NORTH CENTRAL
EMERGENCY CARE COUNCIL
ADVOCACY & EDUCATION

NORTH CENTRAL REGION EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

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

July 1, 2021 – June 30, 2023

Submitted by the North Central Region EMS and Trauma Care Council

Approved by EMS & Trauma Steering Committee *May 2021*

CONTENTS

INTRODUCTION

The North Central Region is comprised of Chelan, Douglas, Grant and Okanogan Counties of Washington State. The region covers 12,813 square miles with a population of approximately 261,871 residents. The region is rural in nature, with the Greater Wenatchee and Moses Lake areas being the largest population demographic. There are 48 Licensed and Trauma Verified aid, ambulance, and Emergency Service Support Organization (ESSO) response agencies within North Central Region; the region has 747 certified EMS providers, with 44% of those being volunteer.

- Chelan County is on the eastern slopes of the Cascade Mountain range. The county covers 2,921 sq. miles with a population of 77,280, it is the third largest county by area in WA State. The county has 15 EMS agencies with 275 EMS providers; of which 47%are volunteer. Chelan County has one BLS Aid agencies, four BLS Ambulance agencies, four BLS Verified agencies, two ESSO agencies, and four ALS agencies that provide ALS rendezvous to neighboring towns.

- Douglas County is located near the geographic center of WA State. The county covers 1,820 sq. miles and has a population of 43,429. The county has 5 EMS agencies with 64 EMS providers; of which 71% are volunteer. Douglas County has two BLS Verified Aid agencies, three BLS Verified Ambulance agencies, zero ALS agencies, and depends on ALS rendezvous from neighboring cities.

Chelan and South Douglas County share one Medical Program Director due to ALS rendezvous and patient transport patterns. The Local Council for Chelan S. Douglas County is the Greater Wenatchee Local Council. The North Central Region maintains a regional website and provides access to county council and MPD information. http://ncecc.net/chelan-s-douglas-county/

- Grant County covers 2,791 sq. miles and has a population of 97,733. The county has 18 EMS agencies with 265 EMS providers; of which 35% are volunteer. Grant County has one BLS Aid agency, six BLS Verified Aid agencies, eight BLS Verified Ambulance agencies, and 3 ALS Agencies that provide ALS rendezvous to neighboring towns.

The Local Council for Grant County is the Grant County EMS & TCC. The North Central Region maintains a regional website and provides access to county council and MPD information. http://ncecc.net/grant-county/

- Okanogan County is located along the Canada-Us Border. The county covers 5,281 sq. miles, making it the largest county in WA State, and has a population of 42,132. The county has 10 EMS agencies with 143 EMS providers; of which 47%

are volunteer. Okanogan County has one BLS Aid agency, four BLS Verified Aid agencies, one ILS Verified Ambulance agency, one ESSO agency, and 2 ALS agencies that provide ALS rendezvous to neighboring towns.

Okanogan and North Douglas County share one Medical Program Director due to ALS rendezvous and patient transport patterns. The Local Council for Okanogan N. Douglas County is the Okanogan N. Douglas County EMS & TCC. The North Central Region maintains a regional website and provides access to county council and MPD information. http://ncecc.net/n-okanogan-douglas-county/

The North Central Region EMS and Trauma Care Council website, www.ncecc.org, provides information to the regions agencies, MPDs, county councils, instructors, and other system partners.

Rural EMS agencies continue to face a challenge in recruitment and retention of volunteer providers with an aging volunteer population and increasing costs for initial courses. At this time there is no trauma response area identified by Local Councils and Department of Health without EMS coverage. Agencies are struggling with licensure requirements for each county they operate in which does not accurately reflect true numbers of aid or ambulances responding in each county.

The North Central Region Council was established as part of the Emergency Medical Service (EMS) and Trauma Care System Legislation in 1990. Washington State regulations require Council membership to be comprised of Local Government, Prehospital, and Hospital agencies. Additional positions can be Medical Program Directors, Law Enforcement, Federally recognized Tribes, Dispatch, Emergency Management, Local Elected Official and Consumers. Regulations allow counties to have local EMS & Trauma Care Councils and provide EMS & Trauma System leadership. Local County membership parallels the membership of the Region Council. The Local Councils provide input and recommend membership to represent their local EMS & Trauma System on the Region Council. The North Central Region's Local Councils include: Greater Wenatchee EMS Council (Chelan & South Douglas Counties), Okanogan/North Douglas EMS Council (Okanogan and North Douglas Counties), and Grant County EMS Council.

The North Central Region Council and East Region Council have successfully consolidated administrative services via contract since July 2013. This consolidation has reduced duplication of administrative services, significantly reducing expenses. It also allows both regions to accomplish the work of the DOH contract while maintaining the same level of system support.

Medical Program Directors (MPD) are physicians recognized to be knowledgeable in their county's administration and management of pre-hospital emergency medical care and services. Medical Program Directors (MPD) are physicians certified by the

Department of Health to provide oversight of EMS providers. MPD duties are described in WAC 246-976. MPDs must supervise and provide medical control and direction of certified EMS personnel. This is done verbally and by developing written protocols directing patient care. MPDs must participate with the local and regional EMSTC Councils to develop and revise regional plans.

The Region Council has adopted the following DBA name, mission and motto that are incorporated into the regional planning process and vision for the future of North Central Region.
DBA Name: North Central Emergency Care Council

Mission: To Promote and Support a Comprehensive Emergency Care System"
Vision: "Getting the Right Patient, to the Right Place in the Right Amount of Time"

The North Central Region Council's Strategic EMS & Trauma Care System Plan is comprised of goals adapted from the State Strategic EMS & Trauma Care System Plan. The Region Council utilizes input and recommendations from the local council representatives and stakeholders to meet the goals of the State and Region through development of applicable objectives and strategies.

The North Central Region Council has established committees and workgroups to address Recruitment and Retention, Education for EMS Providers, Injury and Violence Prevention, and Public Information:

- Executive Committee: Comprised of the Council President, Vice President, Treasurer, Secretary, and the Chair of any standing Committee. Provides oversight of Administration and governance of the Region Council.

- Training and Education Committee: Comprised of members of the Region Council, Local Councils, and Training Program Coordinators, to review regional training needs, develop regional training programs based on the needs assessment, and quality improvement for training, and education to improve patient outcomes.

- North Central Region QI Committee: Comprised of members of each designated facility's medical staff, the RN Coordinator of each service, EMS Providers, Medical Program Directors, and Region Council members. The Mission of the North Central Region QI Committee is "strives to optimize Emergency Systems of Care through a collaborative multidisciplinary approach to improve patient outcomes."

- Community Paramedicine/ Mobile Integrated Healthcare Workgroup: Comprised of members of the Region Council, Local Councils, Medical Program Directors, Critical Access Hospital, Hospital Based EMS Agencies, Emergency Room Trauma Coordinators, and other system stakeholders who participate in State and National Initiatives for a community based Paramedicine and/or Mobile Integrated Healthcare System that promotes collaboration of healthcare partners within the North Central Region to address community challenges for care and/or transport of patients.

  This workgroup participates with the North Central Accountable Communities of Health Partners and the Washington Rural Health Association to establish a collaborative effort in the development of an affordable, efficient, and comprehensive community-based system.

The North Central Region Council has had a number of successes during the 2019-2021 planning period:

- Accomplished the work outlined in the 2019-2021 strategic plan including the review of min/max numbers, trauma response area maps, and review of agency information provided by the Department of Health.
- Completed Council roles and responsibilities education required by the State of Washington for Councils.
- Completed State Assessment Audits of financial accountability without findings.
- Provided leadership assistance to Local Councils addressing strategic planning, licensure, certification, financial documentation, and council structure.
- Provided training grants to Local Councils for provider requested training specific to their county needs that included ongoing training required for recertification, COVID-19 related expenses for training, equipment, and PPE, EMS training equipment, partial funding of Initial EMS Courses, and EMS Evaluator renewal courses.
- Provided online format for EMS education, Local Council meetings, and COVID-19 MPD led meetings.
- Collaborated with regional MPD's on development of a regional set of MPD Protocols. This project will benefit providers who work in more than one county within the region and provide consistent patient care across Chelan, Douglas, Okanogan, and Grant Counties.
- Maintained status of the Department of Health approved Training Program for initial EMS courses and EMS course support to Instructors. The Training Program works closely with the Senior EMS Instructors, EMS Evaluators, Lead Instructors, and MPD's to ensure quality courses are provided consistent with National Education Standards and WAC.

- Provided funding to Injury Prevention Partners for continuation of programs that address senior falls, bicycle safety, child passenger safety, distracted driving, driving under the influence, AHA CPR/First Aid, and AED training, and babysitting safety for the child and sitter.
- Participated in Regional Advisory Committee, Prehospital TAC, Rule Making, EMS Education Workgroup, and attended State Steering Committee meetings.
- Continued Administrative Services contract with East Region EMS & Trauma Care Council, decreasing administrative cost and allowing more funding towards programs.
- Region Council members participated at the County and local level in planning and coordination of COVID-19 vaccination clinics.
- Region Council members participated in County MPD led and Public Health COVID-19 information sharing meetings.
- EMS Agencies partnered with Public Health to provide COVID-19 contact tracing, home health checks, and COVID testing.
- Region Council members participated in the EMS & Trauma Care System Assessment and Public Forums.
- Received an EMSC grant from Department of Health for pediatric transport equipment for twenty-seven transporting agencies in the Region.

The North Central Region has had a number of ongoing challenges during the 2019-2021 planning period:

- The North Central Region Council has encountered ongoing challenges of Council Board vacancies.
- Dissemination of Department of Health updates and information at the EMS Provider level is poor due to outdated contact lists.
- Agencies continue to express their frustrations with the rising cost of initial EMS courses. The Region had a significant decrease in funding within 2008-2013 due to the economy, with no increases to accommodate the rising cost of education in the years that followed.
- Increasing challenges in access to EMS services in rural areas related to a dramatic decrease in volunteers.
- Continuing decreases in reimbursement levels that are negatively impacting the long- term sustainability and viability of rural hospitals and EMS agencies.
- Regional QI Committee Meetings provided by the designated trauma facility are not held on a regular basis; trauma coordinator turnover is problematic, and QI requirements for the Region are unmet.
- COVID-19 Pandemic placed a significant burden on EMS agencies in response, treatment, and transport. Response costs increased while transport revenues decreased.

