Injury prevention education for EMS providers
- A regional response to a targeted statewide injury prevention focus

Pre-Hospital Care

The West Region Council provides 25% of its annual contractual funds to prehospital training. The 2009-2012 West Region Plan addresses the following needs:

- Funding to support state approved training at the county level
- Initial Basic Life Support training

- Sufficient and effective Senior Evaluator/Instructors, EMS Evaluators and Instructors

Acute Hospital Care

There are 13 designated trauma care services currently operating within the West Region. The 2009-2012 West Region Plan addresses the following needs:

- Gaps in specialty coverage identified
- Emergency Department nursing shortage
- Gaps in regional hospital education

Pediatric Care

High-quality pediatric hospital care in the West Region is available through Mary Bridge Children's Hospital, a Level II pediatric trauma center. The 2009-2012 West Region Plan addresses the following needs:

- Evidence-based guidelines considered in county reviews of pediatric protocols
- Pediatric educational tools evaluated and gaps identified within the region

Trauma Rehabilitation

Good Samaritan Physical Medicine and Rehabilitation Center in Puyallup is designated as a Level I Adult Trauma Rehabilitation Service and is one of the best rehabilitation centers in the nation. The 2009-2012 West Region Plan addresses the following needs:

- Trauma rehabilitation information and issues are regularly shared at West Region Council meetings
- The Regional Council reviews the minimum/maximum number of trauma rehabilitation services in the West Region
- Resources are explored for post-rehab care of traumatic brain injury (TBI) patients in the West Region

System Evaluation

The West Region Council is involved in the statewide effort to collect and manage prehospital data electronically through the Washington EMS Information System. The West Region Quality Improvement Forum (QIF) evaluates the EMS and trauma system within the West Region, under the leadership of the designated facilities. The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Develop, implement and begin monitoring system performance measures
- Regional quality improvement process for emergency cardiac and stroke care
- Quality improvement training available
- County quality improvement programs developed

REGIONAL SYSTEM

GOALS – OBJECTIVES – STRATEGIES

JUNE 2009 – JULY 2012

ADMINISTRATIVE COMPONENTS

SYSTEM LEADERSHIP

Introduction

The West Region EMS & Trauma Care Council is empowered by legislative authority (RCW 70.168.100-70.168.130) and Department of Health Administrative Code (WAC 246.976-960) to plan, develop, and administer the EMS and trauma care system in the five counties that make up the Region. It is one of eight regional councils statewide composed of volunteer representatives and funded primarily by the Washington State Department of Health (DOH).

The West Region EMS & Trauma Care Council accomplishes comprehensive planning through a committee structure with final approval by the Council. Fifty-eight Council positions represent local healthcare providers, local government agencies, and consumers from areas as metropolitan as Tacoma and as remote as the rainforest on the Olympic Peninsula. The Council benefits from a diverse representation of dedicated decision-makers, many of whom are regular contributors at state Technical Advisory Committee (TAC) meetings where they share their expertise.

Council bylaws provide for an executive board and standing committees. Ad hoc committees may be created to address a specific issue. The eight-member executive board is composed of three officers and one member-at-large from each county.

In addition to the Executive Board, there are three standing committees: Injury Prevention & Public Education, Training, Education & Development (which includes the Conference Planning Sub-Committee), and the Planning & Standards Committee. The Regional Council also provides administrative support to the West Region Quality Improvement Forum (QIF) (see Appendix A for more information on the QIF).

Coordination of local EMS and trauma care planning is administered by county EMS & trauma care councils in Grays Harbor/North Pacific, Pierce and Thurston counties. Lewis County planning is overseen through a collaborative process between the Medical Program Director, Lewis County Fire Chief's Association, and private prehospital providers. Each

council or decision-making body has its unique structure; meetings are held regularly and engage partners within the continuum of care.

The four Medical Program Directors (MPDs) within the West Region are a leadership resource and essential link between prehospital and hospital care within each of their counties. The MPD functions as a liaison between each of the counties and the regional structure.

The four MPDs are active at their local county levels. Medical off-line direction is delegated to the individual county MPDs. They are responsible for overseeing the development and implementation of protocols and establishing countywide quality assessment programs to assure quality care is provided by all prehospital providers. MPDs recommend training content to meet local county needs and training requirements established by DOH. Recommendations to DOH for certification and re-certification reside under MPD authority.

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Membership outreach for local and regional councils
- Optimal engagement with other TACs, groups, networks, coalitions and organizations involved in healthcare industry
- Development of leadership resources and training programs

SYSTEM LEADERSHIP

- Goal #1 -

There are viable, active local and regional EMS and trauma care councils comprised of multi-disciplinary, EMS and trauma system representation.

<p>Objective 1.</p> <p>By May 2012 the Regional Council will have each position required in RCW 70.168.120 on the Council filled by an active participant.</p>	<p>Strategy 1. By June 2010 the Regional Council will review membership positions in the bylaws and identify vacancies.</p>
	<p>Strategy 2. By June 30, 2011 Regional Council staff will attend county EMS council meetings to educate in responsibility for regional participation.</p>
	<p>Strategy 3. By June 2011 Regional Council staff will conduct membership outreach to other county entities and community venues.</p>
	<p>Strategy 4. By April 2012 each RCW-required Regional Council member position will be filled.</p>
	<p>Strategy 5. By May 2012 each Regional Council member will have identified an alternate and informed the Regional Council and DOH.</p>

SYSTEM LEADERSHIP

- Goal #2 -

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

<p>Objective 1.</p> <p>By December 2011 the Regional and Local Councils will collaborate to identify TACs, groups, networks, coalitions and organizations that are doing work that intersects with Regional or Local Council work and establish communication to ensure engagement with the regional EMS & Trauma System.</p>	<p>Strategy 1. By December 2010 the Regional Council staff, in collaboration with Local Council representatives, will develop a matrix of memberships in TACs, groups, networks, coalitions, and organizations in the region and work-projects that intersect with EMS & Trauma System.</p>
	<p>Strategy 2. By December 2010 the Regional Council, in collaboration with Local Council representatives, will identify which organizations are necessary to have formal communications with.</p>
	<p>Strategy 3. By July 2011, utilizing the information in Strategies 1 & 2, the Regional Council, in collaboration with local council representatives, will establish communication with each key TAC, group, network, coalition and organization.</p>
	<p>Strategy 4. By December 2011 Regional and Local Councils will implement and maintain communication with each key TAC, group, network, coalition and organization.</p>

SYSTEM LEADERSHIP

- Goal #3 -

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

<p>Objective 1.</p> <p>By January 2011, the West Region EMS & Trauma Care Council will make leadership resources or training programs that include processes specific to EMS and Trauma Systems available across the West Region.</p>	<p>Strategy 1.</p> <p>In April, annually, the West Region Council's Training, Education & Development (TED) Committee will determine the need for an annual leadership workshop at the West Region EMS Conference.</p>
	<p>Strategy 2.</p> <p>By June 2010, the TED Committee will seek out, evaluate and recommend to the Regional Council and local representatives existing leadership training programs.</p>
	<p>Strategy 3.</p> <p>By January 2011, the Regional Council will recommend leadership training resources and/or programs to local representatives.</p>

SYSTEM DEVELOPMENT

Introduction

The West Region EMS & Trauma Care Council's mission is to assist and guide local EMS and trauma care providers in the coordination and improvement of emergency medical services and injury prevention/public education in the West Region. This mission is tirelessly put into action through dedicated leaders, educators and providers whose top priority is the safety and care of their fellow citizens.

The development and implementation of a regional EMS & Trauma System Plan which addresses the continuum of care from injury prevention through trauma rehabilitation drives the work of that mission. With the advent of the 2007-2009 State of Washington EMS & Trauma System Strategic Plan, the West Region joins the statewide commitment to strategically plan for the future of EMS & trauma care.

The West Region Council supports local agencies in meeting the requirements of WAC to assure adequate availability of prehospital aid and ambulance services for each response area, based upon agency response time standards, geography, and topography and population density. Identification of need and distribution of verified aid and ambulance services is determined by local EMS county councils in Grays Harbor/N. Pacific, Pierce and Thurston Counties. Each council has an operations committee that is responsible for recommending the minimum/maximum (min/max) number of services for subsequent review and recommendation by the county EMS council. In Lewis County, this process is handled through collaborative discussions among the Medical Program Director (MPD), fire chiefs and private prehospital providers. Each county's recommendations are received for review by the Regional Council and forwarded to DOH for approval. Approved min/max numbers of verified services can be found in Appendix 1 of this report.

The West Region Council provides recommendations for minimum and maximum numbers, levels and locations of adult, pediatric, and rehabilitation trauma designations to DOH. As of the writing of this report, the region has received no recommendations for changes in these minimum and maximum numbers. However, Franciscan Health Systems will be opening a new facility, St. Anthony Hospital, in Gig Harbor in 2009 and will pursue a Level IV trauma designation. Approved min/max numbers of designated trauma services can be found in Appendix 3 of this report.

MPD-approved prehospital patient care protocols are on file in each county and are reviewed regularly by the MPD and county EMS Council to verify they meet each community's medical needs and the state medical standards. In addition to county protocols, regional prehospital patient care procedures (PCPs) are on file in each county. PCPs are standardized for the entire region and can be found in Appendix 4 of this document. Annual review and approval of the PCPs is the responsibility of the MPD and the Regional Council.

County operating procedures (COPs) must meet the minimum regional standard, and if they exceed the standard they must be reviewed by the Council and approved by DOH before implementation. Pierce County has a state-approved COP that describes use of the state trauma triage tool in their county and can be found in Appendix A of this document.

Federal guidance has directed states to strengthen their emergency response systems within the past seven years. The Washington State Department of Health (DOH), with the support of federal grant funding and guidance, contracts with each of the EMS and trauma regions to build and improve the statewide system to respond to natural and manmade disasters.

The West Region Council's role in all-hazards preparedness planning and activities has grown during the past seven years through contract activities initiated by DOH's Public Health Emergency Preparedness and Response Program (PHEPR). Through its contract with PHEPR, the West Region Council coordinates all-hazards planning within Public Health Region 3 which includes Grays Harbor, Lewis, Mason, Pacific and Thurston Counties. The counties for the West Region include Grays Harbor, Lewis, Pierce, Thurston, and the northern section of Pacific County. Because the geographical boundaries of Region 3 exclude Pierce County (Public Health Region 5) and include counties from outside of the West Region (Mason & the southern section of Pacific County), the planning process can be challenging.

The Regional Council collaborates with prehospital agencies, hospitals, Homeland Security Region 3, local emergency management, public health jurisdictions and Native American tribes. Regions 3 and 5 continue their efforts to enhance response through ongoing development of healthcare coalitions with regional healthcare and public health partners.

