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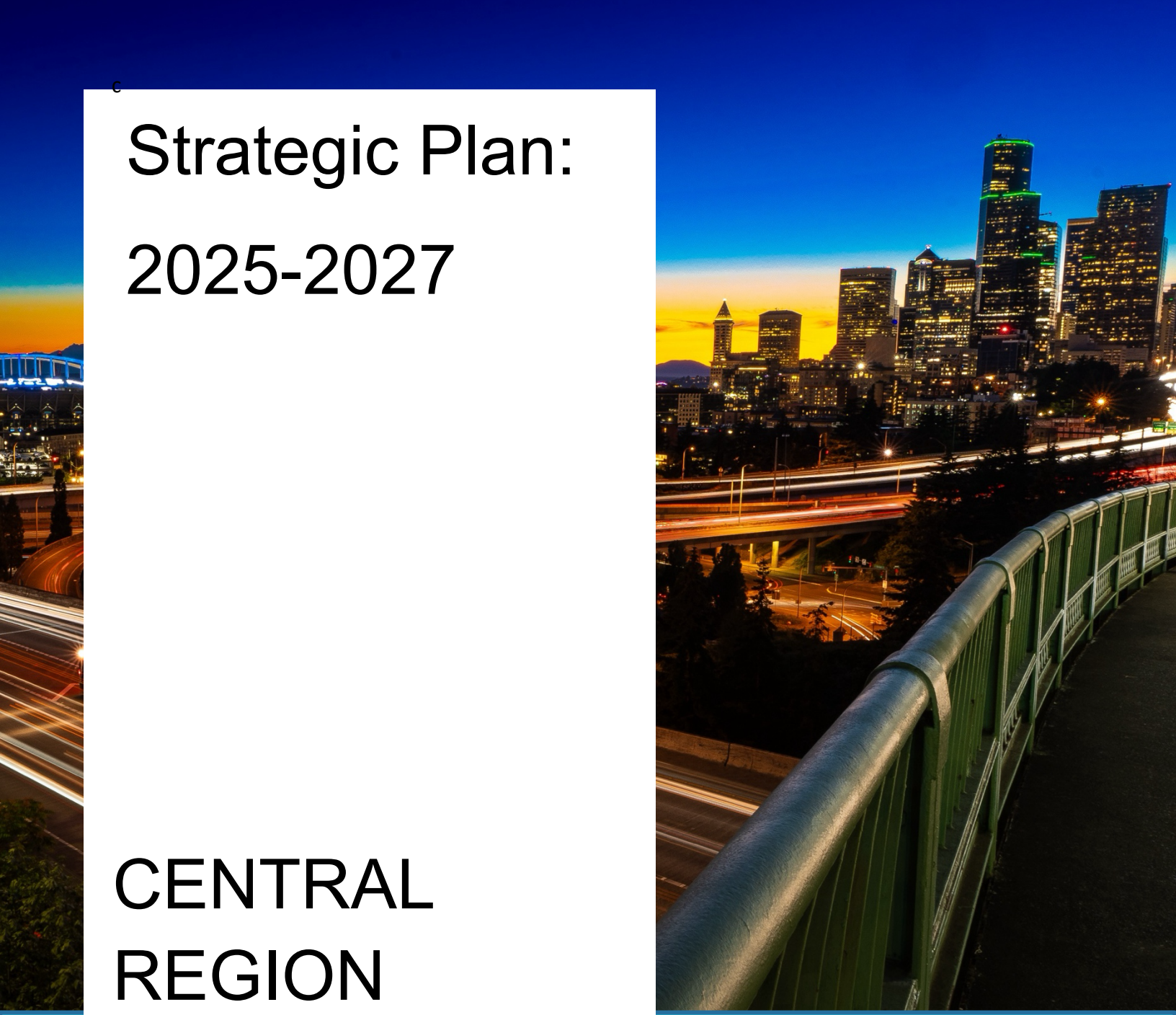
Strategic Plan:

2025-2027



CENTRAL REGION

Emergency Medical Services & Trauma Care Council

CENTRAL REGION
EMS & TRAUMA CARE COUNCIL

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INTRODUCTION

The Central Region EMS & Trauma Care Council has adopted the following mission and vision statements:

Vision

Central Region has an efficient, well-coordinated ~~statewide~~ EMS & Trauma System which reduces death, disability, human suffering and costs due to injury and medical emergencies.

Mission

The Central Region EMS and Trauma Care Council's mission is to provide leadership and coordination of EMS community partners to reduce injury and to ensure provision of high-quality emergency medical and trauma care.

Background

The Central Region is located in King County, Washington. The largest metropolitan county in the State in terms of population, number of cities, and employment. The majority of the County's estimated 2.3 million residents live in urban and suburban communities located along the I-5 and I-405 corridors where emergency medical hospital services are located. This geography covers 2,131 square miles, bounded by the Puget Sound to the west and Cascade Range to the east. Except for rural Vashon Island in Central Puget Sound, the western county is covered by cities while the development patterns become gradually sparser to the east.

There are thirty-two (32) licensed EMS services in King County: five (5) provide advanced life support (ALS) service using paramedics, twenty-six (26) provide basic life support (BLS) service using EMTs and there are six (6) emergency services supervisory organizations. There are ten trauma designated hospitals, sixteen hospitals in total and three stand-alone emergency departments within the Region.

The Central Region EMS and Trauma Care (CREMS) Council is made up of members of the emergency care system community in King County. RCW 70.168 and WAC 246-976 identify the membership, and responsibilities of the regional and local EMS & trauma care councils. The Central Region EMS and Trauma Care Council membership includes local government, prehospital agencies, hospitals, medical directors, rehabilitation facilities, communication centers, training organizations and consumers. The Central Regional EMS and Trauma Care Council provides a forum for open discussion of emergency care system and patient care issues and for sharing of information among system partners. The council has an Executive Board that is made up of seven members elected by the council. The board is comprised of the following positions: chair, vice chair, secretary, treasurer, and three board members. All meetings are open public meetings, and members of the public are welcome and encouraged to attend. The council typically meets every other month and the Executive Board meets monthly. Meetings may be held in a variety of formats including in person, conference call, or video call. The council also helps to coordinate a quality improvement forum, attended by representatives from

hospitals and EMS agencies. Representatives from the Central Region participate on local and state planning committees, task forces, and workgroups so that EMS system issues, guidelines, plans, and information can be shared among local and state EMS partners.

The Central Region has a mature and robust EMS system that began in 1969 when Leonard A. Cobb, M.D. and Chief Gordon Vickery, Seattle Fire Department, created Seattle's paramedic program, Medic One. Beginning with the EMS and Trauma System Act of 1990, trauma system elements mandated by RCW 70.168 and WAC 246-976-960 were incorporated into the existing EMS system. Local fire district levies, the Medic One Foundation, and the King County Medic One/EMS levy support prehospital training, and quality improvement activities. This financial support and oversight allow the Central Region EMS and Trauma Care Council to focus on access to emergency care services and overall system performance. The Central Region EMS and Trauma Care Council receives its funding from the state Department of Health. Central Region representatives participate in several ad hoc workgroups, local and state committees and organizations related to time sensitive emergencies in the region. Within the council, workgroups are formed on an ad hoc basis to discuss specific EMS system and patient care issues and to develop strategies to address those issues. Project-specific ad hoc committees have been formed on an as-needed basis. Outside of the council, members actively participate in regional partnerships and on state Technical Advisory Committees (TAC).

The Central Region EMS and Trauma Care Council accomplished numerous goals in the 2023-2025 plan cycle. The strategic plan included some goals, objectives and strategies that are required in each plan cycle, and others that were unique to the specific needs of Central Region. In the fiscal year 2024 the region granted over $65,000 and in 2025 over $80,000 in funds to support the regional emergency care system. Recipients included hospitals, fire departments, EMS training organizations, schools, and those working with the older adult populations. These projects ranged from injury prevention, pre- and in-hospital provider training, and materials and equipment to support ongoing training. Recipients were chosen based on their alignment to the strategic plan, community needs, relevance to top causes of morbidity and mortality, and the organizations feasibility in accomplishing the stated project.

While successfully funding various programmatic endeavors, the Region must also support expenses associated with administrative functions. Costs of all goods and services required to operate continue to increase, while the budget has remained static. Long term solutions for sustainability are needed in order to continue to support the work going forward.