- It was reported by EMST partners that many funding opportunities at the Federal, State, and County levels were only made available to publicly funded EMS & Fire services and not made available to private for profit EMS services.
- Absence of the previous local Region 7 Healthcare Coalition made it difficult for EMS to quickly access patient placement information and surge capacity. The local nuances for response were lost in the declaration of the COVID-19 Pandemic. REDi Healthcare Coalition reports were delayed in status, and there was no local representative.

GOAL 1

Maintain, Assess, and Increase Emergency Care Resources

The North Central Region relies on the Region EMS TCC Min/Max guidance with standardized methodology to determine the need for minimum and maximum numbers for both trauma service designation and EMS agency verification. The Department has categorized levels of Cardiac and Stroke services.

The local EMS councils and Regional Trauma and Emergency Cardiac and Stroke CQI partners provide input on designation and min/max distribution. This approach has resulted in long-term partnerships between our regional system partners and an understanding of local and regional prehospital and hospital issues.

The Region and Local Councils have developed regional Patient Care Procedures and County Operating Procedures for patient transport to trauma, cardiac, and stroke services. The Region Council relies on input and recommendations from Local Councils and County Medical Program Directors to identify and recommend minimum and maximum numbers for Prehospital levels of licensed and verified agencies.

Objective 1: By May 2023, the Region Council will Determine min/max numbers for verified prehospital services.	Strategy 1: By June 2022, Region Council members will attend a meeting of each Local Council to review the process and provide guidance on determining min/max numbers for verified prehospital services.
	Strategy 2: By October 2022, the Region Council will request Local Councils perform a min/max assessment to determine min/max needs for their county council area.
	Strategy 3: By January 2023, Local Councils will provide the results and recommendations of the Local Council min/max assessment for verified prehospital services to the Region Council.
	Strategy 4: By March 2023, the Region Council will submit recommendations, with supporting documentation from Local Councils, to the Department for verified prehospital services as identified by the Local Councils min/max assessment.
Objective 2: By August 2022, the Region Council will Determine min/max numbers for designated	Strategy 1: By March 2022, the Region Council will submit the current Department list of designated trauma and rehabilitation services to the Regional QI Committee with request for recommendation of trauma service needs.

trauma and rehabilitation services.	Strategy 2: By June 2022, the Regional QI Committee will submit recommendations to the Regional Council for designated trauma and rehabilitation services.
	Strategy 3: By August 2022, the Region Council will submit recommendations to the Department for designated trauma and rehabilitation services identified by the Regional QI Committee.
Objective 3: By August 2022, the Region Council will review and document categorized cardiac and stroke facilities.	Strategy 1: By March 2022, the Region Council will submit the current Department list of categorized cardiac and stroke services to the Regional QI Committee with request for review and recommendations of cardiac and stroke service needs.
	Strategy 2: By June 2022, the Regional QI Committee will submit recommendations for categorized cardiac and stroke services to the Region Council.
	Strategy 3: By August 2022, the Region Council will submit recommendations for categorized cardiac and stroke services to the Department as identified by the Regional QI Committee.

WA State Department of Health Resource links:
Trauma Designated Services List
Cardiac and Stroke Categorized Facilities
Interactive Emergency Medical Care Map

GOAL 2

Support Emergency Preparedness Activities

Regional healthcare preparedness and response coordination in the North Central, South Central, and East Region EMS & Trauma Care Council areas is led by the Regional Emergency and Disaster Healthcare Coalition (REDi HCC). The REDi HCC supports healthcare emergency preparedness across the healthcare system to create resilient communities within the nineteen counties and four tribes of eastern Washington. To fulfill the coalition mission to ensure quality patient care during medical surge events, the REDi HCC collaborates with all healthcare disciplines and provider types, emergency management, public health and emergency medical services (EMS) on capability-based projects and activities that advance regional planning, training, exercise, response and recovery.

With the consolidation of the Healthcare Coalitions from nine to two; the ability to access and participate in planning and exercises on a frequent basis at the local and regional level has diminished. The REDi Coalition continues to host meetings to discuss regional response and include EMS in the Regional Response Plan.

During a declared emergency local Department of Emergency Management and County Public Health collaborate with the EMS agencies serving their taxing districts to provide quality patient care during medical surge events.

Objective 1: During July 2021-June 2023, the Region Council will coordinate with, and participate in, emergency preparedness and response to all-hazards incidents, patient transport, and planning initiatives to the extent possible with existing resources.	Strategy 1: On an ongoing basis, the Region Council, Executive Director will distribute emergency preparedness information and updates received from REDi HCC to regional system partners.
	Strategy 2: By July 2022, the Region Council, Executive Director will distribute the REDi HCC Response Plan to regional system partners.
	Strategy 3: By October 2022, the Region Council will develop and/or revise a PCP for Regional patient placement (Disaster Medical Coordinator Center, DMCC) plans.
	Strategy 4: By December 2022, the Region Council will approve a PCP for Regional patient placement (Disaster Medical Coordinator Center, DMCC) plans.
	Strategy 5: By January 2023, the Region Council will submit the PCP for Regional patient placement (Disaster Medical Coordinator Center, DMCC) plans to the Department for approval.

	Strategy 6: By March 2023, the Region Council will distribute the Department approved PCP for Regional patient placement (Disaster Medical Coordinator Center, DMCC) plans to regional system partners.
	Strategy 7: On an ongoing basis, The Region Council will report on EMS agency collaborations between local Department of Emergency Management and/or County Public Health Departments during a declared emergency.

Regional Emergency and Disaster Healthcare Coalition (REDi HCC)

GOAL 3

Plan, Implement, Monitor, and Report Outcomes of Programs to Reduce the Incidence and Impact of Injuries, Violence, and Illness in the Region

The North Central Region promotes programs and policies to reduce the incidence and impact of injuries, violence and illness.

Programs supported by the North Central Region include; Senior Falls/Fall Risk, Safe Kids for bicycle safety and helmet fittings, Child Passenger Safety, Public Automated External Defibrillator training, AHA First Aid and CPR Courses, Safe Sitter babysitting classes, Life jacket Loaner Boards, and The Force is With You focused on teen injury prevention education. The Region provides funding to Healthy Aging, LLC, which is the lead agency in collaboration with the Department of Health to administer the Stay Active and Independent for Life Program in Washington State.

The State and Region Council recognizes there is a significant change in funding and availability of services within our communities. This will require a multidisciplinary collaborative approach to delivering healthcare in a more efficient and fiscally responsible way in getting "The right patient, to the right facility, with the right transportation, at the right cost, in the right amount of time."

The North Central Region members of the Region and Local Council, Medical Program Directors, Critical Access Hospital, Hospital Based EMS Agencies, Emergency Room Trauma Coordinators, and other system stakeholders participate in State and National Initiatives for a Community based Paramedicine and/or Mobile Integrated Healthcare System that promotes collaboration of healthcare partners within the North Central Region to address community challenges for care and/or transport of patients.

This Region Council participates with the North Central Accountable Communities of Health Partners and the Washington Rural Health Association to establish collaborative efforts in development of an affordable, efficient, and comprehensive community-based system.

Objective 1: Annually, by March, the Region Council will review relevant data from Department of Health and other data sources, and utilize regional injury and violence prevention partners to identify and recommend	Strategy 1: Annually, by July, the Region Council will review relevant regional/injury data from Department of Health, and identify regional partners that will provide best-practice prevention programs.
	Strategy 2: Annually, by October, the Region Council will choose regionally funded prevention activities to support recommended by the Injury and Violence Prevention workgroup.

evidence-based and/or best-practice activities to support prevention efforts in the North Central Region.	Strategy 3: Annually, by December, the Region Executive Director will secure deliverable contracts with selected injury prevention partners to provide injury prevention programs.
	Strategy 4: Annually, by June, the contracted injury prevention partners will provide the Region Council with program activity reports and accomplishments as outlined in the contract agreement.
	Strategy 5: On an ongoing basis, as available, the Region Council will include program activity reports in the bi-monthly deliverable report to Department of Health.
Objective 2: During July 2021-June 2023, the Region Council will identify and explore emerging concepts for Mobile Integrated Healthcare (MIH) Community Paramedicine.	Strategy 1: On an ongoing basis, the Regional Council will continue to collaborate with stakeholders to participate in State Initiatives or trainings regarding MIH Community Paramedicine concepts.
	Strategy 2: On an ongoing basis, the Regional Council will provide stakeholders with information acquired from Initiatives and trainings pertaining to MIH Community Paramedicine.
	Strategy 3: On an ongoing basis, the Regional Council will collaborate with stakeholders to implement Regional PCPs for MIH Community Paramedicine as they are developed.

WA State Department of Health Resource links:
Trauma Designated Services List
Cardiac and Stroke Categorized Facilities
Interactive Emergency Medical Care Map

GOAL 4

Assess Weaknesses and Strengths of Quality Improvement Programs in the Region

The North Central Regional Quality Improvement Committee strives to optimize Emergency Systems of Care through a collaborative multidisciplinary approach to improve patient outcomes. Region Council members attend the Regional QI Committee meetings and are actively involved in QI for the Region.

In July 2019, Substitute Senate Bill 5380 amended RCW 70.168.090, adding requirements for licensed ambulance and aid services to report patient data to the state emergency medical services (EMS) data system.

The Region is active in assisting the DOH Research, Analysis, and Data EMS partners in the transition of EMS partner reporting from hand written records to the use of electronic medical records.

Objective 1: During July 2021-June 2023, the Regional QI Committee will review regional emergency care system performance.	Strategy 1: On an ongoing basis, the Regional QI Committee will identify issues of emergency care system performance during quarterly meetings using key performance indicators.
	Strategy 2: On an ongoing basis, the Region Council representative will participate in Regional QI and report back to the Region Council quarterly.
	Strategy 3: On an ongoing basis, the Region Council will disseminate Regional QI system performance information to EMS partners.
Objective 2: During July 2021-June 2023, the Region Council will support EMS agency participation in WEMSIS.	Strategy 1: By June 2022, the Region Council will distribute legislative updates and reporting requirements for WEMSIS submission to EMS partners within the region.
	Strategy 2: By September 2022, the Region Council will conduct a survey of EMS partners to identify barriers in WEMSIS utilization and agency reporting.
	Strategy 3: By December 2022, the Region Council will provide EMS partner survey results identifying barriers to utilization to the DOH Research, Analysis, and Data section and Workgroup.
	Strategy 4: By March 2023, the Region Council will request DOH Research, Analysis, and Data section provide training in areas identified as barriers to utilization.