Region 3 has used preparedness funding to develop communications interoperability through expansion of the WHEERS (Washington Hospital & EMS Emergency Response System). WHEERS is a shared statewide radio system consisting of numerous linked mountain top repeaters which offer to improve coverage in geographically challenged areas. Use of the WHEERS supports hospital to hospital and hospital to EMS disaster related communications. WHEERS radios have been installed in all nine of the Region 3 hospitals and approximately 50 radios have been purchased for prehospital ALS command units. In 2007 the West Region Council established a Mass Casualty Incident (MCI) workgroup tasked with developing a regional MCI plan to include interoperable communications for emergency responders.

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Evaluation of distribution of EMS and trauma services
- Implementation of evidence-based county EMS protocols
- Production of 2012-2017 WREMS Trauma Care System Plan
- Annual review of West Region Patient Care Procedures
- Distribution of state information to appropriate stakeholders

- All-hazards preparedness planning between the Regional Council, public health, hospitals and EMS in Public Health Regions 3 and 5
- Continued development of interoperable communications

SYSTEM DEVELOPMENT

- Goal #4 -

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

<p>Objective 1.</p> <p>By September 2011, the Regional Council, in collaboration with stakeholders, will develop and submit to the Washington State Department of Health (DOH), a 2012-2017 Regional EMS & Trauma Strategic Plan that addresses injury prevention through rehabilitation services.</p>	<p>Strategy 1. By January 2011, the Regional Council will review goals, objectives and strategies for each component of the existing regional plan.</p>
	<p>Strategy 2. By April 2011, the Regional Council will develop objectives and strategies for the 2012-2017 regional plan with input from stakeholders.</p>
	<p>Strategy 3. By July 2011, the Regional Council will complete a draft plan.</p>
	<p>Strategy 4. By September 2011, the Regional Council will finalize goals, objectives and strategies for each component of the regional plan and submit to DOH for review.</p>
<p>Objective 2.</p> <p>By August 2011, each county will develop a plan for distribution of services that promotes optimal coverage of EMS and trauma services for 2012-2017.</p>	<p>Strategy 1. By March 2010, Local Councils or other county EMS/Trauma planning groups will evaluate the distribution of services within their county.</p>
	<p>Strategy 2. By June 2010, Local Councils or other county EMS/Trauma planning groups will evaluate the needs of services within their county.</p>
	<p>Strategy 3. By September 2010, reviews will commence at quarterly Regional Council meetings to compare services and needs, and identify and negotiate cross-county services available to fill gaps.</p>
	<p>Strategy 4. By March 2011, the Regional Council will produce a report that identifies gaps in coverage at the regional level.</p>
	<p>Strategy 5. By June 2011, the Regional Council will formulate a draft plan to address the gaps.</p>

	<p>Strategy 6. By August 2011, the Regional Council will finalize the draft plan after collaboration with Local Councils or other county EMS/Trauma planning groups.</p>
<p>Objective 3. By May 2011, stakeholder groups will implement clinical guidelines that promote optimal patient care within the West Region.</p>	<p>Strategy 1. By September 2010, the Regional Council will collaborate with the Medical Program Directors and local & regional advisory committees to review the guidelines developed at the state level and make recommendations to adopt or modify for region wide implementation.</p>
	<p>Strategy 2. By May 2011, Local Councils or other county EMS/Trauma planning groups will evaluate county protocols to ensure evidence based guidelines are used during their revisions/updates and then implement them.</p>

SYSTEM DEVELOPMENT

- Goal #5 -

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

<p>Objective 1.</p> <p>By June 2010 the roles and responsibilities for development of the EMS & Trauma Strategic Plan will be determined and assigned by the WREMS Council and the planning process started for the 2012-2017 West Region EMS and Trauma Care System Plan.</p>	<p>Strategy 1. By April 2010 a plan will be developed at the annual Regional Council planning retreat detailing Regional Council, Local Council, key stakeholder and Regional Council staff participation and responsibilities in producing the 2012-2017 West Region System Plan.</p>
	<p>Strategy 2. By April 2010 the Regional Council will establish the plan development process and schedule for working on the 2012-2017 West Region System Plan.</p>
	<p>Strategy 3. By June 2010 the Regional Council will assign responsibilities to designated individuals in planning the 2012-2017 West Region System Plan.</p>
<p>Objective 2.</p> <p>By September 2011 the Regional Council will complete a comprehensive West Region EMS and Trauma Care System Plan that uses regional data and information to define the system direction and work in the West Region for 2012-2017.</p>	<p>Strategy 1. By March 2010 the Regional Council staff will obtain directives from the State Dept. of Health (DOH) for the system plan components.</p>
	<p>Strategy 2. By April 2010 the Regional Council will review and/or update the 2007 analysis of the regional system to determine its strengths, weaknesses, opportunities and threats.</p>
	<p>Strategy 3. By May 2010 the Regional Council will make initial requests for data from the State DOH. The intent is to have some data in hand when the planners meet in June 2010.</p>
	<p>Strategy 4. From June 2010 until June 2011 the designated planners will request or generate data as the need arises.</p>
	<p>Strategy 5. From June 2010 until June 2011 the designated planners will develop objectives identifying work under each plan component to maintain, further develop or refine the regional system and will report progress to the Regional Council at regular meetings.</p>

	<p>Strategy 6. From June 2010 until June 2011 the designated planners will get input to the plan objectives from Local Councils and key stakeholder groups and will report progress to the Regional Council at regular meetings.</p>
	<p>Strategy 7. By July 2011 the designated planners will present a completed draft of the 2012-2017 West Region System Plan to the Regional Council and, subsequently, to the State DOH.</p>
	<p>Strategy 8. By September 2011, the Regional Council will have completed and approved the 2012-2017 West Region System Plan for submission to the State DOH.</p>
<p>Objective 3. Annually, each April, the recommended West Region Patient Care Procedures are reviewed and approved by the Regional Council to ensure ongoing appropriateness for optimal trauma patient care.</p>	<p>Strategy 1. By April 2011, and annually thereafter, Regional Patient Care Procedures (PCPs) are reviewed and updated, if needed, by the West Region Medical Program Directors; taking into account the information generated in Goal 4, Objective 3.</p>
	<p>Strategy 2. The Regional Council will review and approve the PCPs at the annual regional budget and planning retreat in April of 2011 and 2012.</p>

SYSTEM DEVELOPMENT

- Goal #6 -

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

Objective 1.

By June 2010 Regional and Local Councils will identify existing distribution channels for use in timely distribution of Steering Committee & TAC information to regional stakeholders on emerging issues and will implement an information distribution process.

Strategy 1.

By February 2010 Regional Council staff will query Local Council representatives within the region to determine existing information distribution channels.

Strategy 2.

By April 2010 Regional Council staff will implement a process for timely distribution of information on emerging issues.

SYSTEM DEVELOPMENT

- Goal #7 -

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

Objective 1.

From October 2009 to June 2012, the Regional Council will continue planning, collaboration & coordination with public health and hospitals in Public Health Emergency Regions 3 & 5 for disaster preparedness.

Strategy 1.

A Regional Council representative will be present at scheduled Public Health Region 3 & 5 planning and Healthcare Coalition meetings during the plan cycle.

Strategy 2.

The Regional Council and staff will assist healthcare partners in identifying training opportunities for disaster preparedness by April annually at the regional budget and planning retreat.

SYSTEM DEVELOPMENT

- Goal #8 -

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

Objective 1.

By April 2011, the Regional Council will inventory and evaluate the communications capabilities of EMS and hospitals within the West Region & Public Health Region 3 and develop a plan for regional system use.

Strategy 1.

By October 2009, the Regional Council will designate a regional representative in communications interoperability to lead an inventory and evaluation of communication capabilities within the region.

Strategy 2.

By December 2009 the representative & the Regional Council staff will consult with the Region 3 Homeland Security Interoperability Committee to obtain current interoperability status of 911 centers in Region 3.

Strategy 3.

By January 2010, the representative & the Regional Council staff will have developed a questionnaire of needed information.

Strategy 4.

By June 2010 representatives from hospitals, EMS & public health will provide information on communication capabilities of their constituencies to the designated communications representative for the development of a system status report.

Strategy 5.

By September 2010 the designated communications representative will present a communications system status report to the Regional Council.

Strategy 6.

By September 2010 the Regional Council will determine whether action needs to be taken on interoperability within the region based upon the communications system status report generated by the designated communications representative.

Strategy 7.

By April 2011, the Regional Council will use the report to develop a plan to address gaps including addressing funding and other barriers.

SYSTEM PUBLIC INFORMATION & EDUCATION

Introduction

There is a need for the public to be informed of the role of the EMS and trauma care system, locally, regionally and statewide. Specifically, the benefits and the financial costs of the system along with the consequences of reduced funding need to be publicized. Citizens who are aware of the reduction of workforce and funding in EMS and the lower availability of specialty services in trauma care are better informed of the challenges facing their health care environment.

There is currently no formal public information and education campaign in the West Region. Media coverage is dependent upon current political issues, human interest stories and the ongoing misfortunes of injuries and death in our communities. The West Region EMS Council maintains a public website which is mainly used to inform Council members, providers and other community partners. The Council also has membership positions for consumer representatives from each county.

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan identifies the need for a public information plan for distribution and education to the public. The West Region Council will collaborate with the State DOH to make it consistent with the state's public information plan.

SYSTEM PUBLIC INFORMATION & EDUCATION

- Goal #9 -

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

<p>Objective 1.</p> <p>By July 2011 the Regional Council will develop and implement a public information plan (PIP) for distribution and education to the public that is consistent with the state public information plan.</p>	<p>Strategy 1. By July 2010, the Regional Council will identify participants for development of the PIP.</p>
	<p>Strategy 2. By July 2010, the Regional Council will coordinate work sessions for PIP workgroup.</p>
	<p>Strategy 3. By November 2010, the PIP workgroup will identify and select target audiences for the PIP.</p>
	<p>Strategy 4. By November 2010, the PIP workgroup will identify activities to be done.</p>
	<p>Strategy 5. By April 2011, the PIP workgroup will develop public information messages for target audiences.</p>
	<p>Strategy 6. By June 2011, the PIP workgroup will develop a regional implementation plan.</p>

There is no Regional Plan goal #10

SYSTEM FINANCE

Introduction

The West Region population continues to grow at a rapid rate, ever challenging the regional EMS and trauma care system to provide timely and effective service. Projections by the Washington State Office of Financial Management show the average county population increase in the West Region between 2000 and 2007 is 9% with the urban counties having the highest increases upwards of 13-15%. These service challenges stress the regional resources for response, treatment and financial capabilities. An increase in population also increases the demand for rapid, quality services. These needs are in contrast to increasingly elusive funding resources to support public health and safety.

The West Region EMS & Trauma Care Council is one of eight regional councils in the state funded primarily by the Washington State Department of Health (DOH). In addition to state funding, the Council generates revenue from its annual EMS Conference. The Council is a fiscally responsible steward of these funds and uses them to fulfill its mission to assist and guide local EMS and trauma care providers in the coordination and improvement of emergency medical services and injury prevention/public education in the West Region. The West Region Council provides 50% of its annual contractual funds to prehospital training and injury prevention projects.