Central Region continues to maintain a Psychiatric Patient Task Force, which has been active in the efforts to mitigate the impact of increasing census of psychiatric patients in all emergency departments. The Task Force is continually working in pursuit of this goal. This group was instrumental in addressing the use of 'ED Psych Divert' that contradicted the Region's long-standing No Divert Policy. Within Central Region facilities can now communicate via WATrac when they are saturated with behavioral health patients, avoiding the use of hospital diversion while enhancing communication across the system. The group continues efforts to address behavioral health concerns in the context of the overall system and aims to explore furthering use of data and metrics to evaluate the work.

Central Region boasts a uniquely robust EMS system, with few underserved geographical areas and pre-hospital EMS levy funding. Still the region is challenged by continually growing and changing population. The council actively seeks to include in meetings and membership those that support and participate in the overall system, such as dispatch communications, emergency management and preparedness. The Central Region aims to maintain and expand as a diverse and dedicated group.

This 2025-2027 Central Region Strategic EMS & Trauma Care System Plan is made up of goals adapted from the State Strategic Emergency Care System Plan. The objectives and strategies are developed by the Regional Council and its stakeholders to meet needs of the region.

Central to our Vision and Mission, the Regional Council remains steadfast in its commitment to equitable & inclusive care. Throughout our various activities we seek diversity, pursue equity, and promote inclusion for all, considering all activities with a lens of promoting equitable care.

GOAL 1 - MAINTAIN, ASSESS AND INCREASE EMERGENCY CARE RESOURCES

Need and Distribution of Services

Hospital Care: There are four Level III trauma centers and three Level IV trauma centers in Central Region located in the heavily populated communities along the I-5 and I-405 corridors. There are two Level V trauma centers; one is located along highway 410 in the mostly rural city of Enumclaw, and the other is in the rural area of Snoqualmie, near the I-90 mountain pass. There is a level I trauma center located in Seattle which serves patients from Washington, Alaska, Montana and Idaho.

Categorized Cardiac and Stroke Centers are also distributed in the heavily populated areas along I-5, I-405, and I-90. Currently there are eleven Level I and five Level II cardiac centers; and three Level I, nine Level II, and four Level III stroke centers in Central Region.

Designated and categorized hospital services are listed by name and level of service in the regional Patient Care Procedures (PCPs) and EMS guidelines. Annually, the Regional Council will compare the PCPs with the current list of designated/categorized hospitals services on file with the Office of Community Health Systems to ensure that prehospital agencies can transport their patient to the appropriate level of care.

Prehospital Care: King County uses a tiered prehospital response system to ensure 9-1-1 calls receive medical care by the most appropriate care provider. Calls to 9-1-1 are received and triaged by professional dispatchers at three dispatch centers located throughout King County. Using Criteria Based Dispatch, the call receivers are trained to identify the most appropriate level of care needed. These 911-center representatives provide pre-arrival instructions for most medical emergencies, and guide the caller through life-saving steps, including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) instructions, until the Medic One/EMS provider arrives. Basic Life Support (BLS) personnel are dispatched first to an incident, providing rapid basic life support that includes advanced first aid and CPR/AED to stabilize the patient. Staffed by fire department Emergency

Medical Technicians (EMTs), BLS units arrive at the scene in about five minutes on average. Central Region has over 4,200 EMTS.

Advanced Life Support (ALS/paramedic) personnel provide emergency medical care for critical or life-threatening injuries and illness. ALS units are dispatched simultaneously with BLS for life-threatening medical emergencies. Central Region has over 250 paramedics.

RCW 70.168.100 authorizes EMS and Trauma Care Regions to identify the need for and recommend distribution and level of care of prehospital services to assure adequate availability and avoid inefficient duplication and lack of coordination of prehospital services within the region. The Regional Council uses standardized methods provided by the Department of Health along with prehospital response times and call volumes to determine the need and distribution of trauma verified prehospital services in King County. This is reviewed during each Plan cycle.

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
Objective 1: By November 2026 the CREMS Council will follow recommendations and methodology from the Washington State Department of Health to recommend minimum and maximum numbers and levels of trauma designated services (including pediatric and rehabilitation services).	**1**	**Strategy 1.** By November 2026, the CREMS Council will review Central Region trauma data including population demographics and solicit input to determine the recommended min/max number and levels of trauma designated facilities in Central Region.
	2	**Strategy 2.** By January 2027, the CREMS Council will vote on the recommended number and levels of trauma designated services in Central Region.
	3	**Strategy 3.** By February 2027, the CREMS Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding the number and levels of trauma designated services in Central Region (King County).
	4	**Strategy 4.** By April 2027, the CREMS Council will perform an in-depth review and analysis of designated services min/max number and level recommendations to the EMS & Trauma Steering Committee as needed.
	5	**Strategy 5.** Based on the Department of Health's updated Trauma Service Assessment, CREMS Council will work to understand a newly updated process. Communicating and facilitating this work with stakeholders.

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
Objective 2: By May 2026 the CREMS Council will use Washington State Department of Health, Office of Community Health Systems standardized methodology and King County EMS system data to determine the minimum and maximum numbers and levels of verified prehospital service types in King County and provide recommendations to the Washington State Department of Health Office of Community Health Systems and the EMS & Trauma Steering Committee.	**1**	**Strategy 1.** By January 2026, the CREMS Council and EMS Stakeholders will review EMS data including response and transport times, service demands, and population to determine the minimum and maximum levels of verified prehospital services in Central Region (King County).
	2	**Strategy 2.** By March 2026, the CREMS Council will vote on the recommended minimum and maximum numbers of verified ALS and BLS aid and ambulance services in Central Region (King County). Assessment data will include, but is not limited to, dispatch times and call volumes per annum and population growth since the prior review period. As necessary, needs assessments may be submitted by organizations wishing to modify their trauma verification status.
	3	**Strategy 3.** By May 2026, the CREMS Council will make any necessary recommendations to the Washington State Department of Health Office of Community Health Systems regarding the minimum and maximum numbers of verified ALS and BLS aid and ambulance services in Central Region.
	4	**Strategy 4.** By May 2026, the CREMS Council will submit verified services min/max and level recommendations to the EMS & Trauma Steering Committee as needed.
Objective 3: Throughout the planning cycle, the Regional Council will review the Patient Care Procedures and participate in statewide standardization.	**1**	**Strategy 1.** Throughout the planning cycle, the CREMS Council will review the list of currently categorized facilities and update the Patient Care Procedures (PCPs) so that they accurately reflect current appropriate destinations.
	2	**Strategy 2.** Throughout the planning cycle, the CREMS Council will consider and review additional PCPs to be added or amended.
	3	**Strategy 3.** Throughout the planning cycle, the CREMS Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding revisions to the Region' s PCPs.

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
	4	**Strategy 4.** Throughout the planning cycle, the CREMS Council will submit revisions to the Region's PCPs to the EMS & Trauma Steering Committee as needed.
Objective 4. By January 2026, CREMS will identify and communicate specific challenges as they relate to pre-hospital services.	**1**	**Strategy 1.** By November 2025, the CREMS board will conduct a survey of EMS agencies within the region to identify specific challenges facing the EMS workforce in the region. This survey will explore challenges related to recruitment, retention, training, and resources.
	2	**Strategy 2.** By January 2026, the CREMS council will summarize and share results of the prehospital survey with stakeholders at a regularly scheduled Council meeting. Results will be prioritized and solutions explored.
	3	**Strategy 3.** By March 2026, CREMS will summarize and provide a report of survey results with Washington State Department of Health Office of Community Health Systems and others as applicable.
	4	**Strategy 4.** By May 2026, CREMS will work to explore, communicate strategies identified in the workforce survey.

GOAL 2 - SUPPORT EMERGENCY PREPAREDNESS ACTIVITIES

The Central Region EMS and Trauma Care Council will make continued efforts to collaborate and coordinate with emergency preparedness groups in the area, to facilitate the smooth functioning of the EMS and Trauma System in the event of an emergency. The region already works with several, such as the Northwest Healthcare Response Network (NWHRN), King County Emergency Management Advisory Committee (EMAC), and Public Health Seattle & King County and the division of King County EMS. These groups will continue to have opportunities to share information at regional council meetings. The Council will continue to seek, support, and expand these collaborations and partnerships.

GOAL 2: Support Emergency Preparedness Activities		
Objective 1. Throughout the planning cycle, CREMS Council will collaborate with emergency management to support all hazards preparation and response.	**1**	**Strategy 1.** At each CREMS Council meeting, representatives from NWHRN, WATrac, EMAC and WMCC will have the opportunity to present information to the region about emergency management and preparedness work that is happening in the region.
	2	**Strategy 2.** Throughout the plan cycle, CREMS Council staff will share opportunities for council members to actively participate in emergency preparedness activities in the region.
Objective 2. Throughout the planning cycle, CREMS Council will consider ways to expand and improve emergency preparedness.	**1**	**Strategy 1.** During July 2025 – June 2027, the CREMS Council will consider developing PCP to incorporate the current King County Multiple Casualty Incident (MCI) Plan.
	2	**Strategy 2.** Throughout the plan, the CREMS Council will assist partners in improving response and resilience to disasters and emergencies.