WA State Department of Health Resource links:
Trauma Designated Services List
Cardiac and Stroke Categorized Facilities
Interactive Emergency Medical Care Map
WA State Data Section and Key Performance Measures

GOAL 5

Promote Regional System Sustainability

Pursuant with RCW 70.168.100 and WAC 246-976-960; The East and North Central Region has demonstrated efficiency by sharing administrative resources since 2013. The two regions maintain independent business operations while serving the needs of the communities.

The North Central Region has multi-disciplinary workgroups and committees, Local EMS Councils, and County MPDs involved in regional programs provided to strengthen the emergency care system.

The North Central Region is an approved Training Program for initial EMR, EMT, and AEMT courses. This provides the ability for instructors to maintain their autonomy with their instructor credential while working under a program that provides policy and procedures consistent with DOH guidelines, monitors delivery of courses to be consistent with National Education Standards, and provide ongoing training and evaluation of SEI quality.

The Regional Training and Education Committee utilizes the Local Council Training Survey results to determine funding for educational programs for Prehospital providers. They also utilize the approved Training Program with the Department of Health to maintain quality assurance of initial EMS courses by monitoring Instructors, participant success with National Registry Testing, and providing reports to County MPDs.

With the increasing costs for EMS Education, agencies have difficulty with recruitment and retention of EMS Providers.

The Prehospital and Transportation workgroup reviews County Operating Procedures, Regional Patient Care Procedures, and Min/Max numbers in determining unserved or underserved areas. The workgroup will collaborate with the regional Training and Education Committee to distribute and educate providers on the Regional Patient Care Procedures and County Operating Procedures.

Objective 1: During July 2021-June 2023, the Region Council will manage the business of the Council,	Strategy 1: Annually, by June, the Region Council will review and approve a fiscal year budget for Administration and Programs as outlined in the Department contract.

501(c)(3) status, and Department contractual work, of the Region Council.	Strategy 2: On an ongoing basis, the Region Council will review and approve financial reports and Department contract deliverables.
	Strategy 3: On an ongoing basis, the Region Council Executive Director, will coordinate Council and Committee meetings and communications with regional partners.
	Strategy 4: On an ongoing basis, the North Central and East Region councils will continue to evaluate the collaboration of administrative resources and additional opportunities for sustainability.
Objective 2: During July 2021-June 2023, the Region Council will manage Council membership to ensure membership as outlined in RCW is represented.	Strategy 1: Annually by January, the Region Council will review current membership to identify and recruit for open positions.
	Strategy 2: On an ongoing basis, the Region Council Executive Director, will maintain a current roster with Region Council membership positions, appointment expirations, and maintain records of all Council appointments and reappointments.
	Strategy 3: On an ongoing basis, the Region Council Executive Director, will maintain a current roster with Region Council member compliance with Open Pubic Meeting Act and other pertinent council member training.
Objective 3: Annually, by June, the Region Council will enhance workforce development, and support training and education for prehospital providers.	Strategy 1: By February 2022, the Regional Training and Education Committee will distribute a Needs Assessment Survey to EMS Agencies, providers, and MPDs.
	Strategy 2: Annually, by April, the Regional Training and Education Committee will review the compiled results of the Needs Assessment Survey.
	Strategy 3: Annually by June, the Regional Training and Education Committee will utilize the results of the Needs Assessment Survey to determine a fiscal year training plan and budget.
	Strategy 4: Annually, by June, the Regional Training and Education Committee will submit the proposed fiscal year training plan and program budget to the Region Council for approval.
	Strategy 5: Annually, by July, the Region Council will submit the compiled results of the Needs Assessment Survey to the Department with the Region Council approved program budget.

Objective 4: During July 2021-June 2023, the Region Council will review and update regional Patient Care Procedures (PCPs); and work toward statewide standardization of Regional PCPs.	Strategy 1: On an ongoing basis, the Regional Prehospital and Transportation Committee will utilize Department of Health guidance document and format to review Regional Patient Care Procedures (PCPs).
	Strategy 2: On and ongoing basis, the Regional Prehospital and Transportation Committee will include system partners, local councils, and county MPDs in review and development of Regional PCPs.
	Strategy 3: Annually by February, the Regional Prehospital and Transportation Committee will review, develop, and submit recommended drafts and revisions of the Regional PCPs to the Region Council for approval.
	Strategy 4: Annually by April, the Region Council will submit approved Regional PCPs to the Department for approval.
	Strategy 5: Annually, by July, The Region Council will distribute Department approved Regional PCPs to system partners, local councils, and Medical Program Directors.

WA State Department of Health Resource links:
Trauma Designated Services List
Cardiac and Stroke Categorized Facilities
Interactive Emergency Medical Care Map

APPENDICIES

NOTE: The appendices within this plan contain detailed charts with specific information for use in system planning. These are living documents and as such change during the plan period. The use of links (as available) to the WA DOH website will provide the most current information.

Appendix 1. Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Services (General Acute Trauma Services).

Level	State Approved		Current Status
	Min	Max	
I	0	0	0
II	1	1	0
III	2	2	1
IV	4	7	7
V	3	3	2
II P	1	0	0
III P	1	1	1

WA State Department of Health Resource links:
Trauma Designated Services Facility List
Trauma Designated Services Minimum/Maximum List

Appendix 2. Washington State Emergency Care Categorized Cardiac and Stroke System Hospitals.

Categorization Level		Hospital	City	County
Cardiac	Stroke			
NP	NP	Cascade Medical Center	Leavenworth	Chelan
I	II	Confluence Health	Wenatchee	Chelan
II	III	Columbia Basin	Ephrata	Grant
II	III	Coulee Medical Center	Grand Coulee	Grant
II	III	Lake Chelan Community Hospital	Chelan	Chelan
II	III	Mid-Valley Hospital	Omak	Okanogan
II	III	North Valley Hospital	Tonasket	Okanogan
II	III	Three Rivers Hospital	Brewster	Okanogan
II	III	Quincy Valley Medical Center	Quincy	Grant
II	III	Samaritan Hospital	Moses Lake	Grant

WA State Department of Health Resource links:
Cardiac and Stroke Categorized Facilities

Appendix 3. Approved Minimum/Maximum (Min/Max) numbers of Designated Rehabilitation Trauma Care Services

Level	State Approved		Current Status
	Min	Max	
II	1	1	1
III*	0	0	0

WA State Department of Health Resource links:
[Trauma Designated Services Minimum/Maximum List]

Appendix 4. EMS Resources, Prehospital Verified Services, Prehospital Non-Verified Services.

						Ground Vehicles		Personnel		
County	**Credential #**	**Agency Name**	**City**	**Agency Type**	**Care Level**	**# AMB**	**# AID**	**# BLS**	**# ILS**	**# ALS**
Chelan	**15**					**24**	**47**	**232**	**1**	**42**
	AIDV.ES.61171887	Chelan Fire and Rescue	Chelan	AIDV	BLS	0	16	14	0	0
	AID.ES.60281110	Mission Ridge Ski Area	Wenatchee	AID	BLS	0	0	4	0	0
	AIDV.ES.00000029	Chelan County Fire District #1	Wenatchee	AIDV	BLS	0	11	54	0	0
	AIDV.ES.00000030	Chelan County Fire District #3	Leavenworth	AIDV	BLS	0	3	2	0	0
	AIDV.ES.00000042	Chelan County Fire District 6	Monitor	AIDV	BLS	0	5	4	0	0
	AIDV.ES.60449836	Lake Wenatchee Fire and Rescue	Leavenworth	AIDV	BLS	0	2	10	0	0
	AMBV.ES.00000032	Chelan County Fire District #8	Entiat	AMBV	BLS	1	1	11	0	0
	AMBV.ES.00000039	Cashmere Fire Department	Cashmere	AMBV	BLS	1	1	12	0	0
	AMBV.ES.00000047	Ballard Ambulance	Wenatchee	AMBV	ALS	9	0	19	0	13
	AMBV.ES.00000048	Cascade Medical	Leavenworth	AMBV	ALS	4	2	43	1	9
	AMBV.ES.00000049	Lake Chelan Community Hospital Emergency Medical Services	Chelan	AMBV	ALS	5	1	15	0	11
	AMBV.ES.00000051	LifeLine Ambulance	Wenatchee	AMBV	ALS	4	3	21	0	7
	AMBV.ES.60358237	Chelan County Fire	Manson	AMBV	BLS	0	2	9	0	0

		Protection District #5								
	ESSO.ES.60343761	Chelan County Public Utility District	Wenatchee	ESSO				14		
	ESSO.ES.60427779	Beacon Occupational Health & Safety Services	Anchorage-Holden	ESSO						2
Douglas	**5**					**5**	**10**	**64**	**0**	**0**
	AIDV.ES.00000117	Douglas County Fire District #2	East Wenatchee	AIDV	BLS	0	6	33	0	0
	AIDV.ES.00000118	Douglas County Fire District #4	Orondo	AIDV	BLS	0	1	7	0	0
	AMBV.ES.00000120	Bridgeport Volunteer Fire and EMS Department	Bridgeport	AMBV	BLS	1	1	7	0	0
	AMBV.ES.00000121	Mansfield Ambulance	Mansfield	AMBV	BLS	2	2	11	0	0
	AMBV.ES.00000122	Waterville Ambulance Service	Waterville	AMBV	BLS	2	0	6	0	0
Grant	**18**					**34**	**39**	**218**	**12**	**35**
	AID.ES.60356927	Reclamation Fire Dept	Grand Coulee	AID	BLS	0	1	4	2	0
	AIDV.ES.00000138	Grant County Fire Dist #3	Quincy	AIDV	BLS	0	11	29	0	0
	AIDV.ES.00000142	Grant County Fire Protection District 7	Soap Lake	AIDV	BLS	0	2	11	0	0
	AIDV.ES.00000146	Grant County Fire District #13	Ephrata	AIDV	BLS	0	4	7	0	0
	AIDV.ES.60053432	Grant County Fire Protection Dist #12	Wilson Creek	AIDV	BLS	0	1	9	0	0
	AIDV.ES.60795718	Centerra Fire Department	Moses Lake	AIDV	BLS	0	1	7	0	0
	AID.ES.61023441	Boeing Fire Department	Seattle/Moses Lake	AIDV	BLS	0	1	0	0	0
	AMBV.ES.00000140	Grant County Fire Dist # 5	Moses Lake	AMBV	BLS	1	5	31	0	1
	AMBV.ES.00000141	Grant County Fire Dist #6	Hartline	AMBV	BLS	1	0	2	0	0
	AMBV.ES.00000143	Grant County Fire District #8	Mattawa	AMBV	BLS	4	0	11	1	0
	AMBV.ES.00000144	Grant County Fire District No 10	Royal City	AMBV	BLS	3	2	11	5	0