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Regional Council budget updated according to the current economic climate
- Resources available to regional EMS agencies for grant writing and research

SYSTEM FINANCE

- Goal #11 -

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

<p>Objective 1.</p> <p>By April 2011 the Regional Council will determine the critical work of the Council and the base cost to do that work.</p>	<p>Strategy 1. At the April 2010 annual Regional Council planning retreat the Regional Council will identify the critical work of the Council for FY2011 and FY2012.</p> <p>Strategy 2. By November 2010 the West Region Executive Board will gather data on the costs of the Council's critical work.</p> <p>Strategy 3. At the April 2011 annual Regional Council planning retreat the West Region Executive Board will present critical work and the base cost to the Regional Council.</p>
<p>Objective 2.</p> <p>By September 2010 the Regional Council will serve as an educational resource for West Region EMS agencies who need assistance with grant writing and research.</p>	<p>Strategy 1. By September 2009 the West Region Conference Planning Committee will determine the feasibility of an introductory workshop in grant writing to be given at the 2010 West Region Conference.</p> <p>Strategy 2. By January 2010 the Regional Council will have a webpage on its website dedicated to grants and grant writing resources for regional EMS agencies.</p> <p>Strategy 3. By September 2010 the Regional Council staff will be available as a resource during business hours to agencies with inquiries on grants and grant writing.</p>

CLINICAL COMPONENTS

INJURY PREVENTION & CONTROL

Introduction

The West Region EMS & Trauma Care Council's Injury Prevention Program has evolved from a passion-driven group of programs addressing nearly all mechanisms of injury to data-driven projects targeting the leading causes of injury. In the past two years 75% of the allocated prevention dollars have been aimed at preventing the two leading causes of injury in the West Region, senior falls and motor vehicle crashes. The West Region Council has developed a comprehensive mini-grant selection committee process that includes specialists from several areas of the injury prevention community. The committee uses a detailed grading system & selection criteria that evaluates a project's supporting data, objectives, strategies and evaluation plan.

The next step in the maturation process of the West Region Council's Injury Prevention Program will be to fund prevention projects that target recommended strategies clearly presented in the 2008 Washington State Department of Health's Injury & Violence Prevention Guide. This guide has filled a critical need in Washington State to have a comprehensive list of evidence-based programs.

In 2006 poisonings surpassed motor vehicle crashes as the leading cause of accidental death in the state of Washington. "At present, the primary cause of the increased unintentional poisoning death rate is unclear."¹ The West Region Council will stay tuned for recommended strategies from the state. These strategies will become a priority & integrated part of the West Region Council's Injury Prevention Program beginning in 2010.

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Fall related injuries in seniors 55 and older
- Injuries from motor vehicle crashes
- Unintentional poisoning & suicide related injuries
- Injury prevention education for EMS providers
- A regional response to a targeted statewide injury prevention focus

¹ Washington State Department of Health. Injury and Violence Prevention Guide (2008), Poisoning & Drug Overdose, 50

INJURY PREVENTION & CONTROL

- Goal #12 -

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

<p>Objective 1.</p> <p>By September, annually in 2009, 2010 & 2011, the Regional Council will provide funding to regional injury prevention partners to reduce fall-related injury rates among Seniors 55 and over by funding programs that use recommended strategies as outlined in the 2008 Washington State Injury and Violence Prevention Guide (2008 WA IVP Guide).</p>	<p>Strategy 1.</p> <p>By September 2009, 2010 & 2011, the Regional Council will allocate funding for the grant cycles of 2009-2012 to support the growth of new & existing annual community senior falls prevention & safety workshops which offer risk assessment, medication review, education about fall risk factors & resources for balance & strength training classes.</p>
	<p>Strategy 2.</p> <p>By September 2009, 2010 & 2011, the Regional Council will allocate funding for the grant cycle of 2010-2012 to support the growth of new & existing balance and strength training classes for Seniors 55 and over. Instructors should be trained on presenting the “Stay Active & Independent for Life Exercise and Education Program.”</p>
	<p>Strategy 3.</p> <p>By September 2011, the Regional Council will fund programs in the grant cycle of 2011-2012 which teach EMTs/Paramedics to offer Senior Falls Prevention education/materials and hazard assessment on calls with non emergent patients. Encourages utilization of the on-scene “Teachable Moment” opportunity.</p>
<p>Objective 2.</p> <p>By September, annually, in 2009, 2010 & 2011, the Regional Council will provide funding to regional injury prevention partners to reduce MVC injury rates by funding programs that use recommended strategies as outlined in the 2008 WA IVP Guide.</p>	<p>Strategy 1.</p> <p>By September 2009, 2010 & 2011, the Regional Council will allocate funding for the grant cycle of 2009-2012 to support county coalitions and organizations that aim to educate the public and increase the use and availability of child safety seats to low income families.</p>
	<p>Strategy 2</p> <p>By September 2010 the Regional Council will allocate funding for the grant cycle of 2010-2011 to support impaired driving prevention programs which target the leading group of offenders: Males 21 – 25 years old.</p>

<p>Objective 3. By September, annually, in 2010 & 2011, the Regional Council will provide funding to regional injury prevention partners to reduce the rate of unintentional poisoning related injuries by funding a program that uses recommended strategies as outlined by the Washington State Poison Center.</p>	<p>Strategy 1. By September 2010 & 2011 the Regional Council will allocate funding for the grant years of 2010-12 to support unintentional poisoning prevention programs that practice research and tested strategies presented by the Washington State Poison Center.</p>
<p>Objective 4. Annually, in September 2010 and 2011 the Regional Council will provide funding to regional injury prevention partners to reduce suicide related injuries and deaths by funding at least one program that uses recommended strategies as outlined in the 2008 WA IVP Guide..</p>	<p>Strategy 1. By September 2010, the Regional Council will allocate funding to support the growth of teen suicide prevention programs in middle and high schools classrooms and expand programs into all counties of the region.</p> <p>Strategy 2. By September 2011, the Regional Council will require a senior depression & emotional support resource component at all West Region Council funded Senior Safety Fairs with approved components being a suicide prevention speaker and/or staffed vendor table offering resources.</p>
<p>Objective 5. By March, annually, in 2010, 2011, & 2012, the Regional Council will sponsor and coordinate at least one educational event that includes information on prevention principles and practices for prehospital EMS and trauma care providers.</p>	<p>Strategy 1. By December, annually, in 2009, 2010, & 2011, the West Region Council’s Injury Prevention Coordinator and Prevention Committee will determine the content of Injury Prevention education for prehospital EMS providers that will be presented at the following year’s West Region EMS Conference.</p> <p>Strategy 2. By March annually in 2010, 2011, & 2012, the West Region Council’s Injury Prevention Coordinator and Prevention Committee of the Council will present a Prevention Workshop which will include information on prevention principles and practices for prehospital EMS providers to be held as part of the West Region EMS Conference.</p>
<p>Objective 6. By May 2012, the Regional</p>	<p>Strategy 1. By September 2010, the Regional Council and West Region Injury Prevention Coordinator will develop a</p>

<p>Council will incrementally implement the statewide injury prevention project, Injury & Violence Prevention Media Outreach Project (IVP), with coordinated effort from the state office, all EMS and trauma regions and other state and local partners.</p>	<p>West Region implementation plan for the statewide injury prevention project.</p>
	<p>Strategy 2. By September annually between 2010 & 11, the West Region Injury Prevention Coordinator will report at the IPPE TAC meetings, the implementation progress (formative evaluation) of the West Region’s component of the statewide project.</p>
	<p>Strategy 3. By May 2012, the Regional Council will incrementally implement the IVP Media Outreach Project in the West Region and report results.</p>

PREHOSPITAL

Introduction

Grays Harbor, Lewis, North Pacific, Pierce and Thurston Counties all have Advanced Life Support (ALS) and Basic Life Support (BLS) coverage. Each county has a mixture of paid, volunteer, public and private responders that makes each system unique. Recruitment and retention of first responders continues to be an issue. In some of the rural districts first responders and EMTs are not being replenished. In most of the rural counties there is not enough money to pay for training of volunteers.

The West Region Council provides 25% of its annual contractual funds to prehospital training. The Council maintains contracts with each of the county EMS Councils or designated representatives to deliver training to providers. The West Region Training, Education & Development (TED) Committee oversees EMS and trauma care instructional programs for prehospital and hospital personnel within the region. In addition, the TED oversees one sub-committee: the West Region Conference Planning Committee. The Conference Planning Committee holds monthly meetings to produce the annual West Region EMS Conference which delivers quality education to providers.

Skill maintenance is provided through BLS and ALS OTEP. BLS and ALS skills workshops are also offered at the annual West Region EMS Conference.

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Funding to support state approved training at the county level
- Initial Basic Life Support training
- Sufficient and effective Senior Evaluator/Instructors, EMS evaluators and instructors

PREHOSPITAL

- Goal #13 -

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

<p>Objective 1. Annually, by November 2009-2011, the Regional Council will allocate funding for county EMS training programs supporting state approved Ongoing Training & Education Program (OTEP), Continuing Medical Education (CME) or initial Basic Life Support (BLS) training within the West Region.</p>	<p>Strategy 1. Annually, at the West Region Council’s Retreat in April, Council members will review needs and approve educational funding levels for each local county EMS council or designated representative.</p>
	<p>Strategy 2. Annually, by November 2009-2011, the Regional Council staff will initiate contracts with local county EMS councils or designated representatives to distribute funds for coordination and delivery of OTEP and CME EMS training.</p>
<p>Objective 2. Annually, by March 2010-2012, the Regional Council will provide EMS education and training opportunities within the West Region through a regional EMS conference.</p>	<p>Strategy 1. By December 2009-2011, the Council’s Training, Education & Development (TED) Committee will select topics and secure speakers for the regional EMS conference.</p>
	<p>Strategy 2. By March 2010-2012, the Regional Council will conduct an EMS conference which provides EMS education and training opportunities within the West Region.</p>

<p>Objective 3.</p> <p>By March 2010-12, annually, the Regional Council will educationally assist SEIs and EMS Evaluators & Instructors with currency and competency in WA State requirements by offering an SEI workshop.</p>	<p>Strategy 1.</p> <p>Annually, by March 2010-2012, the Regional Council will offer an SEI Workshop at the West Region EMS Conference to assist SEIs and EMS Evaluators & Instructors with currency and competency in WA State requirements.</p>
<p>Objective 4.</p> <p>By June 2011, the TED Committee will facilitate training and quality improvement for SEIs, EMS Evaluators & Instructors throughout the region through development and implementation of a regional process.</p>	<p>Strategy 1.</p> <p>By November 2009, the TED Committee will distribute a list of all SEIs in the region to each county EMS office.</p>
	<p>Strategy 2.</p> <p>By June 2010, the TED Committee will develop a tool to document and report results of cross-county evaluation, to track and enhance standardization and performance improvement.</p>
	<p>Strategy 3.</p> <p>By September 2010, the TED Committee will provide opportunities for extended peer evaluation by inviting cross-county evaluation to enhance regional standardization and performance improvement.</p>

ACUTE HOSPITAL

Introduction

The West Region has an appropriate number and distribution of designated trauma services for the successful implementation of a region-wide trauma system. There are 13 designated trauma care services currently operating within the region.