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

The Central Region EMS Council uses DOH and King County EMS injury data to identify prevention needs, prioritize and develop activities to address those needs. During this Plan cycle, the Central Region EMS and Trauma Care Council will continue to focus activities on injury causes that are most prevalent in the region. In the 2023-2025 planning period, the top causes of injury and mortality included falls, overdoses, motor vehicle accidents and suicide. In past years, the council has support projects that aim to address and reduce injuries, hospitalizations and mortality and plans to continue doing so.

GOAL 3: PLAN, IMPLEMENT, MONITOR AND REPORT OUTCOMES OF PROGRAMS TO REDUCE THE INCIDENCE AND IMPACT OF INJURIES, VIOLENCE AND ILLNESS IN THE REGION		
Objective 1: By March 2027, the CREMS Council will identify regional injury prevention priorities and support partners in implementing evidence	**1**	**Strategy 1.** By November 2026, the CREMS Council will review the intentional and unintentional injury and illness data to identify injury and illness prevention needs in King County.
	2	**Strategy 2.** By January 2027, the CREMS Council will support the development of activities and programs to address one or more of the identified injury and/or illness prevention needs.

GOAL 3: PLAN, IMPLEMENT, MONITOR AND REPORT OUTCOMES OF PROGRAMS TO REDUCE THE INCIDENCE AND IMPACT OF INJURIES, VIOLENCE AND ILLNESS IN THE REGION		
based or best practice programs and activities.	**3**	**Strategy 3.** By May 2027, the CREMS Council will review reports from council-supported prevention activities and programs.
	4	**Strategy 4.** By February 2027, the CREMS Council will incorporate the identified injury prevention activities in the 2027-2029 Regional Plan.
Objective 2: By September of 2025 and throughout the plan cycle, the CREMS Council will create and execute plans to address issues around transfer of care of patients from EMS into the hospital.	**1**	**Strategy 1.** Throughout the plan, the CREMS Council will monitor hospital capacity and its effect on the time interval to transfer EMS patients, commonly referred to as wall times.
	2	**Strategy 2.** By December 2025 and throughout the plan, stakeholders will explore, develop, and communicate metrics to describe and raise awareness of the issues.
	3	**Strategy 3.** Throughout the plan, the CREMS Council will develop strategies aimed at addressing and mitigating these issues.
	4	**Strategy 4.** Throughout the plan, the CREMS Council will evaluate outcomes and progress of their strategies and efforts.
Objective 3. By May of 2027, the CREMS Council will work to develop strategic partnerships with community programs.	**1**	**Strategy 1.** By November 2026, CREMS Council will provide outreach and invitation to community groups aimed at addressing leading causes of injury and hospitalization to participate in council meetings and activities.
	2	**Strategy 2.** By March 2027, CREMS Council will work to build sustainable and mutually beneficial partnerships with various community programs through the small grant program.

GOAL 4 - ASSESS WEAKNESSES & STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS

The Central Region EMS and Trauma Care Council has an active Quality Improvement (QI) forum that meets four times per year. The QI group collectively presents & reviews case studies and specific incidents for education and improvement of emergency medical care in the region.

GOAL 4: ASSESS WEAKNESSES AND STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS IN THE REGION		
Objective 1: The CREMS Council will coordinate with regional partners to maintain QI forums at regular intervals throughout the year.	**1**	**Strategy 1.** In September 2025 and annually, CREMS staff will work with QI committee leadership to review, plan, and schedule QI meetings that will work for members in the region.
	2	**Strategy 2.** By November 2025, the CREMS Council will confirm and disperse the QI meeting schedule to regional council members. Throughout the plan cycle, CREMS Council staff will continue to assist with scheduling and coordinating regional QI meetings based upon the established schedule.
	3	**Strategy 3.** Throughout the plan cycle, QI leadership will maintain and promote attendance and participation by hospitals and EMS in the region for well-rounded attendance and participation.
Objective 2: During the 25-27 plan, the Regional Council will support EMS agency participation and data quality in WEMSIS	**1**	**Strategy 1.** Throughout the plan, CREMS Councill will share reports related to data quality and completeness in WEMSIS.
	2	**Strategy 2.** By November 2026, CREMS Council will work to utilize WEMSIS data to support regional quality improvement and planning efforts.
Objective 3: During the 25-27 plan, the Regional Council will support participation and data quality in the trauma registry.	**1**	**Strategy 1.** Throughout the plan, CREMS Councill will share reports related to data quality and completeness in the state's trauma registry.
	2	**Strategy 2.** By November 2026, CREMS Council will work to utilize the state trauma registry and individual facilities to support regional quality improvement and planning efforts.
Objective 4: By May 2026, the Quality Improvement Forum will consider strategies to improve emergency care systems performance in areas highlighted by data analysis and reports presented at EMS & Trauma Care Steering Committee meetings.	**1**	**Strategy 1.** By May 2027, the Quality Improvement Forum will seek out opportunities to further utilize data and reports shared at other settings and from other sources.
	2	**Strategy 2.** Throughout the plan cycle, the Chair of QI Forum and Chair of the Board will consider if any data and reports from other venues, such as Steering Committee, could be further reviewed at the local and regional levels.

GOAL 5 - PROMOTE REGIONAL SYSTEM SUSTAINABILITY

In Central Region emergency medical technicians receive more than 150 hours of basic training and hospital experience with additional training in defibrillation, along with at least 30 hours of continuing education annually. All paramedics in King County are graduates of the University of Washington Paramedic Training Program regardless of previous training. Paramedic candidates receive 2,500 hours of rigorous training, including classroom instruction, clinical rotations at Seattle Children's, University of Washington Medical Center, and Harborview Medical Center, as well as extensive field training supervised by experienced senior paramedics. Dispatch, BLS and some ALS continuing education is provided by the King County EMS Online program which is funded through the King County Medic One/EMS levy. Paramedics receive 30 hours of continuing medical education classes each year along with surgical airway management laboratories, advanced cardiac life support, and pediatric advanced life support classes. Paramedic continuing education is funded through the Medic One Foundation and through the Medic One/EMS Levy. In the next plan cycle, the Central Region EMS Council will provide opportunity to request funding for additional training adjuncts.

Regional Patient Care Procedures (PCP)s are operating guidelines that are consistent with state standards that have been adopted by the Central Region Council in accordance with WAC 246-976-960. PCPs provide direction to emergency care system partners for activities such as triage, transport, and destination determination and have been developed by the Central Region Council in consultation with emergency care systems partners and EMS Medical Program Directors.

Local fire district levies, the Medic One Foundation, and the King County Medic One/EMS levy support prehospital training, and quality improvement activities. This financial support and oversight allows the Central Region EMS and Trauma Care Council to focus on access to emergency department services and overall EMS system performance. During this Plan cycle:

- The Central Region EMS & Trauma Care Council will continue to monitor hospital compliance with the Central Region No Diversion Policy and the regional WATrac reporting policy.
- The Psychiatric Patient Care Task Force will continue to monitor psychiatric patient care access and work toward finding long-term solutions to providing adequate psychiatric patient care in King County.
- The council will develop action plans to address increasing patient census in hospital emergency departments.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
Objective 1: By July 2025 and throughout the plan cycle Central Region hospitals will continue to monitor and support the no diversion policy.	**1**	**Strategy 1.** On an ongoing basis, CREMS Council staff will monitor hospital diversion as reported by WATrac and provide monthly reports to hospitals and stakeholders.
	2	**Strategy 2.** On an ongoing basis, CREMS Council staff will monitor hospital ED status reports on WATrac and provide monthly reports to stakeholders on reporting frequency compliance and reporting errors.
	3	**Strategy 3.** By March 2026, CREMS will promote and provide continued education and training around the use and capabilities of WATrac.
Objective 2: By July 2025 and throughout the plan cycle, the CREMS Council will monitor psychiatric patient access to appropriate care in Central Region.	**1**	**Strategy 1.** Throughout the plan cycle, CREMS Council staff will schedule Psychiatric Patient Task Force (PPTF) meetings as needed to discuss issues which affect psychiatric patient care in the region.
	2	**Strategy 2.** By July 2026, the PPTF will consider gathering and distributing data to measure and evaluate the impact of any issues and potential solutions.
	3	**Strategy 3.** By June 2027 and throughout the plan cycle, the PPTF will discuss best practices for addressing psychiatric patient care issues that have been identified. The PPTF will consider any action plans to address identified psychiatric patient care issues.
	4	**Strategy 4.** Throughout the plan cycle, the Regional Council will evaluate the impact of the action plans on psychiatric patient care in the region.
Objective 3: By March 2026, and throughout the plan cycle, the CREMS Council will develop action plans to address increasing patient census in hospital emergency departments.	**1**	**Strategy 1.** By September 2025 and throughout the plan cycle, the CREMS Council will measure and evaluate patient census, wall times, and diversion in King County.
	2	**Strategy 2.** By January 2026, the CREMS Council will bring together appropriate groups and stakeholders to identify and develop action plans, as applicable, to mitigate the effects of high patient census in King County.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
	3	**Strategy 3.** By May of 2026, the CREMS council will compile and disseminate best practices from, and for the use of, stakeholders around capacity management and EMS-to-Emergency department throughput.
	4	**Strategy 4.** Throughout the remainder of the plan cycle, the council will continually assess the action plans previously developed.
Objective 4: During the Plan cycle the CREMS Council will facilitate the exchange of information throughout the emergency care system.	**1**	**Strategy 1.** By July 2025, and throughout the plan cycle, the CREMS Council will facilitate and host for the Council, various workgroups and administrative meetings.
	2	**Strategy 2.** By July 2025, and throughout the plan cycle, CREMS Council members will participate in EMS stakeholder meetings including: King County EMS Advisory Council, Medical Directors Committee, Northwest Healthcare Response Network, EMS & Trauma Steering Committee, and associated Technical Advisory Committees and share information with the CREMS Council at regularly scheduled meetings, via email distribution lists, and the CREMS Council website.
	3	**Strategy 3.** Throughout the plan cycle, CREMS Council staff and EMS stakeholders will bring EMS system and patient care issues forward to the EMS and Trauma Care Steering Committee and other appropriate TACs as necessary.
Objective 5: During the plan cycle, the CREMS Council will work with the Washington State Department of Health Office of Community Health Systems and the State Auditor's Office to ensure the Regional Council business structure and practices remain compliant with RCW.	**1**	**Strategy 1.** By November annually, the CREMS Council staff will submit the previous year's financial information and related schedules to the Washington State Auditor's Office.
	2	**Strategy 2.** Beginning in July 2025, the Regional Council or Council staff will maintain a council budget and provide financial reports to DOH as needed for Exhibit B reporting.
	3	**Strategy 3.** By September annually, the CREMS Board will review semi-annual budget vs. actual revenues & expenditures.
	4	**Strategy 4.** By July annually, the CREMS Board will review the end of fiscal year annual budget vs. actual revenues & expenditures.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
	5	**Strategy 5.** By November annually, Council staff will coordinate with an accountant to file appropriate federal and state filings.
	6	**Strategy 6.** By October 2026 annually, the CREMS Board will review the CREMS Council financial policies and Board/Staff roles and responsibilities.
Objective 6: At CREMS Council meetings, the Regional Council will identify areas to improve the quality of patient care provided by emergency care system partners and develop strategies to address the patient care issues.	**1**	**Strategy 1.** Throughout the plan cycle, the CREMS Council will discuss issues which affect patient care in the region.
	2	**Strategy 2.** Throughout the plan cycle, the CREMS Council will discuss best practices for addressing patient care issues that have been identified.
	3	**Strategy 3.** Throughout the plan cycle, the CREMS Council will develop action plans to address patient care issues which have been identified.
	4	**Strategy 4.** Throughout the plan cycle, the CREMS Council will evaluate the impact of the action plans on patient care in the region.
Objective 7: By May 2027, the CREMS Council will develop a FY 2027-2029 strategic plan.	**1**	**Strategy 1.** By October 2026, the CREMS Council and Regional Council Board will begin developing a FY 2027-2029 strategic plan.
	2	**Strategy 2.** By February 2027, the CREMS Council will approve the future plan.
	3	**Strategy 3.** By February 2027, the approved plan will be submitted to the Department of Health.
	4	**Strategy 4.** By March 2027, the CREMS Council will submit the FY 2027-2029 plan to the EMS & Trauma Steering Committee.
Objective 8: By October 2025 annually, the CREMS Council will allocate available funding to support EMS and trauma system training needs.	**1**	**Strategy 1.** By May 2025 annually, the CREMS Council will develop a budget for prehospital training support.
	2	**Strategy 2.** By October 2025 annually, the CREMS Council will allocate available funding for prioritized training needs.
	3	**Strategy 3.** By June 2026 annually, organizations that received grant funding will report on outcomes & accomplishments supported with this funding.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
Objective 9: By May 2026 annually, the CREMS Council will provide any new or revised Patient Care Procedures to the Washington State Department of Health Office of Community Health Systems and the EMS & Trauma Steering Committee for review and approval.	**1**	**Strategy 1.** By January 2026 annually, the CREMS Council, MPD and other EMS stakeholders will review Central Region Patient Care Procedures and make revisions as necessary.
	2	**Strategy 2.** By March 2026 annually, the CREMS Council will submit any revised Patient Care Procedures to the Washington State Department of Health Office of Community Health Systems for review and approval.
	3	**Strategy 3.** By May 2026 annually, the CREMS Council will submit any revised Patient Care Procedures to the EMS & Trauma Steering Committee as needed.
Objective 10: Throughout the planning cycle, the CREMS Council will continually identify ways to improve Council membership, establish and cultivate relevant partnerships, and ensure the Central Region has representation and participation in statewide committees.	**1**	**Strategy 1.** On an ongoing basis, CREMS Council staff will maintain a current roster with Council Membership appointments. This information will be updated on the Council website.
	2	**Strategy 2.** By June 2027, CREMS Council staff will work to fill vacant council seats to ensure representation form a variety of organizations in accordance with the Bylaws.
	3	**Strategy 3.** By May 2027, CREMS Council will evaluate and identify ways to improve participation and representation in Washington State Department of Health Office of Community Health Systems and the various EMS and trauma Steering Committee Technical Advisory Committees.

APPENDICES

APPENDIX 1: Adult & Pediatric Trauma Designated Hospitals & Rehab Facilities

WA Department of Health Trauma Designated Services					
REGION	Trauma Designation			Facility	City
	Adult	Pediatric	Rehab		
CENTRAL	I	I P	I R	Harborview Medical Center	Seattle
	III			EvergreenHealth Medical Center	Kirkland
	III			MultiCare Auburn Medical Center	Auburn
	III			Overlake Hospital Medical Center	Bellevue
	III			Valley Medical Center	Renton
	IV			St. Anne Hospital	Burien
	IV			St. Francis Hospital	Federal Way
	IV			University of Washington Medical Center - Northwest	Seattle
	V			Snoqualmie Valley Hospital	Snoqualmie
	V			St. Elizabeth Hospital	Enumclaw
			I PR	Seattle Children's Hospital	Seattle

Information is current as of July 2024

REF: DOH 530-101 /July 2024

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

APPENDIX 2: Approved Minimum/Maximum Numbers of Designated Trauma Care Services

REGION	Level	State Approved		Current Status (#)
		MIN	MAX	
Central	I	1	-	1
	II	0	0	0
	III	4	4	4
	IV	3	3	3
	V	1	2	2
	* I P	1	0	1
	* II P	0	0	0
	* III P	0	0	0

* Pediatric

Numbers are current as of January 2025

REF: DOH 689-163 / August 2023

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

APPENDIX 3: Approved Minimum/Maximum Numbers of Designated Rehabilitation Trauma Care Services

REGION	Level	State Approved		Current Status (#)
		MIN	MAX	
Central	I R	1		1
	II R	0	0	0
	I Ped R	1	1	1

Numbers are current as of January 2025

REF: DOH 689-163 / August 2023

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

APPENDIX 4: Washington State Emergency Care Categorized Cardiac & Stroke System Hospitals

Washington State
Emergency Cardiac and Stroke System
Participating Hospitals by Region

REGION	Categorization Level		Facility	City	County
	Cardiac	Stroke			
CENTRAL	I	II	Multicare Auburn Medical Center	Auburn	King
	I	II	EvergreenHealth Medical Center	Kirkland	King
	I	I	Harborview Medical Center	Seattle	King
	I	II	St. Anne Hospital	Burien	King
	I	II	Northwest Hospital and Medical Center	Seattle	King
	I	II	Overlake Hospital Medical Center	Bellevue	King
	II	III	Snoqualmie Valley Hospital	Snoqualmie	King
	II	III	St. Elizabeth Hospital	Enumclaw	King
	I	II	St. Francis Hospital	Federal Way	King
	II	III	Swedish Ballard	Seattle	King
	I	I	Swedish Cherry Hill *	Seattle	King
	II	II	Swedish First Hill	Seattle	King
	I	II	Swedish Issaquah	Issaquah	King
	I	III	University of Washington Medical Center	Seattle	King
	I	II	Valley Medical Center - PDH #1	Renton	King
	I	I	Virginia Mason Medical Center	Seattle	King