	AMBV.ES.00000147	Coulee City Fire Department	Coulee City	AMBV	BLS	2	0	7	0	0
	AMBV.ES.00000148	Grand Coulee Volunteer Ambulance	Grand Coulee	AMBV	BLS	3	0	25	1	0
	AMBV.ES.00000149	Moses Lake Fire Department	Moses Lake	AMBV	ALS	5	5	23	0	15
	AMBV.ES.00000155	Ephrata Fire Department	Ephrata	AMBV	BLS	1	3	13	0	0
	AMBV.ES.60162099	American Medical Response	Spokane	AMBV	ALS	8	1	9	2	13
	AMBV.ES.60231631	Protection-1 LLC	Quincy	AMBV	ALS	5	0	7	1	5
	AMBV.ES.60642727	Grant County Fire District #4	Warden	AMBV	BLS	1	2	12	0	0
Okanogan	**10**					**24**	**22**	**100**	**27**	**16**
	AID.ES.60875601	Okanogan County Fire District #12	Tonasket	AID	BLS	0	2	1	0	0
	AIDV.ES.00000442	Loomis Fire and Rescue	Loomis	AIDV	BLS	0	1	4	0	0
	AIDV.ES.00000446	Conconully Fire and Rescue	Conconully	AIDV	BLS	0	1	4	0	0
	AIDV.ES.60310971	Okanogan County Fire Protection District #16	Tonasket	AIDV	BLS	0	1	1	1	0
	AIDV.ES.60483069	Okanogan County Fire District #3	Okanogan	AIDV	BLS	0	3	8	0	0
	AMBV.ES.00000443	Douglas Okanogan County Fire Dist.15	Brewster	AMBV	ILS	4	2	10	7	0
	AMBV.ES.00000453	Aero Methow Rescue Service	Twisp	AMBV	ALS	4	8	28	10	7
	AMBV.ES.00000454	Colville Tribal Emergency Services	Nespelem	AMBV	BLS	6	0	22	7	0
	AMBV.ES.00000456	LifeLine Ambulance Inc	Omak	AMBV	ALS	11	4	19	2	9
	ESSO.ES.60291376	North Cascades Smokejumber Base	Winthrop	ESSO	0	0	0	3	0	0

Numbers are current as of February 2021 EMS Resource List

Total Prehospital Verified Services by County*						
County	**AMBV-ALS**	**AMBV-ILS**	**AMBV-BLS**	**AIDV-ALS**	**AIDV-ILS**	**AIDV-BLS**
Chelan	4	0	3	0	0	5
Douglas	0	0	3	0	0	2
Grant	3	0	8	0	0	6
Okanogan	2	1	1	0	0	4

Numbers are current as of December 2020 EMS Resource List

Total Prehospital Non-Verified Services by County*							
County	**AMB-ALS**	**AMB-ILS**	**AMB-BLS**	**AID-ALS**	**AID-ILS**	**AID-BLS**	**ESSO**
Chelan	0	0	0	0	0	1	2
Douglas	0	0	0	0	0	0	0
Grant	0	0	0	0	0	1	0
Okanogan	0	0	0	0	0	1	1

Numbers are current as of February 2021 EMS Resource List

Appendix 5. Approved Minimum/Maximum (Min/Max) numbers of Verified Trauma Services by Level and Type by County.

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

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Chelan	AIDV	BLS	4	6	5
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	3	3	3
		ILS	0	0	0
		ALS	4	4	4

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Douglas	AIDV	BLS	1	2	2
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	3	3	3
		ILS	0	0	0
		ALS	0	0	0

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Grant	AIDV	BLS	4	11	6
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	4	8	8
		ILS	0	5	0
		ALS	1	4	3

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Okanogan	AIDV	BLS	1	5	4
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	3	4	1
		ILS	0	1	1
		ALS	1	2	2

WA State Department of Health Resource links:
Interactive Emergency Medical Care Map

Appendix 6. Trauma Response Areas (TRAs) by County.

Chelan County

Chelan County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS as available	Type and # of Verified Services available in each Response Areas (*use key below- **see explanation)
	#1	Current Boundaries of Chelan County Fire District #1 Proper	A1, F2
	#2	Current Boundaries of Lake Wenatchee Fire and Rescue	A1, F3
	#3	Current Boundaries of Chelan County Fire District #4 Proper	F3
	#4	Current Boundaries of Chelan County Fire District #6 Proper	A1, F3
	#5	Current Boundaries of Chelan County Fire District #8 Proper	D1, F3
	#6	Current Boundaries of Chelan County PHD #2 Proper	F1
	#7	Current Boundaries of City limits of Cashmere Proper	D1, F2
	#8	Current Boundaries of City limits of Wenatchee proper	A1, F2
	#9	Town of Stehekin and surrounding wilderness area	F2
	U-1	East border encompasses NF7340, NF7322. NW Border encompasses Colchuck Lake, Mile Lake and westerly riverbed. Northern most borders include NF7601, NF11 and border the southern border of trauma response area U-2. Northeastern border follows the southwestern border of trauma response area #4. Eastern border, borders western border of U-17, encompassing Sand Creek Road, the westerly border of trauma response area U-19, including Devils Gulch Trail.	F3

	U-2	Western border includes Trout Lake heading north to Donell Lakes. Northern border includes trauma response area U-4's southern border, Chwaukum Lake, Winton Road, Carl Road, Hill Street. Eastern borders include the Western boundary of trauma response area #2 and trauma response area #3, including Alder Street.	A1, F3
	U-3	Southwest border follows trauma response area U-2 northwest boundary, including NF125, and Derby Canyon. Northwest border encompasses trauma response area U-5 SE border, including NF020, NF 7503 NF 7500. Eastern border includes trauma response area U-10 western border, including Ollala Canyon Road, NF7410.	A1, F3
	U-4	Western border includes Upper Mill Creek Road, Yodelin Place, Smithbrook Road, north to the eastern end of the Little Wenatchee River Bed, encompassing NF400. Northwestern border includes 65 Road, NF6506, NF6400, NF6200, Eastern border includes NF1408. Southeastern border includes NF1409, Chikamin Ridge Road, and includes northwestern boundary of trauma response areas U-6 and trauma response area U-9. Southeastern boundary includes NF6208, NF6102, NF300 and borders the trauma response area U-12 northwestern boundary. Southern boundary includes CR22, Bretz Road, Riche Road and borders the trauma response area U-2 north boundary.	F3

	U-5	Western boundary follows the trauma response area #2 and trauma response area #3 eastern boundaries. Northern boundary includes NF6103 eastern boundary borders the western trauma response area U-12 boundary, including NF315, NF7801, NF7502. Southern boundary includes NF7502, NF7500, NF7503, NF7401 and borders the trauma response area U-3 NW boundary.	F3
	U-6	West boundary includes NF1409, and borders the NE trauma response area U-4 boundary. Northern boundary includes the northern Entiat River Bed, encompasses NF5100, Hope Ridge Road, NF1433, NF112 and the trauma response area U-16 southern border. Eastern border includes NF1443, NF116, NF1448, NF211, Johnson Creek Road and borders the west trauma response area U-7 border and the trauma response area #5 west border. South border includes north border of trauma response area U-8 and NF5300, NF5320, NF114. The southwestern border encompasses the bordering northern section of trauma response area #4, to include NF5390, NF312, and NF5503.	F3
	U-7	Western border includes NF8410, NF118, NF114, Shady Pass Road, and the trauma response area U-6 eastern border. North border includes Shady Pass Road, NF5900, NF127 and the SE corner of trauma response area U-16. Eastern border includes NF127, NF233 and the western border of trauma response area #6. Southern border includes NF1448, and the southeastern border of trauma response area U-6.	F1

	U-8	Western border encompasses the section of NE trauma response area #4, including NF5305, NF5310, and County Road 287. The Northern border includes trauma response area U-6 southern border, NF114, NF5320, Mudd Creek Road and County Road 63. Eastern Border includes trauma response area #5's western border from County Road 63 to Tiny Canyon Road. Southern border follows the NE section of trauma response area #4, including Tiny Canyon Road, NF302.	D1, F2
	U-9	Southwest border encompasses NF500 and the trauma response area U-12 NE border, Western border encompasses Mad Lake and the trauma response area U-4 NE border. Northern border includes the trauma response area U-6 S border and eastern border is the NW section of the trauma response area #4, including NF5702, NF5700, NF400, and NF800.	D1, F2
	U-10	West Border includes the east border of trauma response area U-3, NF7410, Ollala Canyon Road, North Fork Road; Northern border encompasses a portion of the trauma response area U-12 south border, including NF11. Eastern border, borders trauma response area U-11 West border, NF5200, Orchid Street and the northwestern section of trauma response area #7. South border includes the north section of trauma response area #7 including Hay Canyon and NF7410.	D1, F2
	U-11	West border includes the east border of trauma response area #7, NF7415, Orchid Street, North border includes NF6210, South border of trauma response area U-12 and northern section of trauma response area #4, including Mills Canyon Road. Eastern border is the west boundary of trauma response area #4, including Swakane Road. Southern border includes northern trauma response area #8, including Burch Mtn. Road.	A1, D1, F2