In Pierce County there are six trauma centers serving the needs of the region. Tacoma Trauma Services, a joint Adult Level II, is shared by Tacoma General Hospital and St. Joseph Medical Center. Madigan Army Medical Center (MAMC), located inside Fort Lewis also serves as an Adult Level II. Although MAMC's primary recipients of care are military beneficiaries, the hospital will care for civilian trauma patients with pre-set boundaries and as they are able when the Tacoma Level II is on divert status. Mary Bridge Children's Hospital & Health Center is the West Region's Level II Pediatric trauma designated facility in Tacoma. Good Samaritan Hospital in Puyallup is an Adult Level III and is now affiliated with MultiCare Health System. St. Clare Hospital in Lakewood is an Adult Level IV. St. Anthony Hospital will be opening in 2009 in Gig Harbor, and is part of the Franciscan Health System. Level IV designation will be pursued sometime after the hospital has opened.

The remaining West Region counties house six additional adult trauma facilities. Two Level III trauma centers: Providence St. Peter Hospital in Olympia and Grays Harbor Community Hospital in Aberdeen. Four hospitals are designated at Level IV: Capital Medical Center in Olympia, Providence Centralia Hospital in Centralia, Morton General Hospital in Morton and Willapa Harbor Hospital in South Bend. One hospital within the region is Level V: Mark Reed Hospital in McCleary.

Adult	Pediatric	Rehab		
II			Madigan Army Medical Center	Fort Lewis
II			Tacoma Joint: St. Joseph Medical Center Tacoma General Hospital	Tacoma
III		IR	Good Samaritan Community Healthcare	Puyallup
III			Grays Harbor Community Hospital	Aberdeen
IV			Providence Centralia Hospital	Centralia
III		II-R	Providence St. Peter Hospital	Olympia
IV			Capital Medical Center	Olympia
IV			Morton General Hospital	Morton
IV			St. Clare Hospital	Lakewood
IV			Willapa Harbor Hospital	South Bend
V			Mark Reed Hospital	McCleary
	II-P		Mary Bridge Children's Hospital	Tacoma
		II-R	St. Joseph Medical Center	Tacoma

P=Pediatric Trauma Svc R=Trauma Rehab Svc PR=Pediatric Trauma Rehab Svc

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Gaps in specialty coverage identified
- Emergency Department nursing shortage
- Gaps in regional hospital education

The West Region Council will appoint a systems representative to develop and distribute a questionnaire to all trauma program managers in the West Region to identify gaps in coverage and unnecessary duplication of resources. Information gleaned from the questionnaire will be compiled into a report together with information identified by the State in a similar query (available by January 2010). Based upon the report, the Regional Council will determine action plans for improvement.

ACUTE HOSPITAL

- Goal #14 -

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

<p>Objective 1.</p> <p>By January 2011, the regional trauma system stakeholders will review gaps in coverage and unnecessary duplication of resources.</p>	<p>Strategy 1.</p> <p>By January 2010 the Regional Council will appoint a systems representative to develop a questionnaire identifying gaps in coverage (eg staffing) and unnecessary duplication of resources for distribution to all designated trauma service managers in the West Region.</p>
	<p>Strategy 2.</p> <p>By April 2010 the systems representative will work with Regional Council staff to distribute the questionnaire to all designated trauma service managers in the West Region.</p>
	<p>Strategy 3.</p> <p>By September 2010 the systems representative will compile information from the questionnaire and produce a report for the West Region EMS Council.</p>
<p>Objective 2.</p> <p>By September 2010, the Regional Council will review the regional educational report and make a recommendation for action, if appropriate.</p>	<p>Strategy 1.</p> <p>By January 2010, the Regional Council will solicit hospital representation on the West Region EMS Council.</p>
	<p>Strategy 2</p> <p>By April 2010, the systems representative will include regional hospital education gaps in the questionnaire developed in Goal 14, Objective 1, Strategy 1.</p>
	<p>Strategy 3.</p> <p>By September 2010 regional educational information compiled by the systems representative will be reviewed by the WREMS Council which will make a recommendation for action, if appropriate.</p>

PEDIATRIC

Introduction

High-quality pediatric hospital care in the West Region is available through Mary Bridge Children's Hospital (MBCH), a Level II pediatric trauma center. Pediatric Intensivist and Pediatric Hospitalist physicians are in-house and ready to care for children 24/7. MBCH serves as a pediatric base station as well as a resource for trauma education and prevention.

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Evidence-based guidelines considered in county reviews of pediatric protocols
- Pediatric educational tools evaluated and gaps identified within the region

The Regional Council will collaborate with Medical Program Directors (MPDs) and other regional stakeholders to review the newly developed state pediatric care guidelines with a recommendation to adopt or modify for region-wide use. Local councils will evaluate county protocols to ensure evidence based pediatric guidelines are considered during revisions or updates. The Regional Council will evaluate pediatric educational methods, identify any gaps and make recommendations of alternative methods of pediatric education to regional stakeholders.

PEDIATRIC

- Goal #15 -

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

<p>Objective 1.</p> <p>By December 2011, state pediatric care guidelines that ensure ongoing appropriateness for optimal pediatric patient care will be reviewed by West Region stakeholder groups and adopted or modified, as appropriate.</p>	<p>Strategy 1. By June 2010, the Regional Council will collaborate with the MPDs, local & regional advisory committees, to review the pediatric guidelines developed at the state level with recommendations to adopt or modify for region-wide use.</p>
	<p>Strategy 2. By December 2010, County MPDs and Local Councils will evaluate county protocols to ensure evidence-based pediatric guidelines from Strategy 1 are considered during their revisions/updates.</p>
	<p>Strategy 3. By December 2011, a Pediatric TAC representative will present state pediatric care guidelines to the West Region Quality Improvement Forum for review.</p>
<p>Objective 2.</p> <p>By December 2011, the Regional Council will recommend/develop alternative methods to facilitate pediatric emergency medical & trauma education within the West Region.</p>	<p>Strategy 1. By July 2010, the Regional Council will evaluate pediatric educational methods/tools and identify gaps within the region (included in the questionnaire goal 14, objective 1, strategy 1.)</p>
	<p>Strategy 2 By July 2011, the Regional Council will make recommendations of alternative methods of pediatric education to Local Councils and other West Region stakeholders.</p>
	<p>Strategy 3. By December 2011, the Regional Council will evaluate the need for and, if needed, include topics on pediatric trauma and medical emergencies in the annual West Region EMS Conference.</p>

TRAUMA REHABILITATION

Introduction

Good Samaritan Physical Medicine and Rehabilitation Center in Puyallup, an affiliate of MultiCare Health System, is designated as a Level I Adult Trauma Rehabilitation Service and is one of the best rehabilitation centers in the nation. Their outpatient and inpatient rehabilitation treatment outcomes are consistently at or above the national averages. Providence St. Peter Hospital in Olympia and St. Joseph Medical Center in Tacoma serve the West Region as Level II Adult Trauma Rehabilitation Centers.

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Trauma rehabilitation information and issues are regularly shared at West Region Council meetings
- The Regional Council reviews the minimum/maximum number of trauma rehabilitation services in the West Region
- Resources are explored for post-rehab care of traumatic brain injury (TBI) patients in the West Region

The Trauma Rehabilitation Centers in the West Region provide high-caliber care to traumatic brain injury (TBI) patients which can be undercut by the lack of resources available in the region post-rehab. Specifically, there are no cognitive therapy day programs where TBI patients can go while families are at work. Those who do not have 24-hour assistance post-rehab and lack the funds or insurance for an adult family home or assisted living facility, are stranded without adequate care. There are no quick solutions to these issues provided in the 2009-2012 Regional Plan; however, the Regional Council hopes to advocate for better resources for TBI patients through the newly-appointed Trauma Rehabilitation Representative to the West Region Council.

TRAUMA REHABILITATION

- Goal #16 -

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

<p>Objective 1. By January 2010 the Regional Council will integrate trauma rehabilitation information/issues into Regional Council meetings</p>	<p>Strategy 1. By September 2009, the Trauma Rehabilitation Representative will begin regular reports & updates to the Regional Council meetings.</p>
<p>Objective 2 By January 2010 the West Region Trauma Rehab Rep will identify a systematic approach to “fast-tracking” Medicaid-pending patients through the system.</p>	<p>Strategy 1. By January 2010 the Trauma Rehab Rep will contact appropriate personnel at the State Dept of Social and Health Services to gather information on how Medicaid applications are processed and assess the possibility of changes in order to expedite the process of getting active funding.</p>
<p>Objective 3. By June 2010 the Regional Council will review the minimum and maximum number (min/max numbers) of trauma rehabilitation services in the West Region and identify any gaps for regional planning.</p>	<p>Strategy 1. By January 2010 the Regional Council will review the assessment of trauma rehabilitation services conducted by the State and identify gaps specific to the West Region.</p> <p>Strategy 2. At the April 2010 West Region Council Retreat, the Trauma Rehabilitation Representative will organize stakeholders to review the minimum and maximum number of trauma rehab services in the West Region.</p> <p>Strategy 3. By June 2010 stakeholders will present the review of the min/max numbers and make a recommendation to the West Region Council</p>
<p>Objective 4. By April 2012 the West Region Trauma</p>	<p>Strategy 1. By September 2011 the Trauma Rehab Rep will identify stakeholders in the continuum of care and research services they can provide, to include but not limited to,</p>

<p>Rehabilitation Representative will identify community resources for traumatic brain injury (TBI) patients in the West Region.</p>	<p>Brain Injury Assoc of WA, Home & community Services, Skilled Nursing Facilities, Adult Day Health programs, Dept of Vocational Rehab and TACID.</p>
	<p>Strategy 2. By November 2011 the Trauma Rehab Rep will form a group of stakeholders to discuss the challenges faced and to assist in problem solving</p>
	<p>Strategy 3. By January 2012 the Trauma Rehab Rep will identify Regional/National resources for TBI patients</p>
	<p>Strategy 4. By April 2012 the Trauma Rehab Rep will provide a report to the West Region Council identifying community resources.</p>
<p>Objective 5. By November 2011 the West Region Trauma Rehab Rep will establish a task force to review funding for services needed for TBI patients. Research the possibility of carve outs, exceptional rates, grant funding that could be set aside for trauma patients to extend the continuum of care post-rehab to assist in discharging to the community.</p>	<p>Strategy 1. By November 2011 the Trauma Rehab Rep will identify members for the task force to assist in gathering of current funding available and assess the possibility of increased funding as described in the objective.</p>

SYSTEM EVALUATION

Introduction

The West Region Council is involved in the statewide effort to collect and manage prehospital data electronically through the Washington EMS Information System (WEMSIS). At this time agencies within the West Region collect and transmit data through different delivery systems; some are electronic and others are paper-based. The Regional Council signed a contract in 2008 to educate prehospital agencies in WEMSIS through regional mentors. Representatives of the Council attend the DOH EMS Registry TAC and regularly deliver reports to the Council on the planning and implementation of WEMSIS.