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

Information is current as of January 2025

REF: DOH 345-299 / March 2024

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

APPENDIX 5: EMS Agency Report/Data

CENTRAL REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
King	AMBV.ES.00000296	American Medical Response	Tukwila	AMBV	BLS	91	0	440	0	2
King	AMBV.ES.00000260	Bellevue Fire Department	Bellevue	AMBV	ALS	14	17	175	0	0
King	AMBV.ES.00000298	Boeing Fire Department	Seattle	AMBV	BLS	5	0	125	1	0
King	AMBV.ES.00000262	Bothell Fire Department	Bothell	AMBV	BLS	4	19	60	0	0
King	AMBV.ES.00000240	Duvall - King County Fire District 45	Duvall	AMBV	BLS	3	3	26	0	0
King	AMBV.ES.61155981	Eastside Fire & Rescue	Issaquah	AMBV	BLS	13	45	183	0	0
King	AMBV.ES.00000263	Enumclaw Fire Department	Enumclaw	AMBV	BLS	3	3	27	0	0
King	AMBV.ES.00000236	King County Fire District #39	Federal Way	AMBV	BLS	6	12	147	1	0
King	AIDV.ES.00000224	King County Fire District 2	Burien	AIDV	BLS	0	4	75	0	0
King	AMBV.ES.60230529	King County Fire District 20	Seattle	AMBV	BLS	2	1	25	0	0
King	AMBV.ES.00000233	King County Fire District 27	Fall City	AMBV	BLS	2	2	20	0	0
King	AID.ES.00000242	King County Fire Protection Distrct #47	Ravensdale	AID	BLS	0	2	7	0	0
King	AIDV.ES.60274272	King County International Airport	Seattle	AIDV	BLS	0	2	23	0	0
King	AMBV.ES.00000294	King County Medic One	Kent	AMBV	ALS	17	2	0	0	0
King	ESSO.ES.60330466	King County Sheriff Search and Rescue	Maple Valley	ESSO		0	0	57	0	0
King	AMBV.ES.00000266	Kirkland Fire Department	Kirkland	AMBV	BLS	8	15	110	0	0
King	AMBV.ES.00000267	Mercer Island Fire Department	Mercer Island	AMBV	BLS	3	4	27	0	0
King	ESSO.ES.60378936	Michael K Copass MD Harborview Medical Center	Seattle	ESSO		0	0	0	0	257
King	AMBV.ES.00000239	Mountain View Fire and Rescue	Auburn	AMBV	BLS	5	10	36	0	0

King	AIDV.ES.00000229	Northshore Fire Department	Kenmore	AIDV	BLS	0	8	8	0	0
King	AMBV.ES.60818569	Northwest Ambulance	Arlington	AMBV	BLS	1	0	1	0	0
King	ESSO.ES.60669992	Pioneer Human Services	Seattle	ESSO		0	0	14	0	0
King	AMBV.ES.60730439	Port of Seattle Fire Department	Seatac	AMBV	BLS	2	4	85	0	0
King	AMBV.ES.60247342	Puget Sound Fire RFA	Kent	AMBV	BLS	6	31	249	0	0
King	AMBV.ES.00000270	Redmond Fire Department	Redmond	AMBV	ALS	13	25	121	1	0
King	AMBV.ES.60866037	Renton Regional Fire Authority	Renton	AMBV	BLS	9	19	139	0	0
King	AMBV.ES.00000272	Seattle Fire Department	Seattle	AMBV	ALS	23	0	1037	0	1
King	AMBV.ES.00000225	Shoreline Fire Department	Shoreline	AMBV	ALS	10	0	115	0	1
King	AMBV.ES.00000243	Skykomish Fire Department/King County FPD #50	Skykomish	AMBV	BLS	3	2	14	0	0
King	AMBV.ES.60265555	Snoqualmie Fire Department	Snoqualmie	AMBV	BLS	2	2	28	0	0
King	AMBV.ES.00000244	Snoqualmie Pass Fire and Rescue	Snoqualmie Pass	AMBV	BLS	1	1	19	0	0
King	AID.ES.60429244	Summit at Snoqualmie Ski Patrol	Snoqualmie Pass	AID	BLS	0	0	34	0	0
King	AMBV.ES.00000307	Tri-Med Ambulance	Kent	AMBV	BLS	56	0	181	0	0
King	AIDV.ES.00000274	Tukwila Fire Department	Tukwila	AIDV	BLS	0	8	60	0	0
King	AMBV.ES.00000310	Valley Regional Fire Authority	Auburn	AMBV	BLS	5	10	108	0	0
King	AMBV.ES.00000228	Vashon Island Fire and Rescue	Vashon	AMBV	BLS	5	0	24	0	0
King	ESSO.ES.60428351	Washington Poison Center	Seattle	ESSO		0	0	0	0	0
King	ESSO.ES.60428351	Washington Poison Center	Seattle	ESSO		0	0	0	0	0

APPENDIX 6: Approved MIN and MAX Numbers for Trauma Verified EMS Services

Approved Minimum and Maximum of Verified Prehospital Trauma Services by Level and Type by County					
COUNTY	**Verified Service Type**	**Care Level**	**State Approved Minimum #**	**State Approved Maximum #**	**Current Status (total # verified for each service type)**
KING	AIDV	BLS	1	6	2
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	1	25	22
		ILS	0	0	0
		ALS	5	5	5

Numbers are current as of January 2025

Link is included for approved WA air ambulance Strategic Plan

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

APPENDIX 7: Trauma Response Area and EMS Services

Trauma Response Area (TRA) by County			
COUNTY	**TRA #**	**Name of Verified Service(s) Responding in TRA**	**Type & Level of Verified Services in TRA**
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Number of Verified Services in response area**
King	Primary Zone 1	Shoreline FD Northshore FD Bothell Fire & EMS Kirkland FD Redmond FD Eastside Fire & Rescue Kirkland FD Bellevue FD King Co. FD45 King Co. FD27 Snoqualmie FD Mercer Island FD	1 AIDV- BLS 9 AMBV-BLS 3 AMBV-ALS
King	NE Zone 1	Skykomish KCFD 50	0 AIDV- BLS 1 AMBV-BLS 0 AMBV-ALS
King	E Zone 1	Snoqualmie Pass F&R /KCFD51 Bellevue Medic One	0 AIDV- BLS 1 AMBV-BLS 1 AMBV-ALS
King	Zone 3	King Co. FD20 Burien FD Port of Seattle FD Puget Sound RFA Renton RFA South King F&R Valley RFA Tukwila FD Mountain View F&R Enumclaw FD King Co. FD47 Vashon Island F&R King County Medic One	2 AIDV- BLS 11 AMBV-BLS 1 AMBV-ALS

King	Zone 5	Seattle FD	0 AIDV- BLS 0 AMBV-BLS 1 AMBV-ALS
King	Zone SW		No designated service
King	Zone NW		No designated service

APPENDIX 8: Education and Training Programs

CENTRAL REGION TRAINING PROGRAMS APPROVED BY WASHINGTON STATE DEPARTMENT OF HEALTH				
Credential #	**Status**	**Expiration Date**	**Facility Name**	**Site City**
TRNG.ES.60124884-PRO	APPROVED	03/31/2027	American Medical Response	Tukwila
TRNG.ES.60940802-PRO	APPROVED	03/31/2029	Fire Tech	Kirkland
TRNG.ES.60117628-PRO	APPROVED	03/31/2029	King County Emergency Medical Services	Seattle
TRNG.ES.60124347-PRO	APPROVED	03/31/2028	Michael K Copass, MD Paramedic Training Program	Seattle
TRNG.ES.60135401-PRO	APPROVED	03/31/2025	North Seattle College	Seattle

Information is current as of January 2025

CENTRAL REGION - PATIENT CARE PROCEDURES

The supplement section containing the region's Patient Care Procedures (PCPs) is included in the Regional Plan per regulations.

The following PCPs are approved with the Central Region 2025-2027 Strategic Plan. Future updates or amendments to these PCPs will be submitted to the department for review. Approved PCP updates and/or amendments will require an update to the entire PDF document for the Central Region 2025-2027 Strategic Plan. The Central Region will continue to follow the website posting and distribution requirements for the regional plan.