	U-12	Western border includes east border of trauma response area U-5, NF6102, NF300, NF6104. North border is the south boundary of trauma response area U-9, including NF5700. Eastern border includes the western boundary of trauma response area #4 including Mad River Road, NF110, Roaring Creek Road. Southern border includes the North boundary of trauma response area U-11 and trauma response area U-10, including NF6210.	D1, F2
	U-13	West border is the trauma response area #5 east border. North border is the trauma response area #6 south border, including Foot Trail. East border follows the western border of trauma response area #6. South border is the northern border of trauma response area #5.	F1
	U-14	West border is the eastern shore of Lake Chelan from the North section of trauma response area #6 to the south border of trauma response U-15. NW border includes the trauma response area U-15 border and NF8200. NE border is the County Line, including NF8220, NF3107, NF430, NF3107, NF8210. South border is the north section of trauma response area #6 including NF8045.	F1
	U-15	West and southwest border is the eastern shore of Lake Chelan from trauma response area U-14 NW border, encompassing the entire trauma response area #9. The western border follows the northern shores of Lake Chelan. The northwest and north borders encompass trauma response area #9. The north and eastern borders follow the Okanogan County Line encompassing the Sawtooth Wilderness Area in Chelan County. The southern border is the northern border of trauma response area U-14.	F1

	U-16	Western border is the eastern border of ARCA#1. The Northwestern border encompasses Lyman Lake, continues north to the NW corner of trauma response area U-15. The Northern border includes Battalion Lake and the NW border of trauma response area U-15. Eastern border is the south shore of Lake Chelan, including NF112, the southern border includes the northern borders of trauma response area U-7 and trauma response area U-6.	F1
	U-17	Western border includes Sand Creek Road, Tripp Canyon Road, and the eastern border of trauma response area U-1. Northern and eastern border is the southern and western borders of trauma response area #7. Southern border includes GR11 and the SE border of trauma response area #7.	D1, F2
	U-18	Western borders area the eastern boundary of trauma response area #7, including Mission Creek Road, Northern borders area the southern borders of trauma response area #7, including Yaksum Canyon Road. The eastern border is the southern border of trauma response area #7. The Southern borders are the northern border of trauma response area U-19, including Horse Lake Road.	D1, F2
	U-19	Western border includes NF9712, Devils Gulch and the Eastern border of trauma response area U-1. Northern border includes the southern border of trauma response area U-18 and the southern border of trauma response area #7. Eastern border includes the western border of trauma response area #1and trauma response area #8, NF7101, Upper Reservoir Loop Road, Stemilt Loop Road, Upper Hedges Road, Jump Off Road, the southern borders are the county line, including Ingersoll Road, Schaller Road,	A1, F2

		and Naneum Ridge Road as well as NF330, NF9712.	

*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.

Douglas County:

Douglas County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS as available	Type and # of Verified Services available in each Response Areas (*use key below **see explanation)
	# 1	Current Boundaries of Douglas County Fire District #1 Proper	D1, F1
	#2	Current Boundaries of Douglas County Fire District #2 Proper	A1, F2
	#3	Current Boundaries of Douglas County Fire District #3 Proper	D2
	#4	Current Boundaries of Douglas County Fire District #4 Proper	A1, F3
	#5	Current Boundaries of Douglas County Fire District #5 Proper	D1, F1
	#6	Current Boundaries City of Bridgeport Proper	D1, F1

	U-1	Encompassed by response area #1 to the West, North and East borders. Southern border is the north west border of trauma response area U-9 including the south Jamison Lake Road.	D1, F2
	U-2	Western and Southern border is the east border of trauma response area U-3, North border is the south border of trauma response area #6. East border is the west border of trauma response area #3.	D1
	U-3	West border is the Douglas County Line, including Bailey Way. North border is the South border of U-10, including CR73960, Grange Road NE, Moe Road NE. East border is the county line and west border of trauma response area #6. Southern border is the north border of trauma response area #5, including CR72300.	E1
	U-4	Southwest and North borders area encompassed by trauma response area #1. The east border is encompassed by trauma response area U-9.	None
	U-5	West border is the east border of trauma response area U-6. North border is the south border of trauma response area #1, including Ponderosa Drive. Northern border is encompassed by trauma response area #1 and trauma response area U-9. The East border is the southwest trauma response area U-9 boundary, and includes Road C SE. The South border is the North border of trauma response area #10 and the north border of trauma response area U-8, including Road 12 SE, Douglas/Grant shared and Grant County Route.	D1, F1

	U-6	Southwest border is the NE boundary of trauma response area U-7. North border is the South border of trauma response area #1. East border is the west trauma response area U-5 border. South border is the north border of trauma response area U-8, including Road 24 NW.	D1, F1
	U-7	Southwest border is the NE border of trauma response area #2. NW border is the SE border of trauma response area #1. NE Border is the SW border of trauma response area U-6, and the SE border is the NW border of trauma response area #1.	D1, F2
	U-8	West border is the east border of trauma response area U-7. North border is the south border of trauma response area U-6 and trauma response area U-5 including Road 24 NW. The east border is the northwest border of trauma response area #10. The south border is the north border of trauma response area #1.	D1, F1
	U-9	West border includes Road C SE, and the west borders of trauma response area U-5, trauma response area U-4 and trauma response area U-1. The North border includes the southern border of trauma response area #5, including Road 6 NE, St Andrews West Road NE, St. Andrews East Road NE, Road O NE. The East and SE borders are the Grant County Line, including Road 6 SE. South border follows the Grant County Line, including Road 24 NW.	D1

	U-10	To the West, East and North borders the Okanogan County Line, including Chambers Road. South border follows the North border of trauma response area U-3, including CR74690 and CR73960.	E1

*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.

Grant County:

Grant County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS as available	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	#1	The current boundaries of Grant County Fire District #3 Proper	A1, D2, F2
	#2	The current boundaries of Grant County Fire District #4 Proper	A1, E1, F1
	#3	The current boundaries of Grant County Fire District #5 Proper	D1, E1, F1
	#4	The current boundaries of Grant County Fire District #6 Proper	D3

	#5	The current boundaries of Grant County Fire District #7 Proper	A1, D2, E1, F1
	#6	The current boundaries of Grant County Fire District #8 Proper	D1, E1, F1
	#7	The current boundaries of Grant County Fire District #10 Proper	A1, F1
	#8	The current boundaries of Grant County Fire District #11 Proper	D1, E1, F1
	#9	The current boundaries of Grant County Fire District #12 Proper	D2, E1, F1
	#10	The current boundaries of Grant County Fire District #13 Proper	D1, E1, F1
	#11	The current boundaries of Grant County Fire District #14 Proper	D1, E1, F1
	#12	The current boundaries of Grant County Fire District #15 Proper	D1, E1, F1
	#13	The current boundaries of City Limits of Coulee City Proper	D1, E1, F1
	#14	The current boundaries of City Limits of Ephrata Proper	F1
	#15	The current boundaries of City Limits of Grand Coulee Proper	D1, E1, F1
	#16	The current boundaries of City Limits of Moses Lake Proper	E1, F1
	#17	Port District boundaries, Grant County International Airport & surrounding industries.	A1, E1, F1
	U-1	Northrup Canyon area between Grant County Fire District #14 south & Grant County Fire District #6 east.	D1
	U-2	Banks Lake North, south of Grant County Fire District #14 – Section 16 North, west of Grant County Fire District #6, North of Million Dollar Mile.	D1
	U-3	Banks Lake South of Coulee City Area, Section 26: Township 26N: Range 28E, south and west of Grant County Fire District #6 to Douglas County Line.	D1

	U-4	Sun Lakes West and North, west to Grant County Fire District #7 – Over to County Line; west of Park Lake, west of Blue Lake.	A1, D2, E1, F1
	U-5	West Lake Lenore.	A1, D2, E1, F1
(3 Devils Grade Area)	U-6	North of Grant County Fire District #7 boundary, along shoreline of Lake Lenore, along Grant County Fire District #7 boundary, over to county line.	A1, D2, E1, F1
	U-7	South of Road 24 NW west to County line. 1 mile south, 2 miles west, 1 mile south, 4 miles east to Grant County Fire District #13 boundary. West 2 miles to County Line (Road 24 NW).	A2, F1
	U-8	Between Grant County Fire District #7 and Grant County Fire District #13: North of Road 20 NE.	D2, E1, F1
	U-9	East of Grant County Fire District #7; North of Grant County Fire District #13; Canal Bank NE; South of Road 19NE; South of E SW.	D2, E1, F1
	U-10/10A	South and east of Grant County Fire District #12 to County Line. North of Grant County Fire District #5, North of Road 12 NE; west of County Line; north to Road 16 NE over to V NE, 1 mile north – 1 mile west – 3 miles south – 2 miles west – south to Road 12 NE.	D2, E1, F1

	U-11	East of Grant County Fire District #5, north of Grant County Fire District #13, east of Grant County Fire District #3, west of Potholes Reservoir, West Potholes Reservoir edge to 4 miles, one piece is north and east of Grant County Fire District #11/east of Potholes. West – 3 miles south.	D1, E1, F1

*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.

Okanogan County:

Okanogan County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS as available	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	#1	The current boundaries of Okanogan County Fire District #1 Proper	D1
	#2	The current boundaries of Okanogan County Fire District #2 Proper	D2
	#3	The current boundaries of Okanogan County Fire District #3 Proper	A1, F1

	#4	The current boundaries of Okanogan County Fire District #4 Proper	D1
	#5	The current boundaries of Douglas/Okanogan County Fire District #15 Proper	E1
	#6	The current boundaries of Aero Methow Rescue Response area	A1, F1
	#7	The current boundaries of Okanogan County Fire District #7 Proper	A1, F1
	#8	The current boundaries of Okanogan County Fire District #8 Proper	A1, D1, E1, F1
	#9	The current boundaries of Okanogan County Fire District #9 Proper	A1, F1
	#10	The current boundaries of Okanogan County Fire District #10 Proper	A1, D1, E1, F1
	#11	The current boundaries of Okanogan County Fire District #11 Proper	D1
	#12	The current boundaries of Okanogan County Fire District #12 Proper	D2
	#13	The current boundaries of the Colville Tribal Reservation within Okanogan County	D2
	U-1	East Boundary: West boundary of trauma response area #7. North Boundary: Encompasses Chewiliken Road, east to NF125, Southeast through NF200 and NF30. South Boundary is a portion of the North border of trauma response area #13.	A1, F1
	U-2	West border of trauma response area #4, encompassing areas to the north, Longaneker Road. Northwestern boundary includes Talkire Lake Road, heading southwest, along vehicle road. Southern boundary along northern boundary of trauma response area U-1.	A1, D1, E1, F1
	U-3	Aeneas Valley	D1