The West Region Quality Improvement Forum (QIF) evaluates the EMS and trauma system within the West Region, under the leadership of the designated facilities. This effort is in compliance with their responsibility for regional quality assurance as defined in WAC 246-976-910. The regional quality improvement plan was approved by DOH in May 1997 and revised in 2001 and 2002. The QIF completed its third revision of its plan in January 2009 to include a cardiac and stroke component to the regional QI/QA process. The January 2009 West Region Quality Improvement Plan is included in this document as Exhibit B.

Responsibility for the internal quality assurance/quality improvement presentations, individual case presentations, and education is shared among the designated trauma facilities and prehospital agencies at the QIF. The overall agenda is inclusive of the full continuum of care. There are three vital components at each meeting: 1)review of regional data and trends, 2)performance improvement project presentations, and 3)focused case reviews with directed discussion. The State Trauma Registry data presented enhances the efforts to improve trauma patient care and is utilized if system changes are needed. West Region Council representation to the forum includes the Council Chair and MPDs. The Regional Council office staff provides administrative and meeting support to meetings held five times a year.

County MPDs work with their local councils to provide oversight of QI for prehospital agencies. Councils have varying degrees of development in the QI process. The Pierce County EMS Council has a sub-committee which gives case presentations or topic review every month; they are revisiting their bylaws and will submit a QI plan for DOH approval within this plan period. Thurston County established monthly QI meetings in 2007 after state approval of its QI plan the same year.

The 2009-2012 West Region EMS & Trauma Care System Strategic Plan addresses the following needs:

- Develop, implement and begin monitoring system performance measures
- Regional quality improvement process for emergency cardiac and stroke care
- Quality improvement training available
- County quality improvement programs developed

SYSTEM EVALUATION

- Goal #17 -

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

Objective 1.
By December 2010 the Regional Council will implement and begin monitoring system performance measures developed by the WA State Department of Health.

Strategy 1. By June 2010 the WREMS Council will review the initial set of system performance measures developed by the WA State Department of Health.

Strategy 2. By December 2010 the WREMS Council will implement the performance measures developed by the WA State Department of Health.

Strategy 3. Begin development of a system performance measure monitoring process by December 2010.

SYSTEM EVALUATION

- Goal #18 -

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

<p>Objective 1.</p> <p>Annually in November 2009-11, the West Region Quality Improvement Forum (QIF) will review regional EMS and trauma data.</p>	<p>Strategy 1.</p> <p>Annually, in November of 2009, 2010 and 2011, the voting members of the West Region QIF will establish a yearly schedule of meetings to review regional EMS and trauma data and to allow for comprehensive system evaluation.</p>
<p>Objective 2.</p> <p>By June 2011, the West Region QIF will initiate a QI process for emergency cardiac and stroke care.</p>	<p>Strategy 1.</p> <p>By November 2010 the QIF voting members will have established a date, location, agenda and list of potential participants for the first QIF Cardiac/Stroke meeting.</p> <p>Strategy 2.</p> <p>By June 2011 the QIF voting members will have a cardiac/stroke care component to the West Region QIF established to review regional data, as available.</p>
<p>Objective 3.</p> <p>By May 2012, prehospital and hospital quality assurance/improvement training and education will be offered by the Regional Council.</p>	<p>Strategy 1.</p> <p>By September 2009, 2010 & 2011, 2011, the West Region Training, Education & Development (TED) Committee will determine the need for an annual QI/QA educational workshop at the West Region EMS Conference.</p> <p>Strategy 2.</p> <p>By May 2012, the Regional Council will identify other mechanisms for providing prehospital and hospital QI/QA training and education.</p>
<p>Objective 4.</p> <p>By May 2012, each West Region county will begin the process to establish a quality improvement (QI) program for EMS.</p>	<p>Strategy 1.</p> <p>By June 2010 the West Region TED Committee will review the status of county EMS QI programs within the West Region.</p> <p>Strategy 2.</p> <p>By January 2011 the West Region TED Committee will offer support and suggestions for establishing QI programs to those counties who wish to begin the process of establishing a QI program for EMS.</p> <p>Strategy 3.</p> <p>By May 2012, counties will begin the process to establish a QI program for EMS.</p>

APPENDICES

Appendix 1.

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

County (Name)	Verified Service Type	State Approved - <i>Minimum number</i>	State Approved - <i>Maximum number</i>	Current Status (Total # Verified for each Service Type within the whole county)
GRAYS HARBOR	Aid – BLS	9	12	11
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	4	6	3
	Amb – ILS	3	6	1
	Amb - ALS	6	6	6

County (Name)	Verified Service Type	State Approved - <i>Minimum number</i>	State Approved - <i>Maximum number</i>	Current Status (Total # Verified for each Service Type within the whole county)
LEWIS	Aid – BLS	8	21	2
	Aid –ILS	0	2	0
	Aid – ALS	0	2	0
	Amb –BLS	11	21	10
	Amb – ILS	1	6	2
	Amb - ALS	1	6	5

Appendix 1. (continued)

County (Name)	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
NORTH PACIFIC	Aid – BLS	3	4	1
	Aid – ILS	0	0	0
	Aid – ALS	0	0	0
	Amb – BLS	0	0	0
	Amb – ILS	0	0	0
	Amb - ALS	1	1	1

County (Name)	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
PIERCE	Aid - BLS Φ Ω	1	14	13
	Aid – ILS	0	0	0
	Aid – ALS Φ	0	10	0
	Amb-BLS Ω	1	11	9
	Amb – ILS	0	0	0
	Amb - ALS Ω	1	13	13

Φ Any current BLS agency may submit a variance request to upgrade to Aid-ALS.

Ω Any current Fire Department which provides EMS (city, town, county) may upgrade to Amb-ALS within their own jurisdiction. Any new application from an ambulance service must serve Buckley, PCFD #12, Eatonville, PCFD #15, Roy, McKenna, PCFD #17, Carbonado, Greenwater, PCFD #26, Ashford, Elbe, and PCFD #23.

Appendix 1. (continued)

County (Name)	Verified Service Type	State Approved - <i>Minimum number</i>	State Approved - <i>Maximum number</i>	Current Status (Total # Verified for each Service Type within the whole county)
THURSTON	Aid – BLS	8	8	7
	Aid – ILS	0	1	0
	Aid – ALS	0	1	1
	Amb – BLS	7	9	7
	Amb – ILS	0	1	0
	Amb - ALS	1	4	3

Appendix 2.

Trauma Response Areas by County

County (name)	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
Grays Harbor	# 1	Encompasses the geographic boundaries of GHFD # 1, GHFD # 5 and City of McCleary FD. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	A-2 F-1
Grays Harbor	# 2	Encompasses the geographic boundaries of GHFD # 2 and Montesano FD. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	
Grays Harbor	# 3	Encompasses the geographic boundaries of Aberdeen FD, Cosmopolis FD, Hoquiam FD, GHFD # 6, GHFD # 10, GHFD # 15, GHFD #17. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	A-5 F-2
Grays Harbor	# 4	Encompasses the geographic boundaries of South Beach Ambulance, Westport FD, GHFD # 3, GHFD # 11, GHFD # 14. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	A-3 F-1
Grays Harbor	# 5	Encompasses the geographic boundaries of Ocean Shores FD, Taholah FD, GHFD # 7, GHFD # 8, GHFD # 16. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	A-2 D-1 F-2
Grays Harbor	# 6	Encompasses the geographic boundaries of GHFD # 4 and Quinault Nation Ambulance. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	D-1

Appendix 2. (continued)

County (name)	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
Lewis	# 1	Within the current city limits of the <i>City of Centralia and urban growth area</i>	F-3
Lewis	# 2	Within the current boundaries of the <i>City of Chehalis and urban growth area</i>	A-1 F-1
Lewis	#3	Area 3 is located in the NW corner of Lewis County bordering Thurston County to the North, Grays Harbor County and Pacific County to the West, and on the South by an imaginary line proceeding due West from the intersection of US Highway 12 and I-5 and on the east by Interstate 5.	F-3 D-2 A-1
Lewis	# 4	Area 4 is bordered on the east side of Interstate 5, bordering Thurston County to the North and US Highway 12 to the south, the eastern border is the community of Mossyrock.	F-2 D-3
Lewis	# 5	Area 5 is located West of Interstate 5 and South of an imaginary line running west from US Highway 12 and Interstate 5 to Pacific Co, then South to Cowlitz County	F-1 A-1 D-2
Lewis	# 6	Area 6 is located East of Interstate 5 and North of the Cowlitz Co line bordering US Highway 12 to the North and Mossyrock to the East	F-1 D-4
Lewis	# 7	Area 7 is east from Mossyrock to Kiona Creek 5 miles west of Randle on Us Highway 12, then North to the Pierce Co line and South to the Cowlitz Co and Skamania Co line.	D-4
Lewis	# 8	East on US Highway 12 from Kiona Creek to the Summit of White Pass at milepost 151 at the Yakima Co line, south to the Skamania Co and Yakima Co lines and North to the Pierce Co line/Nisqually River including the Mt Rainier wilderness area.	D-2 B-2

Appendix 2. (continued)

County (name)	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
North Pacific	# 1	City of Raymond, City of South Bend, Pacific County FD # 3, # 6, # 7 & # 8 and all adjoining forest lands, both public and private. Encompasses FD # 5 to milepost 17 on Highway 105 and any adjoining forest lands, both public and private. Encompasses area of Pacific County in and around the community of Brooklyn in the northeast corner of Pacific County.	D-2 F-4
North Pacific	# 2	Pacific County FD # 4 including the community of Naselle and outlying areas to include adjoining forest lands, both public and private.	D-1 B-2 E-2

Appendix 2. (continued)

County (name)	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
Pierce	# 1	<p>Area #1 (North) Area 1 is bordered by Kitsap County in NE by an imaginary line running along 160th St east to Colvos Passage at water, then west along 160th St KPN to NW corner at Kitsap/Mason/Pierce counties border where the imaginary line goes south along 198th Ave KPN to water at Rocky Bay in Case Inlet to Thurston county border at Nisqually River at Nisqually Beach, then follows water line north to Chambers Creek Rd W, then east to Waller Rd, then north to River Rd, then east to Freeman Rd E, then north to Yuma St , then east to Meridian-Hwy 161 then north to an imaginary line bordering King County running west along 384th St through city of Milton to Pacific Hwy ,then north to a point at 7th St Ct NE where it runs NNW to a point at Water St in Dash Point. There it enters the water and crosses the Puget Sound to meet the point at Colvos Passage.</p>	A-4 D-4 F-9
Pierce	# 2	<p>Area #2 (South) Area 2 is bordered by Thurston County in SW at the Nisqually River at Nisqually Beach, then follows water line north to Chambers Creek Rd W, then along an imaginary line east to Waller Rd, then south along an imaginary line along Mountain Hwy to 260th, then west to 8th Ave E, then south along an imaginary line to Thurston county border at Nisqually River, then west along Nisqually River to Nisqually Beach.</p>	A-1 D-2 F-8