CONTENTS:

PATIENT CARE PROCEDURES:

Contacts

Council Chair
Mark Taylor marct@uw.edu

Regional Executive Director
Randi Riesenberg randi@centralregionems.org

Department of Health, Emergency Care System

To Request Additional Copies (206) 627-0493

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.

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

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

Anatomy of a PCP

RCW 18.73.030 – Defines a "Patient Care Procedure".

Other helpful definitions when building the anatomy of the PCP:

- **Purpose:** The purpose explains why it is needed and what it is trying to accomplish
- **Scope:** Describes the situations for which the PCP was created and the intended audience
- **Standards or General Procedures**: The "body" of the PCP, it sets forth broad guidelines for operations

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

Effective Date: 2009

PURPOSE

To define guidelines for triage of trauma patients in the region.

SCOPE

This PCP applies to all 911 calls and EMS and trauma patients in the region.

GENERAL PROCEDURES

Dispatch

Dispatch centers are accessed through the enhanced 911 system. Regional dispatch centers dispatch EMS units in accordance with King County Criteria Based Dispatch Guidelines. Seattle dispatchers use Seattle Fire Department Dispatch Guidelines. Dispatchers provide bystander emergency medical instructions while EMS units are in route to the scene.

The Central Region EMS Trauma Committee requires that emergency dispatching protocols be based on medical criteria. All EMS dispatching guidelines and protocols must be approved by the Program Medical Director of King County EMS in consultation with the Medical Program Directors of the paramedic programs within the County

Basic Life Support

Basic Life Support response is provided by city and county fire department units staffed by EMTs or private ambulance services staffed by EMTs. The nearest unit to an emergency scene will be dispatched following established dispatch guidelines.

BLS Code Red Response and Transport

Note: Primary responding EMS personnel refers to fire department EMT personnel or paramedics response originating as part of the 911 EMS system. Emergency response refers to travel with light and sirens. The following procedures are intended to maximize patient safety and minimize risk to life and limb. Common sense and good judgment must be used at all times.

- The response mode from primary BLS response (fire department EMT personnel) shall be based on information made available to the EMS dispatchers and the decision for mode of travel made according to dispatch guidelines.

- The default mode for travel to the scene for non-primary BLS responders shall be by non-emergency response unless a specific response for code-red (emergency response) is made by primary responding EMS personnel at the scene or specific protocols or contracts defining response modes exist between fire departments or private agencies and private ambulance companies.

• The default mode for BLS transport from scene to hospital shall be by non-emergency response unless a specific response for code-red transport is made by primary responding EMS personnel at the scene.

• If a patient undergoing BLS transport to hospital deteriorates, the BLS personnel should contact the EMS dispatcher and ask for paramedic assistance, unless documentary evidence exists to travel code-red to hospital (such as travel to hospital can occur faster than waiting for paramedic assistance).

Advanced Life Support

The paramedic unit nearest the emergency scene is simultaneously dispatched consistent with dispatch guidelines. Paramedic units provide advanced life support transport.

Wilderness

Wilderness response is directed by the King County Sheriff Search and Rescue Coordinator. EMS units may be dispatched to a staging area depending on the nature and location of the incident. Transportation of trauma patients from wilderness areas is primarily accomplished by helicopter. The Level I trauma center should be the primary destination of these patients.

APPENDICE

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

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

The Central Region EMS and Trauma Care Council does not currently have this patient care procedure.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

3. Air Medical Services - Activation and Utilization

Effective Date: 2019

PURPOSE

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

SCOPE

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

GENERAL PROCEDURES (content based on State Air Medical Procedure)

a. For scene transport to be efficacious and optimize patient outcome, the air medical response should take significantly less time than it takes to travel by ground to the closest appropriate facility. Another strong consideration should be given to activating the helicopter from the scene, and rendezvous at the local hospital. This decision should be made as per local COPS in conjunction with local medical control.
b. Responders should involve dispatch to contact and activate air medical response to maintain system safety and integrity. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units.
c. Responding EMS service may activate air medical service prior to arrival on scene based on dispatch information or upon arrival on scene based on initial assessment.
d. Air medical service will provide ETA of available fully staffed closest air ambulance.
e. The final patient transport and destination decisions will be made on the scene.
f. Air medical service will notify PSAP/dispatch when activated by a mechanism outside the emergency dispatch system.

Air Medical transport is recommended for the following:
Trauma – patient condition identified as a major trauma per the trauma triage tool. (See link to the WA Trauma Triage Destination Procedure in appendix).

Non-trauma:

a. Any patient airway that cannot be maintained.
b. Patient with cardiac disease and is experiencing a progressively deteriorating course, is unstable, and/or requires measures not available en route (e.g. ALS level care, cardiac catheterization, thrombolytic therapy).
c. Patient is experiencing a severe neurological illness requiring neurosurgical or other intervention that is not available en route. (CVA, uncontrolled seizures, etc.).

APPENDICES

WA State Air Medical Plan
https://www.doh.wa.gov/portals/1/Documents/Pubs/530129.pdf

WA Trauma Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

4. On Scene Command

The Central Region EMS and Trauma Care Council does not currently have this patient care procedure.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5. Prehospital Triage and Destination Procedure

Effective Date: 2009

PURPOSE

This patient care procedure provides guidance for patient triage and determination of the appropriate hospital destination.

SCOPE

This procedure applies to prehospital personnel in the field.

GENERAL PROCEDURES

Prehospital care providers respect the right of the patient to choose a hospital destination and will make reasonable efforts to assure that choice is observed. Alternately and under ADAPT guidelines, fire department-based BLS providers may transport or suggest transport of patients to non-hospital settings such as stand-alone emergency rooms and clinics. Reference Appendix II – ADAPT Guidelines

Factors including patient's choices may include personal preference, personal physician's affiliation or HMO or preferred provider.

Modifying factors which may influence the prehospital provider's response:

- 1. Patient unable to communicate choice
- 2. Unstable patient who would benefit from transportation to nearest hospital or to hospital providing specialized services.
- Transport to patient's choice of hospital would put medic unit or aid car out of service for extended period and alternative transport is not appropriate or available.

Prehospital providers should transport unstable patients, i.e. compromised airway, post arrest, shock from non-traumatic causes, etc. to the nearest hospital able to accept the patient.

Emergency patients requiring specialized care such as hyperbaric treatment, neonatal ICU, or high-risk OB care should be transported to the nearest hospital able to provide such care.

When in doubt, prehospital care providers should contact online medical control.

APPENDICES

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

5.1. Trauma Triage and Destination Procedure

Effective Date: The following proposed draft is currently under review)

PURPOSE: These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which trauma center will receive the patient.

SCOPE: This procedure is for prehospital care providers and their medical control physicians.

GENERAL PROCEDURES:
Activation of the trauma system is done through early notification of Medical Control of the closest trauma center or Harborview Medical Center (Reference: Designated Trauma Centers in King County/Paramedic Response Area). Medical Control or Harborview Medical Center will determine patient destination consistent with the WA State of Washington Trauma Triage and Destination Guidelines for Prehospital Providers.

Transport of High Risk or Serious Injury OR Moderate Risk for Serious Injury patients should be to the closest highest level trauma service within 30 minutes transport time (air or ground).

The goal in treating the unstable trauma patient is to provide potential lifesaving interventions and transportation to the highest-level trauma center able to provide definitive treatment. Ideally these interventions will be performed in a manner that does not unduly delay transport of a patient to the appropriate level of trauma center. This may require EMS providers to stop at a local hospital to stabilize and then transfer the patient to the trauma center.

Consistent with inter-facility transfer agreements, trauma patients stabilized at non-designated hospitals should be transferred to a trauma center as soon as possible. Patients stabilized at Level III or IV trauma centers and meeting the criteria for triage to the Level I trauma center should be transferred as necessary. The State's Level I trauma center is Harborview Medical Center.

Patient destination decisions will be monitored by the Regional Quality Assurance Committee.