	U-4	Western boundary includes NF3820 along Cecile Creek Road, heading north to Chopaka Lake, north to Canadian Border. Northwest border encompasses Chopaka Road heading south to Palmer Lake, southwest to Palmer Mt. Road, southwest to Wannacut Lake Road, heading west to trauma response area #1 western border continuing south to trauma response area #4 westerly border. South boundary encompasses Silver Star Mine Road, Horse Springs Coulee Road and the northern border of trauma response area U-6.	A1, D1, E1, F1
	U-5	West border meets the western border of trauma response area U-4. Northern border encompasses Loomis/Oroville Road and north to the Canadian Border. Eastern border is the western border of trauma response area #1. Southern border includes trauma response area U-4's northern border.	D1
	U-6	Western border includes NF3820 and reaches to trauma response area U-7's eastern border. Northern border encompasses trauma response area U-4's southern border including Sinlahekin Road. Eastern trauma response area U-6 border meets trauma response area #4's western border, trauma response area #7, trauma response area #9 and trauma response area #3 eastern borders. Southwestern border includes Old 97 Highway, Monse South Road, and follows the Columbia River south to trauma response area #5 northern border. Follows Okanogan County Line to the west encompassing NF4330 to FS Trail 408-North to the southern border of trauma response area #6.	A2, D1

	U-7	Western border meets trauma response area #6 eastern border; north border is the Canadian Border; western border encompasses eastern border of trauma response area U-4, including NF3820, eastern border of trauma response area U-6 and eastern border of trauma response area #9, including Medicine Lake, County Road 2017, Buzzard Lake Road. Southwest border encompasses trauma response area #3 border including B&O West Road; south border includes Davis Canyon Road, NF115 over to NF325.	A3, F2
	U-8	Responded to out of Ferry County. Unsure of the defined boundaries by State Mapping.	D1
	U-9	City Limits of Twisp	A1, F1

*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.

WA State Department of Health Resource links:
Interactive Emergency Medical Care Map

Appendix 7. Approved EMS Education and Training Programs

Credential #	Status	Expiration Date	Facility Name	Site City	Site County
TRNG.ES.60850963-PRO	APPROVED	10/31/2023	LifeLine Ambulance	Wenatchee	Chelan
TRNG.ES.60119536-PRO	APPROVED	10/31/2023	North Central Region EMSTCC	Wenatchee	Chelan
TRNG.ES.60119457-PRO	APPROVED	10/31/2024	Wenatchee Valley College	Wenatchee	Chelan
TRNG.ES.60124290-PRO	In Renewal	12/06/2018	Grant County Fire District 5	Moses Lake	Grant
TRNG.ES.60751916-PRO	APPROVED	10/31/2023	Moses Lake Fire Department	Moses Lake	Grant

Approved EMS Educators by County

County	SEI	SEI-C	ESE
Chelan	7	0	72
Douglas	3	0	35
Grant	6	1	57
Okanogan	7	0	30

Numbers are current as of February 2021

Appendix 8. Patient Care Procedures

NORTH CENTRAL REGION EMS & TRAUMA CARE COUNCIL
REGIONAL PATIENT CARE PROCEDURES

TABLE OF CONTENTS

REGULATIONS

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

1.1 Revised Code of Washington (RCW):

- **RCW 18.73** – Emergency medical care and transportation services
  - RCW 18.73.030 - Definitions
- **RCW Chapter 70.168** – Statewide Trauma Care System
  - RCW 70.168.015 – Definitions
  - RCW 70.168.100 – Regional Emergency medical Services and Trauma Care Councils
  - RCW 70.168.170 – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

1.2 Washington Administrative Code (WAC):

- **WAC Chapter 246-976** – Emergency Medical Services and Trauma Care Systems
  - WAC 246-976-920 – Medical Program Director
  - WAC 246-976-960 – Regional emergency medical services and trauma care councils
  - WAC 246-976-970 – Local emergency medical services and trauma care councils

1.1 DISPATCH OF AGENCIES

Effective Date: 4/4/2001
Revised: 10/2021

1. PURPOSE:

A. To provide timely & appropriate care to all emergency medical & trauma patients.
B. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
C. To establish uniform & appropriate dispatch of response agencies.
D. To utilize criteria-based trained dispatchers to identify potential major trauma incidents & activate the trauma system by dispatching the appropriate services.

2. **SCOPE**:

All licensed and verified ambulance & aid services shall be dispatched to emergency medical & trauma incidents in a timely manner in accordance with WAC 246.976.

3. **GENERAL PROCEDURES:**

A. The most appropriate aid or ambulance services shall be dispatched as identified in the North Central Region Trauma Response Area maps, or as defined in local and/or county operating procedures.
B. Licensed verified aid or ambulance services shall be dispatched by trained dispatchers to all emergency medical and trauma incidents.
C. All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt a Program and Implementation Guidelines.

4. DEFINITIONS:

- ***"Agency Response Time"*** is defined as "the time from agency notification until the time of first EMS personnel arrive at the scene."
- ***"Appropriate"*** is defined as "the verified or licensed service that normally responds within an identified service area."

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council		10/2021	☐ Major ☒ Minor
			☐ Major ☐ Minor

1.2 TIMELY & APPROPRIATE EMS RESPONSE

Effective Date: 4/4/2001
Revised: 10/2021

1. PURPOSE:

To ensure that emergency medical and trauma patients who live in an area that is serviced by two or more ambulance providers, which have the same level of licensure, receive the timeliest & highest level of care that is available.

2. **SCOPE**:

If available, the highest-level "appropriately staffed" ambulance within the designated area shall be dispatched to emergency medical & trauma incidents.

3. **GENERAL PROCEDURES:**

A. Except when "extraordinary circumstances" exist, the highest-level "appropriately staffed" licensed and verified ambulance shall respond to all emergency medical & trauma incidents.
B. When a licensed ambulance provider is unable to immediately respond an "appropriately staffed" ambulance to an emergency medical or trauma incident, and there exists another ambulance which is "appropriately staffed" and capable of responding to the incident in a timely manner, then the service that was originally dispatched shall transfer the call to the second ambulance for response.
C. This procedure shall only apply to emergency calls received through the county 911 dispatch center.

4. DEFINITIONS:

- ***"Extraordinary Circumstances"*** shall be defined as situations "out-of-the-usual" when all available ambulances from local licensed ambulance providers are committed to calls for service.
- ***"Appropriately staffed"*** shall be defined as an ambulance which immediately initiates its response to an emergency medical or trauma incident with the minimum staffing levels as outlines in WAC 246.976.
- ***"Highest- Level"*** shall be defined as the service within the response area that has the highest level of certified personnel available, at the time of the call.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council		10/2021	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

1.3 RESPONSE TIMES

Effective Date: 4/4/2001
Revised: 10/2021

1. PURPOSE:

A. To define prehospital response times for emergency medical & trauma incidents to urban, suburban, rural and wilderness areas in the North Central Region.
B. To define urban, suburban, rural and wilderness response areas.
C. To provide medical and trauma patients with appropriate & timely care.

2. SCOPE:

All licensed and verified ambulance & aid services shall respond to emergency medical & trauma incidents in a timely manner in accordance with WAC 246-976.

3. GENERAL PROCEDURES:

A. The Regional Council, with input from prehospital providers and Local Councils, shall identify response areas & times as urban, suburban, rural and wilderness. (see chart below)
B. Licensed and Verified aid and ambulance services shall collect and maintain documentation to ensure the following response times are met as established by PCP, COP or WAC 246-976.

	Aid Vehicle	**Ambulance**
Urban	8 minutes	10 minutes
Suburban	15 minutes	20 minutes
Rural	45 minutes	45 minutes
Wilderness	ASAP	ASAP

C. Licensed and verified aid and ambulance services shall maintain documentation on major trauma cases to show the above response times are met 80% of the time.
D. County Operating Procedures must meet the above standards.

4. DEFINITIONS:

As defined in WAC 246-976, *An agency response area or portion thereof:*

- ***"Urban"*** an incorporated area over thirty thousand; or an incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square mile.
- ***"Suburban"*** an incorporated or unincorporated area with a population of ten thousand to twenty-nine thousand nine hundred ninety-nine or any area with a population density of between one thousand and two thousand people per square mile.
- ***"Rural"*** an incorporated or unincorporated area with a total population less than ten thousand people, or with a population density of less than one thousand people per square mile.
- ***"Wilderness"*** means any rural area not readily accessible by public or private maintained road.
- ***"Agency Response Time"*** means the interval from dispatch to arrival on the scene

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council		10/2021	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

3 AIR AMBULANCE SERVICES – ACTIVATION AND UTILIZATION

Effective Date: 9/1/ 2020

1. PURPOSE:

Provide guidelines for those initiating the request for air ambulance services to the scene.

2. **SCOPE**:

Air ambulance services activation and response that provides safe and expeditious transport of critically ill or injured patients to the appropriate designated and/or categorized receiving facilities.

3. **GENERAL PROCEDURES:**

A. Air ambulance services should be used when it will reduce the total out-of-hospital time for a critical trauma, cardiac, or stroke patient by 15 minutes or more; or provide for the patient to arrive at a higher-level trauma, cardiac, or stroke hospital within 30 minutes or less even if a lower level hospital is closer.
B. Prehospital personnel enroute to the scene make the request for early activation of the closest available air ambulance service resource to the location of the scene, or place them on standby for an on-scene response.
C. When appropriate; the call should be initiated through the emergency dispatching system. Notify dispatch of request for air ambulance services if the call has been initiated through a mobile device application.
D. The air ambulance service communications staff will give as accurate of an ETA possible from the closest fully staffed and readily available resource to the dispatch center requesting a scene response. This ETA will include the total time for air ambulance to arrive on scene. If ETA of closest fully staffed resource for that agency is extended, call should go to the next closest fully staffed resource, even if it is another service.
E. The responding air ambulance service will make radio contact with the receiving facility.
F. An air ambulance service that has been launched or placed on standby can only be cancelled by the highest level of certified prehospital personnel dispatched to the scene. Responding personnel may communicate and coordinate whether cancellation is appropriate with the highest-level personnel dispatched prior to their arrival on scene.
G. Scene flights; the air ambulance service responding to the scene will have contact with an agency on scene based on each county's established air to ground frequency.

H. Air ambulance services must be appropriately utilized during an MCI. If such request is made, the requesting prehospital agency should clearly communicate the need for either on scene or rendezvous location to respond to. Air ambulance services will determine most appropriate aircraft for transport based on patient status, weather, and location of incident.