Pierce	# 3	<p>Area #3 (East)</p> <p>Area #3 is bordered by Thurston County in SW at a point where an imaginary line running south along 8th Ave E would then intersect the Nisqually River, it then follows the Nisqually River east to a Thurston, Pierce, and Lewis Counties junction at Hwy 7 in Elbe., then continues east along Nisqually River to Mt. Rainier Nat'l Park at end off Hwy 706 along imaginary line east to Yakima County border, then NE along imaginary line bordering Yakima, Kittitas, King, Pierce Counties junction at Green River, then west along Green Water River to junction with White River continuing NW along White River to a point in Muckleshoot Indian Reservation where the imaginary line goes along imaginary line along 1st Ave E west through Auburn, then along County Line west to 384th St west to Meridian-Hwy 161, then south to Yuma St, then west to Freeman, then south River Rd, then west to Waller Rd, then south along an imaginary line along Mountain Hwy to 260th, then west to 8th Ave E, then south along an imaginary line to Thurston county border at Nisqually River.</p>	<p>A-8 D-4 F-8</p>
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Appendix 2. (continued)

County (name)	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
Thurston	# 1	City of Olympia jurisdictional boundaries	D-2 F-3
Thurston	# 2	City of Tumwater jurisdictional boundaries and FD# 15	D-2 F-3
Thurston	# 3	City of Lacey jurisdictional boundaries and FD# 3 jurisdictional boundaries	D-2 F-3
Thurston	# 4	City of Yelm jurisdictional boundaries and FD# 2 jurisdictional boundaries	A-1 D-2 F-3
Thurston	# 5	City of Rainier jurisdictional boundaries and FD# 4 jurisdictional boundaries	A-1 D-2 F-3
Thurston	# 6	FD# 17 jurisdictional boundaries	D-3 F-3
Thurston	# 7	City of Tenino jurisdictional boundaries and FD# 12 jurisdictional boundaries	A-1 D-2 F-3
Thurston	# 8	Town of Bucoda jurisdictional boundaries	A-1 C-1 D-2 F-3
Thurston	# 9	FD# 16 jurisdictional boundaries	A-1 C-1 D-2 F-3
Thurston	# 10	FD# 1 jurisdictional boundaries	C-1 D-2 F-3

Appendix 2. (continued)

Thurston	# 11	FD# 5 jurisdictional boundaries	D-3 F-3
Thurston	# 12	FD# 6 jurisdictional boundaries	A-1 D-2 F-3
Thurston	# 13	FD# 7 jurisdictional boundaries	D-3 F-3
Thurston	# 14	FD# 8 jurisdictional boundaries	A-1 D-2 F-3
Thurston	# 15	FD# 9 jurisdictional boundaries	D-3 F-3
Thurston	# 16	FD# 11 jurisdictional boundaries	C-1 D-3 F-3
Thurston	# 17	FD# 13 jurisdictional boundaries	A-1 D-2 F-3

***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.

Appendix 3.

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

Level	State Approved		Current Status
	Min	Max	
II	2	3	2 (1 Joint)
III	1	6	3
IV	2	8	5
V	1	1	1
II P	1	1	1
III P	0	0	0

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

Level	State Approved		Current Status
	Min	Max	
II	3	4	2
III*	1	5	0

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

Appendix 4.
Patient Care Procedures (PCPs)
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**WEST REGION EMS & TRAUMA CARE COUNCIL
PATIENT CARE PROCEDURES**

WHO TO CONTACT

Grays Harbor and N. Pacific Counties

Medical Program Director	Daniel Canfield, DO	(360) 533 6038
Grays Harbor County EMS Council	Sharryl Bell	(360) 532 2067

Lewis County

Medical Program Director	Patrick O'Neill, MD	(360) 330 8516
Riverside Fire Authority	Mike Kytta, Assistant Chief	(360) 736 3975

Pierce County

Medical Program Director	Clark Waffle, MD	(253) 798 7722
Pierce County EMS Coordinator	Norma Pancake	(253) 798 7722

Thurston County

Medical Program Director	Joe Pellicer, MD	(360) 704 2787
Thurston County Medic One	Steve Romines	(360) 704 2783

Department of Health

Office of Health Systems Quality Assurance	Michael Lopez	(360) 236 2841
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To request additional copies

West Region EMS & Trauma Care Council	(360) 705 9019
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West Region EMS & Trauma Care Council Patient Care Procedures

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Patient Care Procedure #1

Medical Command at the Scene

OBJECTIVE

To define who is in medical command at the EMS scene, and to define line of command when multiple providing agencies respond.

PROCEDURE

The regional standard shall be for the incident command system to be used at all times. Per the incident command system, medical command will be designated by the incident commander. The medical commander should be the individual with the highest level medical certification who is empowered with local jurisdictional protocols.

Law enforcement will be responsible for overall scene security.

QUALITY ASSURANCE

Departure from this policy shall be reported to the MPD in the jurisdiction of the incident.

Patient Care Procedure #2

Responders & Response Times

OBJECTIVE

To geographically define urban, suburban, rural, & wilderness, and the required prehospital response time for those areas.

PROCEDURE

The regional standard for response times and responders shall be in accordance with current WAC 246-976-390 as follows:

Verified **aid services** shall meet the following minimum agency response times for response areas as defined by the department and identified in the approved regional plan:

- (a) To urban response areas: Eight minutes or less, eighty percent of the time;
- (b) To suburban response areas: Fifteen minutes or less, eighty percent of the time;
- (c) To rural response areas: Forty-five minutes or less, eighty percent of the time;
- (d) To wilderness response areas: As soon as possible.

Verified aid services shall provide **personnel** on each trauma response including:

- (a) Aid service, basic life support: At least one individual, first responder or above;
- (b) Aid service, intermediate life support: At least one IV/airway technician; or two individuals, one IV technician and one airway technician;
- (c) Aid service, advanced life support: At least one paramedic.

Verified **ground ambulance** services shall meet the following minimum agency response times for response areas as defined by the department and identified in the approved regional plan:

- (a) To urban response areas: Ten minutes or less, eighty percent of the time;
- (b) To suburban response areas: Twenty minutes or less, eighty percent of the time;
- (c) To rural response areas: Forty-five minutes or less, eighty percent of the time;
- (d) To wilderness response areas: As soon as possible.

Patient Care Procedure # 2 (continued)

Verified ambulance services shall provide **personnel** on each trauma response including:

- (a) Ambulance, basic life support: At least two certified individuals -- one EMT plus one first responder;
- (b) Ambulance, intermediate life support:
 - (i) One IV/airway technician, plus one EMT; or
 - (ii) One IV technician and one airway technician, both of whom shall be in attendance in the patient compartment, plus a driver;
- (c) Ambulance, paramedic: At least two certified individuals -- one paramedic and one EMT.

IMPLEMENTATION

Per WAC 246-976-430, each prehospital agency is responsible for collecting and submitting response time documentation within its response area through the State Trauma Registry.

QUALITY ASSURANCE

The response times and all agencies that do not meet the state standard will be reviewed by the West Region Quality Improvement Forum as reported by the State Trauma Registry. Response times will be tracked over a two-year period and the standards reevaluated based on input from the MPDs and responder agencies. Per WAC 246-976-440, the Department of Health shall provide registry reports to all providers that have submitted data.

Patient Care Procedure #3

Medical Control - Trauma Triage/Transport

OBJECTIVES

To define the anatomic, physiologic, and mechanistic parameters mandating trauma systems inclusion.

To define the anatomic, physiologic, and mechanistic parameters mandating designated trauma facility team activation.

PROCEDURES

Prehospital Trauma Triage-

Prehospital assessment of injured patients for triage into the trauma system and designated trauma facility team activation will be based on the current approved State of Washington Prehospital Trauma Triage (Destination) Procedures.

Patients that meet trauma triage procedures criteria shall be transported to a designated facility as directed by the triage procedures (see Appendix B).

Pediatric trauma patients will be transported to designated pediatric trauma facilities as directed by the trauma triage procedures (see Appendix B). Where appropriate the patient may be directed to the nearest appropriate designated trauma center for stabilization and physician evaluation. This may be done by ground or air.

Consider transport of unstable patients to nondesignated facilities capable of appropriately stabilizing the patient's medical needs prior to interfacility transfer of trauma patients to designated trauma facilities. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.

County procedures that provide direction to field personnel regarding options when a potential destination facility is on divert are provided in Appendix C: County and Designated Trauma Facility Divert Policies.

Patient Care Procedure #3 (continued)

Medical Control-

Medical control will be contacted when possible for all trauma patients as defined above. When BLS/ALS responds, medical control contact should be made as early as possible by BLS/ALS ground personnel for the purpose of medical control and to confirm transport destination. Steps 1 and 2 require prehospital personnel to notify medical control and activate the Trauma System. Activation of the Trauma System in Step 3 is determined by medical control. Patients will be identified by applying orange trauma band to wrist or ankle. Data collection will be coordinated through band identification.

PHI or Equivalent-

Designated facilities will calculate PHI or an equivalent. Pediatric facilities will calculate pediatric trauma score.

IMPLEMENTATION

As of March 1, 1996, the region will utilize the resources of designated trauma facilities as they are designated within the region.

Providers will transport trauma activation patients according to the regional trauma facility designation plan as the plan is implemented.

QUALITY ASSURANCE

Per WAC 246-976-430, each prehospital agency is required to participate in the state data system by submitting documentation through the State Trauma Registry on all patients entered into the trauma system. The West Region Quality Improvement Forum will review trauma team activation and surgeon activation, as reported by the State Trauma Registry. This will include procedures and guidelines.

Medical controls will keep accurate recorded communications (log book or tape) for auditing as needed by local communication boards/local EMS councils and MPDs. Departure from this policy will be reported to the West Region Quality Improvement Forum.

Patient Care Procedure #4

Air Transport Procedure

OBJECTIVES

To define who may initiate the request for onscene emergency medical air transport services.

To define under what circumstances nonmedical personnel may request air transport onscene service.

To define medical control/receiving center communication and transport destination determination.

To reduce prehospital time for transport of trauma patients to receiving facility.

PROCEDURE

Any public safety personnel, medical or nonmedical, may call to request onscene air transport when it appears necessary and when prehospital response is not readily available. This call should be initiated through dispatch services. In areas where communications with local dispatch is not possible/available, direct contact with the air transport service is appropriate.

Air ambulance activation requires appropriate landing zones are available at or near the scene and at the receiving facility. Consider air transport when:
1) Hoisting is needed; 2) Helicopter transport will reduce the prehospital time to the greatest extent regarding the trauma triage procedures requirements. Do not consider air transport when transport by helicopter to the receiving facility exceeds 30 minutes and exceeds the time for ground transport to another designated trauma or appropriate receiving facility. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility as needed. See Appendix D or most current Washington State list of designated trauma care service facilities. Activation of the helicopter does not predetermine the destination.

Steps 1 and 2 require prehospital personnel to notify medical control and activate the trauma system. Activation of the trauma system in Step 3 is determined by medical control.