Trauma Designation			Facility	City
Adult	Pediatric	Rehab		
I	I P	I R	Harborview Medical Center	Seattle
III			EvergreenHealth Medical Center Kirkland	Kirkland
III			MultiCare Auburn Medical Center	Auburn
III			Overlake Hospital Medical Center	Bellevue
III			Valley Medical Center	Renton
IV			St. Anne Hospital	Burien
IV			St. Francis Hospital	Federal Way
IV			University of Washington Medical Center - Northwest	Seattle

V			Snoqualmie Valley Hospital	Snoqualmie
V			St. Elizabeth Hospital	Enumclaw
		I PR	Seattle Children's Hospital	Seattle

Figure 1. Central Region Trauma Triage Destination Procedure
a modified version of the Washington State Prehospital Trauma Triage Destination Procedure
(intended to be read from top to bottom, left to right)

RED CRITERIA: High Risk for Serious Injury

INJURY PATTERNS

- Penetrating injuries to head, neck, torso, and proximal extremities
- Skull deformity, suspected skull fracture
- Suspected spinal injury with new motor or sensory loss
- Chest wall instability, deformity, or suspected flail chest
- Suspected pelvic fracture
- Suspected fracture of two or more proximal long bones
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

MENTAL STATUS AND VITAL SIGNS

All Patients
- Unable to follow commands (motor GCS < 6)
- RR < 10 or > 29 breaths/min
- Respiratory distress or need for respiratory support
- Room-air pulse oximetry < 90%

Age 0–9 years
- SBP < 70mm Hg + (2 x age in years)

Age 10–64 years
- SBP < 90 mmHg or
- HR > SBP

Age ≥ 65 years
- SBP < 110 mmHg or
- HR > SBP

Patients meeting any RED criteria should be transported to the system's highest appropriate level Trauma Center within 30 minutes transport time (air or ground)

YELLOW CRITERIA: Moderate Risk for Serious Injury

MECHANISM OF INJURY

- High-Risk Auto Crash
  - Partial or complete ejection
  - Significant intrusion (including roof)
    - >12 inches occupant site OR
    - >18 inches any site OR
    - Need for extrication for entrapped patient
  - Death in passenger compartment
  - Child (age 0–9 years) unrestrained or in unsecured child safety seat
  - Vehicle telemetry data consistent with severe injury
- Rider separated from transport vehicle with significant impact (e.g. motorcycle, ATV, horse, etc.)
- Pedestrian/bicycle rider thrown, run over, or with significant impact
- Fall from height > 10 feet (all ages)

EMS JUDGEMENT

Consider risk factors, including:

- Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact
- Anticoagulant use
- Suspicion of child abuse
- Special, high-resource healthcare needs
- Pregnancy > 20 weeks
- Burns in conjunction with trauma
- Children should be triaged preferentially to pediatric capable centers

If concerned, take to a trauma service.

Patients meeting any YELLOW criteria, WHO DO NOT MEET THE RED CRITERIA, should be transported to a designated trauma service; it need not be the highest-level.

APPENDICES

This tool is based on the DOH guidance document: Prehospital Trauma Triage and Destination Procedure.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
Regional Council	Updated tool	2/26/25	☒ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.2. Cardiac Triage and Destination Procedure

Effective Date: 2018

PURPOSE

Provides guidance for the prehospital care and transport of cardiac patients in Central Region.

SCOPE

This procedure applies to prehospital providers caring for cardiac patients.

GENERAL PROCEDURES

These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which Cardiac Center will receive the patient.

Prehospital providers will contact established medical control. Medical Control will determine patient destination consistent with Washington State Cardiac Patient Care Triage Destination Procedure.

Patients shall be managed consistent with the State of Washington Prehospital Cardiac Triage Destination Procedure.

Patient destination decisions and patient outcome will be monitored by the Regional Quality Assurance Committee

Current Approved Cardiac Care Centers

Level I

MultiCare Auburn Regional Medical Center
EvergreenHealth
Harborview Medical Center
UW Medical Center - Northwest
Overlake Hospital Medical Center
St. Francis Hospital
Swedish Cherry Hill
UW Medical Center Montlake
Valley Medical Center
Virginia Mason Medical Center
Swedish Issaquah
St. Anne Hospital

Level II

Swedish First Hill
Snoqualmie Valley Medical Center
St. Elizabeth Hospital
Swedish Ballard

APPENDICES

DOH guidance document on prehospital cardiac care
https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/346050.pdf

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.3. Stroke Triage and Destination Procedure

Effective Date: 2018

PURPOSE

To provide prehospital guidance on the transport and care of stroke patients.

SCOPE

This procedure is appropriate for prehospital providers who are caring for stroke patients.

GENERAL PROCEDURES

Stroke Patient Triage and Destination

These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which Stroke Center will receive the patient. EMTs shall transport patient to the closest appropriate level Stroke Center consistent with the Washington State Stroke Patient Care Triage Destination Procedure and with regard to the patient or family preference.

- For all patients with suspected stroke, EMS personnel will contact the closest Level I, II or III stroke center and describe the situation. The hospital will advise EMS of appropriate patient destination consistent with the Washington State Patient Care Triage Destination Procedure.
- For unstable stroke patients, EMTs shall request Paramedic assistance.
- Paramedics shall contact established medical control. Medical Control will determine patient destination consistent with Washington State Stroke Patient Care Triage Destination Procedure.
- Patients should be managed consistent with the King County ALS Protocols and State of Washington Prehospital Stroke Triage Destination Procedure.
- Patients should be managed consistent with the King County ALS Protocols and State of Washington Prehospital Stroke Triage Destination Procedure.
- Patient destination decisions and patient outcome will be monitored by the Regional Quality Assurance Committee

Current Approved Stroke Centers

Level 1	Harborview Medical Center
	Swedish Cherry Hill
	Virginia Mason Medical Center
Level II	MultiCare Auburn Regional Medical Center
	EvergreenHealth Medical Center
	Overlake Hospital Medical Center
	St. Anne Hospital
	Swedish First Hill

Swedish Issaquah
Valley Medical Center
St. Francis Hospital
UW Medical Center- Northwest

Level III
Snoqualmie Valley Hospital
St. Elizabeth Hospital
Swedish Ballard
UW Medical Center Montlake

APPENDICES

2019 King County Prehospital Stroke Triage Procedure

STEP 1: Assess Likelihood of Stroke

- Numbness or weakness of the face, arm, or leg, especially on one side of the body
- Confusion, trouble speaking, or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance, or coordination
- Severe headache with no known cause

If any of above, proceed to STEP 2, otherwise, transport per regional/county operating procedures

STEP 2: Perform F.A.S.T. Assessment (positive if any of Face/Arms/Speech abnormal)

- **Face:** Unilateral facial droop
- **Arms:** Unilateral arm drift or weakness
- **Speech:** Abnormal or slurred
- **Time:** Best estimate of Time Last Known Well =_____

If FAST negative transport per regional operating procedures

STEP 3: If F.A.S.T Positive - Calculate Stroke Severity Score

Facial Droop:	Absent 0	Present 1			
Arm Drift:	Absent 0	Drifts 1	Falls Rapidly 2		
Grip Strength:	Normal 0	Weak 1	No Grip 2		

Total Stroke Severity Score = _____ (max. 5 points)

STEP 4: Determine Destination: Time Last Known Well & Stroke Severity Score

Time Last Known Well ≤ 24 Hours And patient previously independent **OR** **Time Last Known Well is > 24 Hours (Regardless of Stroke Severity Score)**

What is the Stroke Severity?

Score 4 or more Severe Stroke

Activate ALS Response ASAP
Paramedic triage and hospital alert

Expedite ALS Transport to nearest Endovascular Stroke Center if transport time is no more than an extra 30 minutes from the local acute care hospital.

Score <=3 Mild or Moderate Stroke

BLS transport
EMT-FF alert destination hospital

Transport to nearest acute care hospital.

Exclude persons with chronic illness that makes them bedbound – for example those with advanced dementia or longstanding medical illness who require substantial assistance for basic life activities. These patients should proceed to local hospital regardless of stroke severity or last known well status.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.4. Behavioral Health Facilities Destination Procedure

Effective Date: 2025 Draft currently in progress

Purpose: To operationalize the transport of patients to behavioral health facilities in accordance with RCW 70.168.170.

Scope: In the 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.

General Procedures: EMS should only transport patients to behavioral health facilities when the following criteria are met:

- EMS was dispatched via 911;
- The receiving facility is a licensed behavioral health agency, behavioral health hospital, residential treatment facility, or diversion center approved by the MPD;
- The receiving facility has bed availability;

EMS provider uses their judgment based on MPD protocols; the patient meets the following criteria:

- Have a chief concern related to substance use and/or mental health
- Be willing to go to a crisis center

OR

Be referred by law enforcement for involuntary transport, or detained by a DCR under ITA

- Vital signs are within acceptable range
    - HR 45-120
    - SBP > 100/p
    - Temp. 95-100.3ºF
    - Room air SpO2 ≥ 92%
    - Blood sugar > 70/dl

Exclusion: The patient must NOT have:

- Obtunded or decreased level of consciousness
- Medical issue(s) requiring immediate treatment
- Acute physical trauma (that cannot be definitively cared for by EMTs)
- Overdosed on meds that need hospital eval (i.e. acetaminophen, tricyclics, aspirin, metformin)
- Seizure within the past 24 hours
- Age > 65y with new-onset bizarre behavior (in absence of substance use)
- Pregnancy with complications, 3rd trimester, or impending childbirth
- Inability to mobilize or transfer independently
- Indwelling tubes, lines, or catheters that the patient cannot manage
- Functional needs (developmental delay, traumatic brain injury, dementia, etc.)

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Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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6. EMS/Medical Control Communications

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

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Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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7. Hospital Diversion

Effective Date:

PURPOSE

This procedure outlines Central Region's no-divert policy.

SCOPE

This procedure is appropriate for times of high patient census, and is meant for hospital and prehospital personnel.

GENERAL PROCEDURES

Ambulance diversion is defined as an active statement by a hospital, whether verbal or via WaTrac ED Status, that patients arriving by ambulance will not be accepted. King County hospitals have unanimously adopted a No Diversion Policy for all medical and surgical patients effective May 31, 2011.

Hospitals may close their emergency departments only in an internal emergency such as facility damage or lockdown. There may be circumstances where an advisory to prehospital agencies will allow ambulance services to make transport destination decisions in the best interest of their patient; for example, when a hospital reports "CT down" or "specialty care unavailable." Prehospital service may use this information to make an appropriate transport decision. The decision on where to transport a patient will remain at the discretion of the prehospital provider unless directed to a specific facility by medical control.

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Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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8. Cross Border Transport

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

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Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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9. Inter-Facility Transport Procedure

Effective Date: 2009

PURPOSE

To establish guidelines for the transport of patients between facilities within Central Region.

SCOPE

This procedure is relevant for hospital emergency department personnel and EMS agencies who may transfer a patient from one facility to another within the region.

GENERAL PROCEDURES

Private ALS and BLS agencies provide interfacility patient transfers at the direction of the hospital initiating the transfer. All interfacility patient transfers shall be consistent with the transfer procedures in WAC 246-976-890.

Level III, Level IV, and Level V trauma centers will transfer patients to the State Level I trauma center when appropriate. The State's Level I trauma center is: Harborview Medical Center

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

Effective Date: 2009

PURPOSE

To establish procedures for patient transport in the event of a mass casualty incident.

SCOPE

This procedure is relevant to EMS and hospital personnel in the region in the event of a mass casualty incident.

GENERAL PROCEDURES

The Central Region has adequate resources to meet normal trauma patient volumes. The Quality Assurance Committee monitors mechanism of injury and patient volumes.

Large Multiple Casualty Incidents may require the triage of patients to non-designated King County hospitals or to trauma centers in adjacent counties.

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11. MCI and Severe Burns

Effective Date: 2009

PURPOSE

Provides guidance for transport and care of patients in an MCI who may have suffered severe burns and need specialized care.

SCOPE

This procedure is appropriate for EMS teams in an MCI in which many patients suffer severe burns.

GENERAL PROCEDURES

STANDARD: During a mass casualty incident (MCI) with severely burned adult and pediatric patients,

- All verified ambulance and verified aid services shall respond to an MCI per the King County Fire Chief's MCI Plan
- All licensed ambulance and licensed aid services shall assist during an MCI per King County Fire Chief's MCI Plan when activated by incident command through dispatch in support of the King County Fire Chief's MCI Plan and/or in support of verified EMS services
- All EMS certified personnel shall assist during an MCI per King County Fire Chief's MCI Plans when requested by incident command through dispatch in support of the King County Fire Chief's MCI Plan and/or in support of verified EMS services
- Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
- All EMS agencies working during an MCI event shall operate within the Incident Command System as identified in local protocol and MCI plan.

PURPOSE:

To develop and communicate the information of regional trauma plan section VII prior to an MCI.
To implement King County Fire Chief's MCI Plan during an MCI.
To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region.
To provide safe mass transportation with pre-identified medical staff, equipment, and supplies per mass transport vehicle.

PROCEDURES:

- Incident Command shall follow the King County Fire Chief's MCI Plan and will notify Disaster Medical Control Center (DMCC) when an MCI condition exists, including factors identifying severe burn injuries and number of adult/pediatric patients.
- Medical program directors agree that protocols being used by responding agencies shall continue to be used throughout transport of patients regardless of county, state or country.
- EMS personnel may use the "Prehospital Mass Casualty Incident (MCI) general Algorithm during the MCI incident.

A. The "SAMPLE ONLY" algorithm is intended as a boilerplate or skeleton outline only. It is not intended as a state directed requirement.
B. the DRAFT-SAMPLE Algorithm is attached on the next page.

APPENDICES

1. Receive dispatch
2. Respond as directed
3. Arrive at scene
4. Determine mass causality conditions exist
5. Establish Incident Command (IC)
6. Scene assessment and size-up

CBRNE	NON-CBRNE
1) Notify the DMCC and IC of CBRNE situation 2) Standby for HazMat/LE to clear scene 3) Don PPE if needed 4) Establish hot, warm, and cold zones 5) Begin Initial Triage of Patients 6) Notify medical control and IC of patients conditions 7) Decontaminate patients as needed 8) Begin initial treatment 9) Follow PCPs and MCI Plans 10) Request additional resources that may include activating MAA 11) Initiate patient transport to medical centers as directed by medical control and/or the DMCC 12) Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)	Notify medical control and/or the DMCC and local Emergency Management Office 1) Ensure scene is safe 2) Begin Initial Triage and Treatment of Critically Injured Patients 3) Establish a staging area 4) Follow EMS patient care procedures (PCPs) and MCI Plans 5) Request additional resources that may include activating MAA 6) Initiate patient transport to medical centers as directed by medical control and/or the DMCC 7) Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)

Prepare transport vehicle to return to service

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12. ALL HAZARDS

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

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A. Region Specific Patient Care Procedures: Activation of Trauma Team

Effective Date: 2009

PURPOSE

To provide a general guideline for hospital facilities' activation of their trauma team for incoming patients.

SCOPE

Applies to hospital personnel.

GENERAL PROCEDURES

Trauma team activation is accomplished at the time of contact with Medical Control. Online medical control at the receiving trauma center will activate the trauma team upon notification of the transporting agency or dispatcher. All designated trauma centers will activate their trauma team per WAC 246-976-870 and WAC 246-976-700.

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B. Region Specific Patient Care Procedures: Adapt Clinic and Urgent Care Clinic Transportation Policy

Effective Date: 2009

PURPOSE

To provide guidance about patient transport to urgent care clinics.

SCOPE

This procedure applies to prehospital personnel.

GENERAL PROCEDURES

Selected patients may be transported to a clinic, urgent care clinic, free standing emergency department, or hospital-based emergency department via BLS transport if the patient meets the criteria listed below. These policies apply to non-primary (private) BLS ambulance when EMS personnel request private BLS ambulance to transport the patient.

- The fire department based (primary) EMT provider considers a taxi to be an appropriate and safe method of transportation for the particular clinical problem.
- Paramedic care is NOT required
- Patient is ambulatory
- Patient has a non-urgent condition (clinically stable) including
    - Low index of suspicion for:
        - Cardiac problem
        - Stroke
        - Abdominal aortic aneurysm
        - GI bleed problems
    - Low index of suspicion for major mechanism of injury
- Patient must not have
    - Need for a backboard
    - Uncontrolled bleeding
    - Uncontrolled pain
    - Need for oxygen (except patient self-administered oxygen)
- Patient should be masked if there are respiratory symptoms

For guidance regarding transport decisions EMTs may consult with paramedics or with emergency department personnel at the medical control hospital.
The EMT must notify the destination facility of the clinical problem and the facility must agree to accept the patient.

ADAPT Taxi Voucher Transportation Policy

Selected patients may be transported to a clinic, urgent care clinic, free standing emergency

department, or hospital-based emergency department via taxi if the following conditions listed above are met and the fire department-based EMT considers a taxi to be an appropriate and safe method of transportation for the particular clinical problem.

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C. Region Specific Patient Care Procedures: Paramedic Training and Changes in Service Levels

Effective Date: 2009

PURPOSE

To provide information about paramedic training and service levels in the region.

SCOPE

Applies to prehospital agencies and leadership.

GENERAL PROCEDURES

In order to maintain the highest quality care for prehospital emergencies it shall be required that:

- The standard level response of ALS service shall be two paramedics. Exceptions may be authorized by the King County MPD for outlying districts and when split crews are required to respond to mass casualties.
- King County paramedics shall be trained through and satisfy the educational requirements of the Paramedic Training program at the University of Washington/Harborview Medical Center.
- Requests to expand or reduce service to a trauma response area, to change the level of EMS service provided, and new applications for EMS agencies seeking trauma verification must be reviewed and receive a recommendation by the Regional EMS Council in accordance with WAC 246-976-395(4).

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