4. TRANSPORT CONSIDERATIONS:

A. Mechanism of Injury – considerations utilizing the *"Prehospital Trauma Triage Destination Procedure"*
    a. Death in the same vehicle
    b. Ejected from vehicle
    c. Anticipated prolonged extrication: greater than 20 minutes with significant injury
    d. Long fall: greater than 30 feet for adults, 15 feet for children
    e. Sudden or severe deceleration
    f. Multiple casualty incidents
B. Patient characteristics – considerations utilizing the *"Prehospital Trauma Triage Destination Procedure"*
    a. Glasgow Coma Scale (GCS) less than or equal to 13
    b. Patient was unconscious and not yet returned to GCS of 15
    c. Respiratory rate less than a 10 or greater than 29 breaths per minute
    d. BP less than 90 mmHg or clinical signs of shock
    e. Penetrating injury to the chest, neck, head, abdomen, groin or proximal extremity
    f. Flail chest/unstable chest wall structures
    g. Major amputation of extremity
    h. Burns second-degree >20 percent
    i. Burns third-degree >10 percent
    j. Burns third-degree involving the eyes, neck, hands, feet, or groin
    k. Burns, high voltage-electrical
    l. Facial or airway burns with or without inhalation injury
    m. Paralysis/spinal cord injury with deficits
    n. Suspected pelvic fracture
    o. Multi-system trauma (three or more anatomic body regions injured)
C. Acute Coronary Syndrome – considerations utilizing the *"Prehospital Cardiac Triage Destination Procedure"*
    a. Post CPA – ROSC
    b. Hypotension and/or Pulmonary edema
    c. ST elevation myocardial infarction
    d. High Risk Score > 4
D. Stroke – considerations utilizing the *"Prehospital Stroke Triage Destination Procedure"*

a. F.A.S.T. and L.A.M.S. > 4
   Note: (With the extended window for thrombectomy, particularly for patients outside the window for tPA it is important that direct transport to a thrombectomy capable center be considered if the LAMS is > 4 and time of symptom onset is within 24 hours.

5. CONSIDERATIONS FOR AIR AMBULANCE TRANSPORT:

In general, prehospital providers must communicate to air ambulance any of the following circumstances that could affect ability to transport:

a. Hazardous materials exposure
b. Highly infectious disease (such as Ebola)
c. Inclement weather
d. Patient weight and size

If any of the conditions above are present:

a. Consider initiating ground transport and identifying a rendezvous location if air ambulance confirms the ability to transport.
b. Consider utilization of air ambulance personnel assistance if additional manpower is necessary

6. SAFETY OF GROUND CREWS AROUND AIRCRAFT

To promote safety of all personnel, ground crews must:

a. NOT approach the aircraft until directed to do so by the flight crews.
b. NOT approach the tail of the aircraft.
c. Use situational awareness while operating around aircraft.

7. LANDING ZONE CONSIDERATIONS:

All situations for safety and consideration of landing zones are at the pilot's discretion.

To promote safe consistent practices for EMS and air ambulance services in managing landing zones for helicopters. EMS MUST:

A. Select a location for the landing zone that is at least:
   b. Night; 100 ft. x 100 ft.
   c. Daytime: 75 ft. x 75 ft.
B. Assure the landing zone location is free of loose debris.
C. Assure the approach and departure paths are free of obstructions, and identify to the pilot hazards such as wires, poles, antennae, trees, wind speed and direction, etc.
D. Provide air ambulance services with the latitude and longitude of the landing zone. Avoid using nomenclature such as "Zone 1."
E. Mark night landing zones with lights. Cones may be used if secured or held down. Do not use flares.

F. Establish security for the landing zone for safety and privacy.
G. Avoid pointing spotlights and high beams towards the aircraft. Bright lights should be dimmed as the aircraft approaches.
H. Do not approach an aircraft unless escorted by an aircrew member.
I. Consult with aircrew members before loading and unloading. Loading and unloading procedures will be conducted under the direction of the flight crew.

8. DEFINITIONS:

- ***"Standby"*** Upon receiving the request, dispatch will notify the pilot and crew of the possible flight. The crew will respond to the aircraft and ensure they are in a flight ready status. The crew will then remain at or near the aircraft until such time as they are launched or released from standby.
- ***"Launch time"*** launch time is the time the skids lift the helipad en route to the scene location.
- ***"Early activation"*** Departing for a requested scene prior to arrival of the first responders, based on a high index of suspicion that specialty services will be necessary.

9. APPENDICES

Prehospital Trauma Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf

Prehospital Cardiac Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf

Prehospital Stroke Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	New	6/3/2020	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.2 CARDIAC TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/1/2018

1. PURPOSE:

A. To implement regional policies and procedures for all cardiac patients who meet criteria for cardiac triage activation as described in the State of Washington Prehospital Cardiac Triage Destination Procedure.
B. To ensure that all cardiac patients are transported to the most appropriate categorized facility as described in RCW 70.168.150
C. To allow the receiving facilities adequate time to activate their Cardiac response team.

2. **SCOPE**:

A. All ambulance and aid services shall comply with the State of Washington Prehospital Cardiac Triage Destination Procedure.
B. All ambulance services shall transport patients to the most appropriate categorized cardiac facility as identified in the County Operating Procedures (COPs).
C. All categorized receiving facilities will determine when it is appropriate to divert ambulances to another categorized facility.
D. All ambulance and aid services shall consider ALS rendezvous or Air Medical services if beyond the designated time requirements in the Triage Destination Procedure.

3. **GENERAL PROCEDURES:**

The first certified EMS provider determines that a patient:

A. Presents with signs, symptoms, or past medical history suggesting a cardiac event (in accordance with the State of Washington Prehospital Cardiac Triage Destination Procedure).
B. Meets the cardiac triage criteria.
C. The provider shall care for the patient as described in the Medical Program Director's (MPD) patient care protocol for cardiac patients.
D. The provider then determines destination based upon the criteria identified and the following:
    a. For patients meeting Cardiac Triage criteria, transport destinations will comply with the triage tool and COPs.
    b. Agencies unable to meet the transport destination criteria will utilize Online Medical Control for determination of transport mode.
    c. Online medical control for all counties shall be accessed per County Operating Procedures (COPs).
E. The EMS provider will initiate communication with the receiving facility as soon as possible, to allow the receiving facility adequate time to activate their cardiac response teams.

F. The receiving facility will notify the transporting ambulance service about diversion in accordance with COPs.
G. Medical Control and/or the receiving facility shall be provided with patient information, as outlined in the Prehospital Destination Tool and COPs.
H. All information shall be documented on an appropriate medical incident report (MIR) form approved by the County MPD.

4. APPENDICES:

Appendix 1. State of Washington Prehospital Cardiac Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf
Appendix 2. State of Washington Emergency Cardiac and Stroke Categorized Facilities
https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EmergencyCardiacandStrokeSystem/ForMPDsandEMS

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	02/07/2018	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.3 STROKE TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/1/2018

1. PURPOSE:

A. To implement regional policies and procedures for all stroke patients who meet criteria for stroke triage activation as described in the State of Washington Prehospital Stroke Triage Destination Procedure.
B. To ensure that all stroke patients are transported to the most appropriate categorized facility as described in RCW 70.168.150
C. To allow the receiving facilities adequate time to activate their stroke response team.

2. **SCOPE**:

A. All ambulance and aid services shall comply with the State of Washington Prehospital Stroke Triage Destination Procedure.
B. All ambulance services shall transport patients to the most appropriate categorized stroke facility as identified in the County Operating Procedures (COPs).
C. All categorized receiving facilities will determine when it is appropriate to divert ambulances to another categorized facility.
D. All ambulance and aid services shall consider ALS rendezvous or Air Medical services if beyond the designated time requirements in the Triage Destination Procedure.

3. **GENERAL PROCEDURES:**

The first certified EMS provider determines that a patient:

A. Presents with signs, symptoms, or past medical history suggesting a stroke event (in accordance with the State of Washington Prehospital Cardiac Triage Destination Procedure).
B. Meets the stroke triage criteria.
C. The provider shall care for the patient as described in the Medical Program Director's (MPD) patient care protocol for stroke patients.
D. The provider then determines destination based upon the criteria identified and the following:
    a. For patients meeting Stroke Triage criteria, transport destinations will comply with the triage tool and COPs.
    b. Agencies unable to meet the transport destination criteria will utilize Online Medical Control for determination of transport mode.
    c. Online medical control for all counties shall be accessed per County Operating Procedures (COPs).
E. The EMS provider will initiate communication with the receiving facility as soon as possible, to allow the receiving facility adequate time to activate their stroke response teams.

F. The receiving facility will notify the transporting ambulance service about diversion in accordance with COPs.
G. Medical Control and/or the receiving facility shall be provided with patient information, as outlined in the Prehospital Destination Tool and COPs.
H. All information shall be documented on an appropriate medical incident report (MIR) form approved by the County MPD.

4. APPENDICES:

Appendix 1. State of Washington Prehospital Stroke Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf
Appendix 2. State of Washington Emergency Cardiac and Stroke Categorized Facilities
https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EmergencyCardiacandStrokeSystem/ForMPDsandEMS

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	02/07/2018	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.4 MENTAL HEALTH AND CHEMICAL DEPENDENCY DESTINATION PROCEDURE

Effective Date: 11/1/2018

1. PURPOSE:

To operational licensed EMS aid and/or ambulance services who may transport patients from the field to mental health or chemical dependency services in accordance with WA State legislation HB 1721.

2. **SCOPE**:

In 2015, the WA State Legislature passed HB 1721 allowing Emergency Medical Services (EMS) licensed ambulance and aid services to transport patients from the field to mental health or chemical dependency services. In the North Central Region, licensed EMS ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170, if approved by their county Medical Program Director (MPD).