When BLS/ALS responds, medical control contact should be made as early as possible by BLS/ALS ground personnel for the purpose of medical control and to confirm transport destination. The medical control should contact the receiving facility.

Patient Care Procedure #4 (continued)

When the use of a helicopter is believed by the field personnel to be the most expeditious and efficacious mode of transport, contact of local online medical control and activation of the trauma system will be concurrent to the activation of the helicopter.

Medical control will consider the following in confirming patient destination: location, ETA of helicopter, availability of ground transportation, proximity of other designated trauma receiving centers, their current capabilities and availability.

The air transport service is responsible for communicating to the initiating dispatch center the estimated time of arrival and significant updates as necessary. Air transport services are subject to their own protocols for appropriate activation. Air transport must contact the initiating dispatch center if unable to respond.

QUALITY ASSURANCE

The West Region Quality Improvement Forum will review reports by air transport agencies of launches including cancels, transports, and destinations, as provided by the State Trauma Registry.

Patient Care Procedure #5

Hospital Resource - Interfacility Transfer

OBJECTIVE

To establish recommendations for transport of patients from one designated trauma facility or undesignated medical facility to a designated trauma facility, consistent with established West Region guidelines.

PROCEDURE

All interfacility transfers will be in compliance with current OBRA/COBRA regulations.

Major trauma patients that were transported to undesignated trauma facilities for the purposes of stabilization and resuscitation must be transferred to a designated trauma facility.

The transferring facility must make arrangements for appropriate level of care during transport.

The receiving center must accept the transfer prior to the patient's leaving the sending facility.

The receiving medical provider (physician) must accept the transfer prior to the patient's leaving the sending facility.

All appropriate documentation must accompany the patient to the receiving center.

The transferring physician's orders will be followed during transport as scope of provider care allows. Should the patient's condition change during transport, the sending physician, if readily available, or nearest medical control should be contacted for further orders.

Prehospital protocols from county of origin will be followed during the transport.

To the extent possible, a patient whose condition requires treatment at a higher level facility should be transferred to an appropriate facility within the region.

Patient Care Procedure # 5 (continued)

The destination medical center will be given the following information:

- Brief history
- Pertinent physical findings
- Summary of treatment
- Response to therapy and current condition

Further orders may be given by the receiving physician.

TRAINING

Hospital personnel will be oriented to regional transfer requirements and familiarized with OBRA requirements.

QUALITY ASSURANCE

The numbers of and reasons for interfacility transfers will be reviewed by the West Region Quality Improvement Forum as needed, based on data reports supplied by the State Trauma Registry. Inclusion indicators will be developed by the Forum in accordance with state and federal guidelines, as well as regional standards.

Patient Care Procedure #6

Prehospital Report Form

OBJECTIVE

To define the regional requirements for reporting prehospital patient data.

PROCEDURE

All Patient Care Reports shall be consistent with the requirements specified in **WAC 246.976.330**. Furthermore; the Regional Standard for reporting Trauma Patient Data shall be consistent with **WAC 246.976.430**.

All completed patient care forms will include the following information:

Names and certification levels of all personnel;

Date and time of medical emergency;

Age of patient;

Applicable components of system response time as defined in WAC 246.976.330;

Patient vital signs;

Procedures performed on the patient;

Mechanism of injury or type of illness;

Patient destination;

Any patients meeting the criteria as defined in **WAC 246.976.930** Washington Trauma Triage Procedures will be Trauma Banded by the transporting agency. The transporting agency will report additional Trauma Data elements to the receiving facility within 10 days as described in **WAC 246.976.430**.

Copies of Prehospital Patient Care Forms shall be distributed as follows; one copy to the receiving facility, the original copy should be retained by the prehospital provider, and one copy should be made available to County Medical Control or MPD for review.

Patient Care Procedure #7

EMS/Medical Control - Communications

OBJECTIVES

To define methods of expedient communication between prehospital personnel and medical control and receiving centers.

To define methods of communication between medical controls and regional designated trauma facilities and other facilities.

PROCEDURE

Communications between prehospital personnel and medical controls and receiving medical centers will utilize the most effective communication means to expedite patient information exchange.

IMPLEMENTATION

The State of Washington, the West Region EMS & Trauma Care Council, and regional designated trauma facilities will coordinate with prehospital and hospital EMS providers to create the most effective communication system based on the EMS provider's geographic and resource capabilities. Communication between the EMS prehospital provider and the receiving center can be direct (provider to center) or indirect (provider to medical control to designated trauma facility). Local medical control will be responsible for establishing communication procedures between the prehospital provider(s) and receiving hospital(s).

QUALITY ASSURANCE

Significant communication problems affecting patient care will be investigated by the provider agency and reported to the West Region Quality Improvement Forum for review. The agency will maintain communication equipment and training needed to communicate in accordance with WAC.

The West Region Quality Improvement Forum will address the issues of communication as needed.

Patient Care Procedure #8

EMS All Hazards-Mass Casualty Incident (MCI) Response

OBJECTIVES

To provide direction for the use of appropriate emergency medical care procedures, while in an all hazards environment, that is consistent with the Washington State DOH "Mass Casualty-All Hazards Field Protocols" as well as those protocols established by the County Medical Program Director (MPD).

To provide for the standardization/integration of Mass Casualty Incident (MCI) Plans between counties throughout the West Region.

To enhance the response capability of EMS agencies between counties throughout the West Region during an All-Hazards-MCI incident.

PROCEDURE

Pre-hospital EMS responders will follow, at a minimum, the Washington State DOH "Mass Casualty-All Hazards Field Protocols" during an All Hazards-MCI incident. Prehospital EMS responders will additionally follow any other All Hazards-MCI protocols/procedures set forth by the County Medical Program Director.

The **General EMS All Hazards-Mass Casualty Incident (MCI) Algorithm** follows:

IMPLEMENTATION

The West Region EMS & Trauma Care Council, Regional Disaster Medical Control Center Hospitals, and EMS agencies throughout the West Region will coordinate to plan the most effective response to an All Hazards-Mass Casualty Incident based on the EMS provider's geographic and resource capabilities. Local medical control and/or emergency management and dispatch agencies will be responsible for communicating and coordinating needs between the prehospital provider agencies and the Incident site(s) during an actual event.

TRAINING

In coordination with the county MPDs and EMS directors, the following will be distributed to the regional EMS agencies:

- a. Mass Casualty-All Hazards Field Protocols website address:
www.doh.wa.gov/emstrauma,
- b. West Region Patient Care Procedure # 8, All Hazards-Mass Casualty Incident Response,
- c. Weapons of Mass Destruction Awareness Level web-based or face-to-face training on signs and symptoms AWR160 www.hsi.wa.gov or www.training.fema.gov

- d. Advanced Burn Life Support:
<http://www.ameriburn.org/ABLS/ABLSENow.htm>
- e. WMD Emergency Medical Services Training (EMS) face-to-face at
<http://cdp.dhs.gov/coursesems.html>
- f. Provide burn care training to EMS providers at the annual West Region EMS Conference.
- g. FEMA's NIMS training link: <http://www.training.fema.gov/NIMS/>

QUALITY ASSURANCE

Significant problems affecting patient care will be investigated by the provider agency(ies) and reported to the West Region Quality Improvement Forum for review. A Regional After Action Review will be conducted post an All Hazards – Mass Casualty Incident to identify issues to resolve prior to any subsequent event.

Prehospital Mass Casualty Incident (IC) General Algorithm

Receive dispatch

Respond as directed

Arrive at scene & Establish Incident Command (IC)

Scene Assessment and size-up

Determine if mass casualty conditions exist

Implement county MCI plan

Request additional resources as needed

The dispatch center shall coordinate notification and dispatch of required agencies and resources including notification of the appropriate Disaster Medical Control Hospital (DMCH). The appropriate local Public Health Department shall be notified in events where a public health threat exists.

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

Initiate START

Reaffirm additional resources

Initiate ICS 201 or similar NIMS compliant worksheets

Upon arrival at medical facilities, transfer care of patients to medical facility staff (medical facility should activate their respective MCI Plan as necessary).

Prepare transport vehicle to return to service

Appendix 5.
July 2009- June 2012 Regional Plan Gantt Chart

APPENDICES - ADDITIONAL

Appendix A.

Pierce County Operating Procedure – Trauma Triage Tool

Appendix B.

West Region Quality Improvement Plan

PIERCE COUNTY PREHOSPITAL TRAUMA TRIAGE (DESTINATION) PROCEDURES

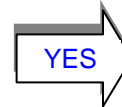
- Prehospital triage is based on the following 3 steps: Steps 1 and 2 require prehospital EMS personnel to notify medical control and activate the Trauma System. Activation of the Trauma System in Step 3 is determined by medical control**

STEP 1

ASSESS VITAL SIGNS & LEVEL OF CONSCIOUSNESS

- Systolic BP < 90°
 - HR > 120°
 - for pediatric (< 15y) pts. use BP < 90 or capillary refill > 2 sec.
 - for pediatric (< 15y) pts. use HR < 60 or >120
- Any of the above vital signs associated with signs and symptoms of shock and/or
- Respiratory Rate <10 > 29 associated with evidence of distress and/or
 - Altered mental status

**If prehospital personnel are unable to effectively manage airway, consider rendezvous with ALS, or intermediate stop at nearest facility capable of immediate definitive airway management.



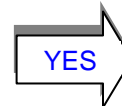
1. Take patient to the nearest Level I or Level II trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures.*



STEP 2

ASSESS ANATOMY OF INJURY

- Penetrating injury of head, neck, torso, groin; OR
- Combination of burns \geq 20% or involving face or airway; OR
- Amputation above wrist or ankle; OR
- Spinal cord injury; OR
- Flail chest; OR
- Two or more obvious proximal long bone fractures.



2. Apply "Trauma ID Band" to patient.

*Burns & amputations transported to Harborview Medical Center



STEP 3

ASSESS BIOMECHANICS OF INJURY AND OTHER RISK FACTORS

- Death of same car occupant; OR
- Ejection of patient from enclosed vehicle; OR
- Falls \geq 20 feet; OR
- Pedestrian hit at \geq 20 mph or thrown 15 feet
- High energy transfer situation
 - Rollover
 - Motorcycle, ATV bicycle accident
 - Extrication time of \geq 20 minutes
- Extremes of age < 15 or > 60
- Hostile environment (extremes of heat or cold)
- Medical illness (such as COPD, CHF, renal failure etc.)
- Second/Third trimester pregnancy
- Gut feeling of medic

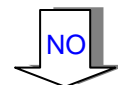
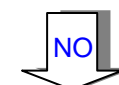


CONTACT
MEDICAL
CONTROL FOR
DESTINATION
DECISION

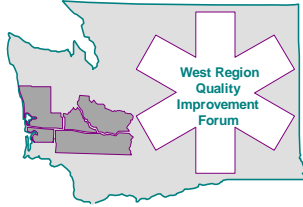


1. Take patient to the nearest appropriate trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures.

2. Apply "Trauma ID Band" to patient.



TRANSPORT PATIENT PER REGIONAL PATIENT CARE PROCEDURES



WEST REGION QUALITY IMPROVEMENT PLAN

Mission Statement

Continuously strive to optimize
Trauma/EMS patient care and outcome through the continuum
of care.

Revised January 15, 2009

Administrative Support Provided by
West Region Emergency Medical Services & Trauma Care Council, Inc.
Proudly Serving Grays Harbor, Lewis, N. Pacific, Pierce and Thurston Counties
2646 RW Johnson Blvd, Suite 112, Tumwater, WA 98512

WEST REGION QUALITY IMPROVEMENT PLAN

360-705-9019 • 1-800-546-5416 • FAX: 360-705-9676 • www.wrems.com

Approved: May 12, 1997
Revised: March 15, 2001
2nd Revision: December 12, 2002
3rd Revision: January 15, 2009

WEST REGION QUALITY IMPROVEMENT PLAN

Mission Statement

**Continuously strive to optimize
Trauma/EMS patient care and outcome through the continuum of care.**

GOAL: EVALUATE & IMPROVE PATIENT CARE THROUGH THE USE OF COMPREHENSIVE, DATA-DRIVEN QUALITY IMPROVEMENT PROCESSES.

1. Collect Accurate, Timely Data

Accurate, timely data is an essential prerequisite to effective quality improvement.

1.a. Patient Care Analysis

QI reviews should include all aspects of patient care from prevention, pre-hospital, hospital and through rehabilitation

2. Analyze Patterns and Trends of Regional Trauma, EMS & Cardiac/Stroke Care

Compare similarities and differences between West Region and other regional, state and national models.

2.a. Assess Patient Flow Patterns

A special concern of West Region is trauma patient flow patterns as well as inter-facility transfers and methods of transport. Ongoing monitoring will be required to provide data for consideration of additional (or fewer) designated trauma centers or when verified cardiac/stroke facilities are available.

2.b. Compare Similar Hospital/Agency Outcomes

Case review requires objective comparisons with similar institutions within the region, state or nationally. In addition, a benchmark is used when available to which comparisons can be made.

2.c. Analyze Individual Cases of Trauma, EMS & Cardiac/Stroke Care

Highlighting the trends and patterns with individual case review. This will provide a specific focus for improvements and changes, as well as affording the opportunity to discuss individual cases.

3. Action Plan/Loop Closure

3.a. Washington State Department of Health

Provide communication on patterns and trends of regional trauma, EMS & Cardiac/Stroke care through the West Region QIF or appropriate agency.

3.b. Opportunities for Improvement

Recommend opportunities for improvement to the training or prevention committee of the West Region Council to disseminate among West Region agencies/facilities.

3.c. Loop Closure

Cases sent to the QIF for review and recommendation require follow-up with action taken at the next meeting. Based upon information learned, key teaching points from each forum may be disseminated.

WEST REGION QUALITY IMPROVEMENT PLAN

PRINCIPLES

- **Trauma Center Leadership**

As described in WAC 246-976-910 (2) and RCW 70.168.090 (2): Levels II, and III trauma care facilities shall establish and participate in regional EMS/TC systems quality improvement programs. West Region QIF encourages full participation from all West Region hospitals.

- **System Analysis**

This is intended to be a process for continuous quality improvement of the regional system of trauma care throughout the age continuum. It is not intended to duplicate or supplant quality improvement programs of prehospital agencies, individual hospitals or rehabilitation units involved in regional trauma care. The state Trauma Registry will provide accurate data to assess regional performance as well as individual provider/agency performance.

- **Confidential Case Review & Education**

Effective identification, analysis and correction of problems require objective review by qualified, appropriate members of trauma care programs, protected by a process which ensures confidentiality. The approach used by the QIF will be standard case review profiling and issue for education and/or process improvement.

WEST REGION QUALITY IMPROVEMENT PLAN

PROCESS

TRAUMA QIF MEMBERSHIP

The West Region QIF membership includes the following voting & non-voting members and is consistent with WAC 246-976-910(3) & (4)

Voting Members:

Trauma Medical Director from each designated trauma and trauma rehabilitation center
Trauma Program Managers from each designated trauma and trauma rehabilitation center
Medical Program Director (MPD) from each county - total 4
Emergency Department Representative from each designated trauma center (director or designee)
EMS representative (field provider preferred) - 3 from each county
CQI Representative – 1 prehospital and 1 hospital from each county
Regional EMS Council Chair
Regional Injury Prevention Representative: 1 pediatric and 1 adult
Regional Aero Medical Provider

**Any of the above members may be replaced by an official designee from the represented facility or agency.*

Non-voting Members:

State Department of Health Staff
Appropriate medical specialists as needed and determined by QIF voting members
Non-designated facility representatives
EMS Coordinator/Director from each county
Regional Council staff member

Quorum: A quorum shall consist of a minimum of 10 voting members at the beginning of the meeting and will continue as long as 6 or more voting members remain.

- **Confidentiality**

Actions of the QIF are confidential as provided in WAC 246-976-910 (5)(e)(f)(g)(h) and protected by RCW 43.70.510 and chapters 18.71, 18.73, and 70.168. *See Attachment A.* A written plan for confidentiality is required. *See Attachment B.* Notification in writing of the confidentiality of each meeting is required. Information identifying individual patients cannot be publicly disclosed without patient consent.

WEST REGION QUALITY IMPROVEMENT PLAN

- **Regional QA meetings**
 - Frequency: 5 meetings per year
 - Chairperson and 2 Vice Chairs: 3 year position elected by the majority of voting members (preferred structure: Chair = MD)
 - 3 hours in length

- **Components to meeting:**
 - Review of regional data and trends
 - Performance Improvement (PI) Project Presentation
 - Focused case(s) review with directed discussion
 - Next QIF meeting goals and targets
 - Yearly process/injury focus will be identified at the last QIF meeting of the year.
 - Selection of goals and objectives for Cardiac/Stroke meetings will be identified annually.

- **Summary Conclusions and Reporting**

The Chairperson is responsible for providing summary conclusions of discussions. Provisions must be provided for feedback to the Department of Health and the West Region EMS & Trauma Care Council on identified EMS and trauma care issues and concerns.

WEST REGION QUALITY IMPROVEMENT PLAN

DETAILS

Component 1: Review of regional data and trends

- The state Department of Health Trauma Registry shall provide a focused report on issues/filters as requested.

Component 2: Performance Improvement Project Presentation

Presentation will include following points:

- Problem identification
- Process changes
- Implementation process
- Evaluation
 - Lessons learned

Component 3: Focused cases reviews:

Designated agencies present injury or process specific case reviews as assigned by the committee. Cases will be not exceed 60 minutes and include:

- Continuum of care from dispatch through rehabilitation
- Major players involved be present or available for questions and discussion
- Audio-visual aids
- Topics from case for discussions
- Lessons learned

Component 4: Identification of next quarter's meeting goals and targets

WEST REGION QUALITY IMPROVEMENT PLAN

ATTACHMENT A

WEST REGION QUALITY IMPROVEMENT FORUM

**QI FORUM MEMBERS AND GUESTS
CONFIDENTIALITY AGREEMENT**
in accordance with RCW 70.168.090(3) and (4)

The undersigned attendees of the QI Forum meeting held (date) , agree to hold in strict confidence all information, data, documentation, and discussions resulting from this meeting, and subsequently documented in meeting minutes. No information will be disclosed to parties outside this QI Forum, except as agreed to by the attendees for the purposes of follow-up, resolution or systems design changes. Failure to observe this agreement will result in dismissal from the Forum and possible personal liability.

First Name	Last Name	Title	Job Title	Agency	Signature

WEST REGION QUALITY IMPROVEMENT PLAN

ATTACHMENT B

West Region Quality Improvement Plan Confidentiality and Exemption from Discoverability Policy and Procedures January 2009

Policy

It is the intention of the West Region Quality Improvement Forum (QIF) to use the information gathered to support clinical research and improve patient care through improved systems performance. It is necessary that providers have protection from discoverability and possible liability to reach that end.

Pledge of Confidentiality

All attendees of the QIF will sign a pledge of confidentiality which will also act as a record of attendance. At each meeting the pledge of confidentiality will be read into the minutes. (See Att A).

Documentation

Patient records will be identified by the unique Trauma Registry identifier. Patient information cannot be publicly disclosed without written permission of the patient or guardian. All QIF handouts shall be labeled "Confidential QI Document/Privilege Information/Not Authorized for Distribution." All confidential documents will be collected at the end of the meeting, and all copies will be destroyed following the meeting. One permanent copy will be kept in a locked cabinet.

Minutes

Minutes from QIF meetings will be prepared by the West Region EMS staff. Minutes will be reviewed and approved by the members. One copy of the minutes will be kept for the purpose of record by the West Region EMS, and its staff will be responsible for collecting and destroying all documents following the meeting. Retention schedule for minutes will be 4 years. The one permanent copy will be kept in a locked cabinet. Any case specific information presented during QIF meetings will be held in strict confidence among those attending the meeting. All identifying references to specific cases will be omitted from meeting minutes.

Reports

A report will be generated to summarize significant findings of the materials reviewed in the QIF meeting. The summary report will be modified to scrub information that might identify individuals or agencies involved in the QI review. Names, dates, times and situations may be modified to prevent loss of confidentiality while communicating intent of the finding(s). The QIF will approve the summary report (redacted meeting minutes) before it is released external to the QIF.

Educational Learning Points

Key learning points will be generated from a review of QI Forum reports and case presentations. To close the loop between quality improvement and training, this information will be distributed to field and in-hospital EMS providers to assist with education and training. All information will be carefully scrubbed to eliminate individual or agency identifiers.

Access to Information

All members of the QIF, and those who have been invited to attend by members of the forum, have access to view or discuss patient, provider, and systems information when the patient and the provider's identifying information has been obscured. It is the obligation of the attendees to keep all information confidential and to protect it against unauthorized intrusion, corruption, and damage.

WEST REGION QUALITY IMPROVEMENT PLAN

ATTACHMENT B

West Region Quality Improvement Plan TEMPLATE FOR CASE REVIEWS

December, 2002

I. WRQIF Case Review

- *Name of presenter*
- *Name of agencies represented*
- *Date*

II. Topic

- *Question or issue to be addressed with this case review*

III. Scene/Background Information

IV. EMS Findings/Interventions

- *Description of Pt*
- *Vital Signs*
- *Interventions*

V. ED Interventions/Findings

- *Vital Signs*
- *Interventions*
- *Findings*
- *Injury List*
- *Consults*
- *Pt Disposition*

VI. Hospital Course

- *Length of Stay*
- *Surgeries*
- *Other Injuries/Procedures Done*
- *Cost*

VII. Rehab (if appropriate)

VIII. Outcome

- *Discharge Status*
- *Current Update on Pt Outcome*

Approved: May 12, 1997
Revised: March 15, 2001
2nd Revision: December 12, 2002
3rd Revision: January 15, 2009