3. **GENERAL PROCEDURES:**

A. Prehospital EMS agency and receiving mental health and/or chemical dependency facility participation is voluntary.
B. Participating agencies and facilities will adhere to the WA State Department of Health Guideline for Implementation of HB 1721 (see attached appendices)
C. Facilities that participate will work with county Medical Program Director (MPD) and EMS agencies to establish criteria that all participating facilities and EMS agencies will follow for accepting patients.
D. MPD and the Local EMS and Trauma Care Council must develop a county operating procedure (COP). The COP must be consistent with the WA State Department of Health Guideline for Implementation of HB 1721 and this PCP.
E. Prior to implementing and during ongoing operation of transport to alternate receiving facilities the following must be in place with DOH approval:
    a) County operating procedure
    b) MPD patient care protocol
    c) Ensure EMS providers receive training in accordance with WA State Department of Health Guideline for Implementation of HB 1721
    d) Facilities that accept referrals directly from prehospital providers

4. **APPENDICES:**

Appendix 1. WA State Department of Health Guideline for Implementation of HB 1721

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	02/07/2018	☒ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.5 IDENTIFICATION OF MAJOR TRAUMA & EMERGENCY MEDICAL PATIENTS

Effective Date: 10/23/1998
Revised: 10/2021

1. PURPOSE:

A. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Destination Procedure.
B. To ensure that all emergency medical patients are transported to the closest most appropriate facility in the shortest time possible.
C. To ensure that all major trauma patients are transported to the most appropriate facility capable of meeting the patient's need in accordance with WAC 246-976.
D. To notify the designated facility to allow sufficient time to activate their emergency medical and/or trauma resuscitation team.

2. SCOPE:

A. Major trauma patients will be identified in the initial EMS field assessment using the most current State of Washington Prehospital Trauma Triage Destination Procedure as published by the Department of Health.
B. Major trauma patients will be identified by the region's prehospital services and hospitals for the purposes of state trauma registry inclusion, using the trauma registry inclusion criteria as outlined in WAC 246-976-420.
C. Major trauma patients will be identified for the purpose of regional quality improvement based on known care issues, facility(s) Trauma Team Activation Criteria, and the State EMS and trauma data registries.
D. Patients not meeting the criteria to activate the trauma system will be transported to the closest most appropriate local facility as outlined in local procedures.

3. GENERAL PROCEDURES:

A. The first certified EMS provider will:

   a. Perform patient assessment.
   b. Determine if patient(s) meet trauma triage criteria.
   c. Determine Step level and most appropriate destination.

d. Contact receiving facility.

B. The receiving facility shall be provided with the following information, as outlined in the Washington Prehospital Triage Destination Tool:

a. Identification of EMS agency.
b. Patient's age
c. Patient's chief complaint or problem.
d. Severity and anatomical location of injuries.
e. Vital signs
f. Level of consciousness
g. Other factors that require consultation with medical control
h. Number of patients
i. Estimated time of arrival to facility.

C. Whenever needed, BLS agencies may request ILS or ALS agencies be dispatched to the scene by ground or air.

D. In accordance with WAC 246-976-330 (2)(b); "Within twenty-four hours of arrival, a complete written or electronic patient care report……." Shall be provided to the receiving facility.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council		10/2021	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

7 HOSPITAL DIVERSION

Effective Date: 10/23/1998
Revised: 10/2021

1. PURPOSE:

A. To define criteria for the initiation of trauma center diversion in the region.
B. To define the methods of notification for the initiation of trauma center diversion.

2. SCOPE:

All trauma facility diversion requirements can be found in WAC 246-976-700 (12)

A. Each designated trauma center will have a hospital-approved policy for the diversion of major trauma patients when the facility is temporarily unable to care for those patients. Designated trauma centers shall consider diversion when the surgeon is unavailable, the operating room is unavailable, CT imaging is down, or in the event of an internal facility disaster.
B. When diversion results in a substantial increase in transport time for an unstable patient, patient safety may over-ride the decision to divert when stabilization to the closest emergency department might be lifesaving based on prehospital county operating procedures. Examples may include, but not limited to; airway compromise and traumatic arrest.

3. GENERAL PROCEDURES:

A. The trauma designated facility will have a method of documenting and tracking trauma diversion to include date, time, duration, and rationale.
B. All facilities initiating diversion must have a procedure to notify EMS transport agencies and other designated trauma centers in their area.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council		10/2021	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

9.0 INTERFACILITY TRANSFER

Effective Date: 10/23/1998
Revised: 10/2021

1. PURPOSE:

A. To define the referral resources for interfacility transfers of patients requiring a higher level of care or transfer, due to situational inability to provide care.
B. To recommend criteria for interfacility transfer of major trauma patients from receiving facility to a higher level of care.

2. **SCOPE**:

A. Written transfer agreements will be in place among all facilities in the region and tertiary care facilities commonly referred to which are out of the region. A standard transfer agreement shall be utilized.
B. All interfacility transfers shall be compliant with EMTALA laws.
C. Level IV and V trauma facilities are recommended to transfer the following adult and pediatric patients to a Level I, II, III or closet higher-level trauma facility for post resuscitation care and stabilization:

   a. Central Nervous System Injury
   b. Head injury with any of the following
      - Open, penetrating, or depressed skull fracture
      - Severe coma (Glasgow Coma Score <10)
      - Lateralizing signs
      - Unstable spine or spinal cord injury
   c. Chest Injury
      - Suspected great vessel or cardiac injuries
      - Major chest wall injury
      - Patients requiring prolonged ventilation
   d. Pelvis Injury:
      - Pelvic ring disruption with shock requiring more than 5 units of blood transfusion
      - Evidence of continued hemorrhage
      - Compounded/open pelvic fracture or pelvic visceral injury
   e. Multiple System Injury
      - Severe facial injury with head injury
      - Chest injury with head injury
      - Abdominal or pelvic injury with head injury
      - Burns with head injury

f. Specialized Problems
   - Burns > 20% BSA or involving airway
   - Carbon Monoxide poisoning
   - Barotrauma

g. Secondary Deterioration (Late Sequelae)
   - Patients requiring mechanical ventilation
   - Sepsis
   - Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation systems)

D. All pediatric patients less than 15 years of age triaged under Step I or II of the Prehospital Trauma Triage Destination Tool; or are unstable after ED resuscitation or emergent observation intervention at hospital with general designations, should be considered for immediate transfer to a designated level I or II pediatric hospital by a WA State licensed and trauma verified Ambulance Service.

3. **GENERAL PROCEDURES:**

A. The Interfacility Transfer Guidelines and/or the Pediatric Transfer Guidelines established by the Department of Health should be followed. Each designated trauma facility is required to develop procedures, protocols, and criteria defining which patients they keep or transfer.
B. The receiving facility must accept the transfer prior to the patient leaving the sending facility.
C. All appropriate documentation must accompany the patient to the receiving facility.
D. The transferring physician's order shall be followed during transport as allowed by MPD protocols. Should the patient's condition change during the transport, the transferring/sending physician, if readily available, should be contacted for further orders.
E. The receiving facility will be given the following information:

   a. Brief history
   b. Pertinent physical findings
   c. Summary of treatment
   d. Response to therapy and current condition.

F. MPD approved Prehospital Protocols will be followed during transport, unless direct medical orders are given to the contrary.
G. The transferring facility must arrange for the appropriate level of care during transport. For interfacility transfer of critical major trauma patients, trauma verified air or ground ALS transport services shall be used. Air or ground

interfacility transport shall be based on patient acuity and consideration of total out of hospital time in consultation with the receiving physician.

H. Transport of patients out of region shall be consistent with these standards.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council		10/2021	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

10.1 MASS CASUALTY INCIDENT (MCI)

Effective Date: 12/06/2006
Revised: 10/2021

1. PURPOSE:

A. To develop and communicate information for response, prior to an MCI.
B. To implement county MCI plans during an MCI.
C. To provide safe mass transportation with pre-identified EMS personnel, equipment, and supplies per the approved County Mass Casualty Incident Plan.

2. **SCOPE**:

A. EMS personnel, licensed and verified ambulance and aid services shall respond to a Mass Casualty Incident (MCI) as identified in this document.
B. All licensed and verified ambulance and aid services shall respond to an MCI per the county MCI plans.
C. Licensed ambulance and aid services shall assist during an MCI, per county MCI plans, when requested.
D. Pre-identified patient mass transportation, EMS staff, and equipment to support patient care may be used.
E. All EMS agencies working during an MCI event shall operate within the National Incident Management System (NIMS) or the Incident Command System (ICS) as identified in the jurisdiction that has authority.

3. **GENERAL PROCEDURES:**

A. Incident Commander (IC) shall follow the county MCI Plan to inform medical control and possible appropriate medical facilities when an MCI condition exists. (Refer to county- specific Department of Emergency Management Disaster Plan).
B. Medical Program directors agree that protocols being used by the responding agency should continue to be used throughout the transport of the patient, whether it is in another county, region or state. This ensures consistent patient care will be provided by personnel trained to use specific medicines, equipment, procedure, and/or protocols, until delivery at the receiving facility has been completed.

4. DEFINITIONS:

- ***"County Disaster Plan"*** County Emergency Management Plan (CEMP)
- ***"Medical Control"*** MPD authority to direct medical care provided by certified EMS personnel in the prehospital system.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council		5/10/2021	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

10.2 ALL HAZARDS

Effective Date: 12/06/2006
Revised: 10/2021

1. PURPOSE:

General Algorithm for response to a Prehospital Mass Casualty Incident (MCI)

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

3. **GENERAL PROCEDURES:**

A. Receive dispatch
B. Respond as directed
C. Arrive at scene and establish Incident Command (IC)
D. Scene assessment and size-up
E. Determine if mass casualty conditions exist
F. Implement county MCI plan
G. Request additional resources as needed
H. The dispatch center shall coordinate notification and dispatch of required agencies and resources including notification of the County Department of Emergency Management (DEM) and possible receiving facilities. The Local Health Jurisdiction (LHJ) shall be notified in events where a public health threat exists.
I. 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)
J. Initiate START
K. Reaffirm additional resources
L. Initiate ICS 201 or similar tactical worksheet
M. Notification to receiving hospital of numbers and severity of patients being transported.
N. Upon arrival at hospital/medical center, transfer care of patients to facility's staff (Hospital/medical center should activate their respective MCI Plan as necessary)
O. Prepare transport vehicle and return to service

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council		10/2021	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

Appendix 9. Other Appendices

County Operating Procedures (COP's) are available upon request in the Regional Council Office and on the NCECC.org website.

Greater Wenatchee EMS Council
http://ncecc.net/chelan-s-douglas-county/county-protocols/

Okanogan – North Douglas County EMS Council
http://ncecc.net/n-okanogan-douglas-county/county-protocols/

Grant County EMS Council
http://ncecc.net/grant-county/county-protocols/

State of Washington Prehospital Stroke Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf

State of Washington Prehospital Cardiac Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf

State of Washington Prehospital Trauma Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf