Strategic Plan:

2025-2027

EAST REGION

Emergency Medical Services & Trauma Care Council

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INTRODUCTION

The East Region was established in 1990 as part of the Emergency Medical Service (EMS) and Trauma Care System through the Revised Code of Washington (RCW 70.168.100-70.168.130) and Washington Administrative Code (WAC 246-976-960). The Regions administer and facilitate EMS & Trauma Care System coordination, evaluation, planning, and develop system recommendations for the WA State EMS and Trauma Steering Committee and the Department of Health. 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, Healthcare Coalition, Local Elected Official and Consumers. Council members are appointed volunteer representatives.

Mission Statement: To promote and support a comprehensive emergency care system.
Vision: To have all EMS agencies verified and all hospitals' trauma designated at the appropriate levels to provide every person in the region with access to medical service and trauma care in all communities.

The Region Council is primarily funded by contract with the DOH to complete the work in this plan. The Region Council is a private 501 (C)(3) nonprofit organization. The Chair, Vice Chair, Treasurer, and Secretary make up the Executive Committee which oversees the routine business of the Council between regular Council meetings. The Region Council is staffed by one employee, the Executive Director. The work performed by the Executive director at the direction of the council includes: work with the region council and system partners to develop, coordinate, and facilitate the work of the Region System Plan, manage the day to day business of the Region Council office, meet the federal 501 (C)(3) standards of financial management and the WA State Auditor Office accounting requirements, administer all contracts and grants, attend and participate in the WA EMS Steering Committee and it's multiple Technical Advisory Committees (TAC) meetings, WA DOH meetings, coordinate Region Council meetings, support and attend local County Council meetings as well as collaborate with EMS and Trauma System partners. Oversight remains the responsibility of the entire Council. All financial transactions are approved at meetings, and substantive business decisions are made by a vote of the full Region Council.

The Region Council informs ongoing WA EMS & Trauma Care System development with relevant partners in the Emergency Care System through the exchange of information, committee participation, meeting attendance, Prehospital and hospital planning, and special projects relevant to the Emergency Care System. The Region Council maintains collaborative partnerships in the Emergency Care System (examples of partners include Cardiac, Stroke, and Trauma QI, local EMS & trauma care councils, healthcare coalitions, local, regional and state public health partners, Emergency Management, E911 communications, accountable communities of health, injury prevention organizations, law enforcement, behavioral health/chemical dependency organizations, the State EMS Steering

Committee and its various TACs.) This broad representation cultivates the development of a practical, system wide approach to the coordination and planning of the WA EMS & Trauma Care System.

The North Central Region Council and East Region Council have successfully consolidated administrative services via contract since July 2013. This consolidation has reduced the duplication of administrative tasks and expenses, which allows both regions to accomplish the work of the DOH contract independently while maximizing system administrative funding. Both region councils work to accomplish the objectives and strategies in their strategic plans and the broader collaboration between the regions helps to maintain the same level of system support across both regions; additionally, it creates congruency in Region PCPs, decision making for minimum and maximum numbers for EMS services and trauma designation and providing support for the training and education of EMS providers.

While successfully funding various programmatic endeavors, the Region also supports costs 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 to continue to support the Regional Council going forward.

The East Region has established committees and workgroups to facilitate the work of the strategic plan:

- Executive Committee: Comprised of the Council President, Vice President, Treasurer, Secretary, and a County Council representative.
- Training and Education Committee: Comprised of members of the Regional and Local Council 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.
- Prehospital and Transportation Committee: Comprised of members of the Regional and Local Councils to review, revise, and provide education on Minimum and Maximum numbers, Regional Patient Care Procedures, and County Operating Procedures.
- Rehabilitation Committee: Comprised of members from local and regional rehabilitation centers to develop the regional strategic plan goals and objectives to correlate with highest risk populations in our region for targeted interventions, injury prevention, and public education.
- East Region QI Committee: Comprised of members of each designated facility's medical staff, the Trauma, Cardiac, and Stroke Coordinators, EMS Providers, Medical Program Directors, Rehabilitation, Trauma Medical Director, and Regional Council members. The Mission of the East Region QI Committee is "to promote and support a comprehensive emergency care system in the East Region."

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 to EMS providers. MPD duties are described in WAC 246-976-920. MPDs of each county supervise and provide medical control and direction of certified EMS personnel. This is done through verbal (online)

medical direction and by developing written protocols directing patient care, attendance at county council meetings, and establishing quality assurance programs. MPDs participate with the local and regional EMSTC Councils to determine education for ongoing training, approve initial training courses; and assist in development of county operating procedures, regional patient care procedures, and regional strategic plans.

East Region Council successes during the 2023-2025 plan cycle:

- Accomplished the work outlined in the 2023-2025 strategic plan including the review of minimum and maximum numbers of service, trauma response area maps, and review of agency information provided by the Department of Health.
- Completed a needs assessment for Spokane County that increased the ability to provide an additional ALS service to the county.
- Provided technical guidance to County Councils with minimum and maximum review of EMS services and EMS service licensing and verification.
- Distributed funds to approved training programs for the purpose of providing Ongoing Training and Education to EMS providers in the region. Continued Administrative Services contract with the North Central Region decreasing administrative costs and allowing more funding towards training, education, and equipment for trauma system providers.
- Distributed funds to support additional education opportunities to EMS Providers that include initial and renewal ESE courses, Initial EMS courses, and initial EMS course materials.
- Distributed funds to support Injury Prevention and Public Education with a strong focus on the leading cause of death and disability in the East Region; Mental Health First Aid for EMS Providers, Senior Falls SAIL courses, Stop the Bleed Campaigns, Car Seat Safety, and Bicycle Safety.
- Participated in Regional Advisory Committee, Prehospital TAC, EMS Education Workgroup, Rule Making, and attended State Steering Committee meetings.
- Continued recruitment efforts of Council membership with increased participation from County Council members and County Commissioners.
- Received funding for opioid naloxone leave-behind and buprenorphine programs and community education for naloxone administration.

East Region Council ongoing challenges during the 2023-2025 plan cycle:

- EMS Agencies have experienced a decline in EMS personnel that has created issues in their ability to staff ambulances and placed a burden on the neighboring agencies to assist in response.

- Hospital staffing issues created an increase in the amount of long-distance interfacility transport being requested of EMS agencies, thus causing a staffing burden on agencies needing to back-fill personnel to cover the response area.

The East Region consists of nine counties: Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, and Whitman; including the Kalispell and Colville Tribal Nations. The region is 15,810 square miles with a population of approximately 727,632 residents. The region is rural in nature, with Spokane being considered urban with the largest population. There are 77 Licensed and Trauma Verified aid, ambulance, and Emergency Service Support Organization (ESSO) response agencies with 1,970 providers.

The East Region EMS & Trauma Care Council maintains a regional website and provides access to local council and MPD information, injury prevention activities, industry partner information, and regional council information. http://eastregion-ems.org/

ADAMS COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	16,428	18,728	20,613	20,820	
Income and Poverty	(2020) Median household income: $65,042			Poverty rate: 20.5%	
Health	(2020) 15.9% - without health care coverage			9.8% - disabled	
Description of county	1,930 sq mi; the county has six unincorporated communities. Wheat farming was the main focus of early residents. In 1909 Adams County proclaimed itself " the bread basket of the world," with Ritzville reportedly being the world's largest inland wheat exporter. Two major highways run through the county: I-90 and U.S. Route 395. The topography of the county often creates dust and snowstorms that cause multiple vehicle accidents and road closures.				
Seasonal influences	Year-round outdoor activities draw an influx of tourists to the area. Wildfire season impacts travel and air quality. Winter weather conditions make travel difficult at times.				

ADAMS COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 14	ILS - 0	ALS - 0		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	2	0	0		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	1	0	0	1	1

ASOTIN COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	20,551	21,623	22,285	22,549	
Income and Poverty	(2020) Median household income: $69,107			Poverty rate: 14.9%	
Health	(2020) 5.8% - without health care coverage			20.6% - disabled	

Description of county	641 sq mi; includes five unincorporated communities. Asotin County is part of the Lewiston, ID-WA metropolitan statistical area, which includes Nez Perce County, Idaho, and Asotin County. The Region includes Lewiston in its trauma system. It is the fifth-smallest county in Washington by area. It is part of the Palouse, a wide and rolling prairie-like region of the middle Columbia basin with one major highway that run throughs the county; U.S. Route 12.
Seasonal influences	Year-round outdoor activities draw an influx of tourists to the area. Wildfire season impacts travel and air quality. Winter weather conditions make travel difficult at times.

ASOTIN COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 56	ILS - 11	ALS - 41		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	4	2	0		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	1	0	0	1	1

FERRY COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	7,260	7,551	7,178	7,497	
Income and Poverty	(2020) Median household income: $54,650 Poverty rate: 15.6%				
Health	(2020) 5.5% - without health care coverage 25.1% - disabled				
Description of county	2,257 sq mi; fourth-least populous county in Washington that includes ten unincorporated communities. It is located on the northern border of WA State and reaches to Canada, the Columbia River, and the Colville Indian Reservation with two major highways; U.S. Route 20 and 21. The county greatly affected by snowstorms and power outages with only one main power line.				
Seasonal influences	Year-round outdoor activities draw an influx of tourists to the area. Wildfire season impacts travel and air quality. Winter weather conditions make travel difficult at times.				

FERRY COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 28	ILS - 1	ALS - 1		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	2	0	0		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	1	0	0	1	1

GARFIELD COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	2,397	2,266	2,286	2,363	
Income and Poverty	(2020) Median household income: $62,411 Poverty rate: 10.8%				
Health	(2020) 4.2% - without health care coverage 25.6% - disabled				
Description of county	718 sq mi; the least populous county in Washington with six unincorporated communities. With about 3.2 inhabitants per square mile, it is also the least densely populated county in Washington. Two major highways run through the county; U.S Route 12 and State Route 127. It is part of the Palouse, a wide and rolling prairie-like region of the middle Columbia Basin.				
Seasonal influences	Year-round outdoor activities draw an influx of tourists to the area. Wildfire season impacts travel and air quality. Winter weather conditions make travel difficult at times.				

GARFIELD COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 22	ILS - 1	ALS - 0		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	1	0	0		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	1	0	0	1	1

LINCOLN COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	10,184	10,570	10,876	11,738	
Income and Poverty	(2020) Median household income: $71,227 Poverty rate: 8.8%				
Health	(2020) 3.1% - without health care coverage 21.3% - disabled				
Description of county	2,317 sq mi; fifth-least populous county in Washington with eight unincorporated communities. Lincoln County lies on the channeled Scablands, known as the Big Bend Plateau with three major highways that run through it: I-90, U.S. Route 2, and U.S. Route 395. The county is dependent on agriculture, primarily wheat farming.				
Seasonal influences	Year-round outdoor activities draw an influx of tourists to the area. Wildfire season impacts travel and air quality. Winter weather conditions make travel difficult at times.				

LINCOLN COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 59	ILS - 12	ALS - 0		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	8	0	0		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	1	0	0	1	1

PEND OREILLE COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	11,732	13,001	13,401	14,361	
Income and Poverty	(2020) Median household income: $63,750 Poverty rate: 13.6%				
Health	(2020) 6.4% - without health care coverage 21.5% - disabled				
Description of county	1,425 sq mi; located in the northeast corner of Washington, along the Canada–US border, with eight unincorporated communities. Five major highways run through the county: U.S. Route 2, State Routes 20,31,41, and 211. As well as the International Selkirk Loop.				
Seasonal influences	Year-round outdoor activities draw an influx of tourists to the area. Wildfire season impacts travel and air quality. Winter weather conditions make travel difficult at times.				

PEND OREILLE COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 71	ILS - 3	ALS - 14		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	5	0	0		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	1	0	0	1	1

SPOKANE COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	417,939	471,221	539,339	551,455	
Income and Poverty	(2020) Median household income: $73,583 Poverty rate: 12.5%				
Health	(2020) 5.0% - without health care coverage 16.7% - disabled				
Description of county	1,781 sq mi; with 37 unincorporated communities, making it the fourth most populous county in Washington, the only county in the East region with an urban city. Ten major highways run through it; I-90, U.S. Routes 2,195, 395, State Routes 27, 206, 290, 291, 902, and 904.				
Seasonal influences	Year-round outdoor activities draw an influx of tourists to the area. Wildfire season impacts travel and air quality. Winter weather conditions make travel difficult at times.				

SPOKANE COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 967	ILS - 40	ALS - 427		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	18	4	2		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	4	1	1	3	3

STEVENS COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	40,066	43,531	46,445	48,837	
Income and Poverty	(2020) Median household income: $67,405 Poverty rate: 8.8%				
Health	(2020) 6.7% - without health care coverage 18.3% - disabled				
Description of county	2,541 sq mi; includes 15 unincorporated communities, ranks 23rd in population to the other counties of Washington State. Only 9.400% of the population lives within the six incorporated cities. Two major highways run through the county: U.S. Route 395 and State Routes 20, 25, 231, and 291.				
Seasonal influences	Year-round outdoor activities draw an influx of tourists to the area. Wildfire season impacts travel and air quality. Winter weather conditions make travel difficult at times.				

STEVENS COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 144	ILS - 38	ALS - 20		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	12	1	1		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	2	0	0	2	2

WHITMAN COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	40,740	44,779	47,973	48,012	
Income and Poverty	(2020) Median household income: $52,893 Poverty rate: 23.7%				
Health	(2020) 11.9% - without health care coverage 23.7% - disabled				
Description of county	2,178 sq mi; includes nine unincorporated communities. Whitman County is part of the Palouse, a wide and rolling prairie-like region of the middle Columbia basin. Whitman County has highly productive agriculture. Whitman County produces more barley, wheat, dry peas, and lentils than any other county in the United States. Eight major highways run through the county; U.S Route 195 and State Routes 23, 26, 27, 127, 270, 271, and 272.				
Seasonal influences	Year-round outdoor activities draw an influx of tourists to the area. Wildfire season impacts travel and air quality. Winter weather conditions make travel difficult at times.				

RESOURCE STATISTICS					
EMS Providers	BLS	ILS	ALS		
	Trauma Verified	**EMS Licensed**	**ESSO**		
EMS Agencies	15	0	0		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	2	0	0	2	2

*United State Census Bureau https://data.census.gov

The Rural Health Research & Policy Centers released a document in May of 2023 titled “Ambulance Deserts; Geographic Disparities in the Provision of Ambulance Services.” 41 states were analyzed using data from 2021-2022. In the Executive Summary it is noted that access to timely ambulance service is an essential part of the emergency medical system, yet access varies widely with significant gaps across the country. The research identifies places and people that are more than 25 minutes from an ambulance station, also called an “ambulance desert.” Washington State is noted as having “ambulance deserts” in 100% of the 39 counites.

SEE: Ambulance Deserts, Geographic Disparities in the Provision of Ambulance Services

GOAL 1 INTRODUCTION

MAINTAIN, ASSESS AND INCREASE EMERGENCY CARE RESOURCES

To increase access to a quality, integrated emergency care system, we involve our local EMS councils, Medical Program Directors, and regional Trauma and Emergency Cardiac and Stroke QI partners to provide input on trauma and rehabilitation designation, and cardiac and stroke categorization, for minimum and maximum levels of facilities to support the system.

The Region Council relies on input and recommendations from Local EMS Councils, County Medical Program Directors, and system partners to identify and recommend minimum and maximum numbers for Prehospital levels of licensed and verified agencies, and development of regional Patient Care Procedures and County Operating Procedures.

The 2025-2027 Strategic Plan cycle will largely focus on assessment and identification of resources needed for Trauma, Cardiac, and Stroke care, as well as Prehospital EMS resources. Recovery of the effects from the COVID -19 Pandemic are still a large part of the recruitment and retention efforts for hospitals, clinics, and EMS personnel. The decrease in the available workforce continues to cause large concerns for the stability of the EMS and Trauma Care System in the region and the effects they had on resources outside of the region who are prevailed upon when regional resources for care are limited.

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.”

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
Objective 1: By June 2026, the Region Council will review and revise minimum and maximum numbers for verified prehospital services needed to support public access to emergency care services.	**1**	**Strategy 1.** By August 2025, Region Council members will revise the minimum and maximum assessment process and guidance document for verified prehospital services.
	2	**Strategy 2.** By October 2025, the Region Council will provide the revised guidance document, education, and data resources, to the Local Councils.
	3	**Strategy 3.** By December 2025, the Local Councils will complete a minimum and maximum assessment of the verified prehospital services utilizing the Region Assessment tool provided.

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
	4	**Strategy 4.** By February 2026, the Local Councils will present the assessment results to EMS agencies, MPDs, and system stakeholders and make recommendations to the Region Council.
	5	**Strategy 5.** By April 2026, the Region Council will submit recommendations to the Department for the minimum and maximum numbers of verified prehospital services.
	6	**Strategy 6.** By June 2026, the Region Councils will inform the Local Councils, EMS Agencies, MPDs, and stakeholders of revision to minimum and maximum numbers of verified services determined.
	7	**Strategy 7.** On an ongoing basis, the Region EMS Council will work through the process to fill vacant TRAs as identified in the minimum and maximum assessment for verified services, or vacancies left from agency licensure changes with the Department.
	8	**Strategy 8.** On a quarterly basis, the Region EMC council will reconcile the resource list of agencies provided by the Department with the TRAs and provide updated information to the local councils, MPDs, and notification to stakeholders and the Department of changes.
Objective 2: By June 2026, the Region Council will review and revise minimum and maximum numbers for designated trauma and rehabilitation services.	**1**	**Strategy 1.** By October 2025, the Region Council will submit the current Department list of designated trauma and rehabilitation services, and the current Washington State Trauma Services Assessment tool to the Regional QI Committee for review and discussion.
	2	**Strategy 2.** By December 2025, the Region Council and Regional QI Committee will determine a list of trauma service stakeholders, MPDs, local Physicians, rehabilitation, and EMS agencies to form a Trauma Service Assessment workgroup.
	3	**Strategy 3.** By February 2026, the Region Council and Regional QI Committee will review data from trauma services, Department data, population growth, transfer patterns, and EMS status, to determine the minimum and

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
		maximum numbers of trauma and rehabilitation services needed and approve recommended changes.
	4	**Strategy 4.** By May 2026, the Region Council and Regional QI Committee will present the determined minimum and maximum numbers of trauma and rehabilitation services to the Department and Steering Committee for approval.
	5	**Strategy 5.** By June 2026, the Region Councils will inform the Local Councils, EMS Agencies, MPDs, and stakeholders of revision to minimum and maximum numbers of trauma and rehabilitation services determined with Regional PCPs and County Operating Procedures for appropriate transport destinations.
	6	**Strategy 6.** On an ongoing basis, the Region EMS Councils will work through the process of trauma and rehabilitation designated service changes with the Department.
Objective 3: By December 2026, the Region Council will review the current categorized cardiac and stroke facilities and determine the number of services needed.	**1**	**Strategy 1.** By June 2026, the Region Council and the Regional QI Committee will request facilities who are not categorized for cardiac and stroke to complete the categorization process with the Department and/or determine why the facility is unable to do so.
	2	**Strategy 2.** By October 2026, the Region Council and Regional QI Committee will submit recommendations for categorized cardiac and stroke services to the Department as identified by the Regional QI Committee.
	3	**Strategy 3.** By December 2026, the Region Council will inform the Local Councils, EMS Agencies, MPDs, and stakeholders of the numbers and levels of cardiac and stroke categorized facilities with Regional PCPs and County Operating Procedures for appropriate transport destinations.

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
Objective 4: By February 2027, the Region Council will review County Operating Procedures for congruence with Regional Patient Care Procedures.	**1**	**Strategy 1.** By October 2026, the Regional Prehospital and Transportation Committee will coordinate a workshop with Local Councils and Medical Program Directors to review County Operating Procedures for consistency with Regional Patient Care Procedures.
	2	**Strategy 2.** By February 2027, the Regional Prehospital and Transportation Committee will assist Local Councils and Medical Programs Directors with updating County Operating Procedures.
	3	**Strategy 3.** On an ongoing basis, the Regional Prehospital and transportation committee will assist Local Councils with submission of County Operating Procedures to the Department for approval.
	4	**Strategy 4.** On an ongoing basis, the Regional Prehospital and Transportation Committee will assist Local Councils with distribution of updated COPs to EMS agencies, providers, and system stakeholders with Regional PCPs for appropriate transport decisions and destinations.
Objective 5: By July 2026, the Region Council will review and update regional Patient Care Procedures (PCPs); and work toward statewide standardization of Regional PCPs.	**1**	**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).
	2	**Strategy 2.** On an ongoing basis, the Regional Prehospital and Transportation Committee will include system partners, local councils, and county MPDs in review and development of Regional PCPs.
	3	**Strategy 3.** By February 2026, the Regional Prehospital and Transportation Committee will review, develop, and submit recommended drafts and revisions of the Regional PCPs to the Regional Council for approval.
	4	**Strategy 4.** By June 2026, the Region Council will submit approved Regional PCPs to the Department for approval.

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
	5	**Strategy 5.** By July 2026, the Region Council will distribute Department approved Regional PCPs to system partners, local councils, and Medical Program Directors.
Objective 6: By April 2026, the Region Council will survey the Prehospital EMS Services to identify challenges for EMS Workforce.	**1**	**Strategy 1.** By October 2025, the Region Prehospital Transportation Committee will survey Prehospital EMS Services to determine challenges in recruitment and retention of personnel.
	2	**Strategy 2.** By December 2025, the Region Prehospital Transportation Committee will summarize survey results and provide a report to the Local Council with a request for suggested solutions.
	3	**Strategy 3.** By April 2026, the Region Council will provide a summary of the prehospital EMS services challenges and identified solutions to the Department of Health.
Objective 7: By April 2027, the Region Council will identify specific challenges for the Department approved EMS Training Programs in the Region.	**1**	**Strategy 1.** By December 2026, the Regional Training and Education Committee will request a list of the approved EMS Training Programs with Training Coordinator contact information from the Department.
	2	**Strategy 2.** By February 2027, the Region Training and Education Committee will survey the EMS Training Programs, and Instructors, to identify specific challenges within their programs.
	3	**Strategy 3.** By April 2027, the Region Training and Education Committee will provide a summary of the challenges to the Department.

GOAL 2 INTRODUCTION

SUPPORT EMERGENCY PREPAREDNESS ACTIVITIES

The East Region participates with Emergency Response Coalitions, DMCC, regional facilities, and EMS partners, in planning processes to ensure that stakeholders are informed of system issues and can be involved in resolving local and regional concerns to enhance EMS system readiness.

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

GOAL 2: Support Emergency Preparedness Activities		
Objective 1: During July 2025-June 2027, the Region Council will coordinate with, and participate in, emergency preparedness and response to all hazard incidents, patient transport, and planning objectives at both the State and local level.	**1**	**Strategy 1.** On an ongoing basis, the Region Council and Executive Director will disseminate emergency preparedness information and updates provided by Healthcare Coalitions, Public Health, and the Department of Health to regional system partners.
	2	**Strategy 2.** On an ongoing basis, the Region Council and Executive Director will monitor for disaster, MCI, Special Pathogens related drills and exercises and disseminate opportunities for participation to system partners.
	3	**Strategy 3.** On an ongoing basis, the Region Council will work with the Department to develop guidance for patient care procedures for all hazards, disaster triage, DMCC, special pathogens transport, and other emergency preparedness topics as identified.
	4	**Strategy 4.** On an ongoing basis, the Region Council will work with Healthcare Coalitions, Public Health, and the Department to compile a list of partnership meetings occurring in the region that address preparedness planning and distribute to system partners.
Objective 2: During July 2025-June 2027, the Region Council will collaborate with system partners to ensure congruent	**1**	**Strategy 1.** On an ongoing basis, the Region Council will collate emergency care system partner meetings and information into one area for easy access and distribution to system stakeholders.

GOAL 2: Support Emergency Preparedness Activities		
connectivity, operations, and awareness.	**2**	**Strategy 2.** On an ongoing basis, the Region Council will request participation from Emergency Management, preparedness coalitions, public health, EMS, and hospitals, in region council meetings.

GOAL 3 INTRODUCTION

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

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

Programs supported by the East 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, EMS Provider Wellness, and The Force is With You focused on teen injury prevention education.

Other system partners in prevention include Prehospital EMS, Fire Departments, Law Enforcement, Public Health, and hospital facilities.

Data provided by the WA State Department of Health, can be accessed on the department website. Data shows the number of suicides, homicide, and unintentional deaths have increased for all age groups from the 2000-2020.

Data provided by the WA State Department of Health, can be accessed on the department website, indicates an increase in the annual number of opioid overdose deaths has nearly doubled from 827 in 2019 to 1619 in 2021. Numerous funding streams are in place from State and Federal sources to assist regions, MPDs, and EMS agencies in Naloxone leave-behind and Buprenorphine programs to reduce opioid misuse, abuse, and mortality rates.

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: Annually, by December, the Region Council will identify and fund evidence-based and/or best-practice injury and violence prevention (IVP) efforts in the East Region.	**1**	**Strategy 1**. Annually, by August, the Region Council will review and prioritize relevant regional/injury data from the Department of Health and identify regional partners that will provide prevention programs.
	2	**Strategy 2.** Annually, by October, the Region will choose regional IVP program efforts to support.
	3	**Strategy 3.** Annually, by December, the Region Executive Director secures funding agreements with selected injury prevention partners providing injury prevention activities.

GOAL 3: PLAN, IMPLEMENT, MONITOR AND REPORT OUTCOMES OF PROGRAMS TO REDUCE THE INCIDENCE AND IMPACT OF INJURIES, VIOLENCE AND ILLNESS IN THE REGION		
	4	**Strategy 4.** Annually, by June, the injury prevention partners will provide the Region Council with injury prevention activity reports and accomplishments as outlined in the funding agreement.
	5	**Strategy 5.** On an ongoing basis, as available, the Region Council will include program activity reports in the deliverable report to Department of Health.
Objective 2: During July 2025-June 2027, the Region Council will support activities that reduce the impact of the opioid crisis.	**1**	**Strategy 1.** On an ongoing basis, the Region Council will support MPDs in development and implementation of county leave behind or buprenorphine protocols, procedures, and guidance to EMS Providers.
	2	**Strategy 2** On an ongoing basis, the Region Council will support community diversion and deflection programs for naloxone education and awareness efforts.

GOAL 4 INTRODUCTION

ASSESS WEAKNESSES AND STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS IN THE REGION

The East Region Quality Improvement Committee is committed to optimal clinical care and system performance in the Region as it relates to trauma, cardiac, and stroke patients as evidenced by patient outcomes. A multidisciplinary team approach to concurrent and retrospective analysis of care delivery, patient care outcomes, and compliance with the requirements of Washington State as per RCW 70.168.090 is the fundamental goal.

Region Council members, Local Council members, and EMS agency providers, attend the Regional QI Committee meetings and are actively involved in QI for the Region.

Local Councils support MPDs in QI efforts. Each local council has assisted the MPD with staffing, coordination of, and in some instances, a platform, for continuous monitoring of the state KPIs.

GOAL 4: ASSESS WEAKNESSES AND STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS IN THE REGION		
Objective 1: During July 2025-June 2027, the Regional QI Committee will review regional emergency care system performance.	**1**	**Strategy 1.** By October 2025, the Regional QI Committee will identify data sources for use in emergency care system performance measures from hospitals and EMS agencies.
	2	**Strategy 2.** By December 2025, the Regional QI Committee will identify key performance indicators for monitoring.
	3	**Strategy 3.** On an ongoing basis, the Regional QI Committee will identify issues of emergency care system performance during quarterly meetings.
	4	**Strategy 4.** On an ongoing basis, the Region Council representative will participate in Regional QI and provide a report to the Region Council quarterly.
	5	**Strategy 5.** On an ongoing basis, the Region Council will disseminate Regional QI system performance information, and outcomes, to EMS system partners and Medical Program Directors.

GOAL 4: ASSESS WEAKNESSES AND STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS IN THE REGION		
Objective 2: During July 2025-June 2027, the Region Council will support MPDs in system monitoring, utilizing KPIs, to determine training, education, and patient care protocol compliance.	**1**	**Strategy 1.** By October 2025, the Region Council will provide MPDs with the State approved KPIs for EMS.
	2	**Strategy 2.** On an ongoing basis, the Region Council will distribute KPI report from WEMSIS to MPDs with request for review.
	3	**Strategy 3.** By February 2026, the Region Council will request MPDs recommend training and education based on KPI data.
	4	**Strategy 4.** On an ongoing basis, the Region Council will assist MPDs with training and education for EMS providers to address KPI deficiencies.
Objective 3: During July 2025-June 2027, the Region will review WEMSIS submission quality metrics.	**1**	**Strategy 1.** On an ongoing basis, the Region Council will distribute WEMSIS Region Level Data Submission Report provided by DOH to region EMS providers, Region QI, and Medical Program Directors for the purpose of education and quality improvement.
Objective 4: During July 202-June 2027, the East Region Rehabilitation Committee will provide public education to the Region Council and community partners.	**1**	**Strategy 1.** Annually, in October, as resources are available, the Rehabilitation Committee will present a trauma case review to the Regional Council and/or community partners that include all components of the Emergency Care System.
	2	**Strategy 2.** On an ongoing basis, the Rehabilitation Committee will post educational opportunities related to trauma topics on the eastregion-ems.org website.

WA State Department of Health Links:

WA State Data Section and Key Performance Measures

GOAL 5 INTRODUCTION

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 Region Council maintains a 501 (C)(3) status as a quasi-government agency. While successfully funding various programmatic endeavors, the Region also supports costs associated with administrative functions.

The Region Council develops a Strategic Plan every two years that supports the state's EMS and Trauma Systems of Care and associated goals of the statewide strategic plan. Inside the planning process the region provides a snapshot of each county's demographics, infrastructure, and EMS resources.

The East Region has multi-disciplinary workgroups and committees, Local Councils, and County Medical Program Directors involved in regional programs provided to strengthen the emergency care system.

The Regional Training and Education Committee provides funding for educational programs for Prehospital providers. This funding includes Ongoing Training Programs and vendor support, initial EMS courses, provider credential endorsements, instructor education and development, and Medical Program Directors protocol implementation.

The East Region agencies indicate a decrease in personnel, aging population, and the cost of living in low job market areas as making it difficult to engage constituents in a desire to be a part of the EMS system, impacting the ability to maintain enough personnel to staff ambulances. Agencies are having to depend on neighboring agencies to respond to calls because they are at level zero for staffing. The East Region Council has identified Initial EMS Training as a priority to support funding and EMS course oversight.

To ensure the highest level of pre-hospital care in Washington, the Department of Health has developed a statewide model for improving the sustainability of Rural EMS systems. Funding for this model has been awarded to the department through a series of grants from the Medicare Rural Hospital Flexibility Program Emergency Medical Services Competing Supplement (FLEX EMS). Each grant cycle has a specific focus area within rural EMS; however, the materials are available to all. Numerous agencies in the Region have participated in the projects offered and have indicated a strong benefit to their agency and providers in being offered this opportunity.

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GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
Objective 1: During July 2025-June 2027, the Region Council will manage the business of the Council, 501(c)(3) status, and Department contractual	**1**	**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.
	2	**Strategy 2.** On an ongoing basis, the Region Council will review and approve financial reports and Department contract deliverables.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
work, of the Regional Council.	**3**	**Strategy 3.** On an ongoing basis, the Region Council, Executive Director, will coordinate Council and Committee meetings and communications with regional partners.
	4	**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 2025-June 2027, the Region Council will manage Regional Council membership to ensure membership as outlined in RCW 70.168.120 is represented.	**1**	**Strategy 1.** Annually by June, the Region Council will review current membership to identify and recruit for open positions.
	2	**Strategy 2.** On an ongoing basis, the Region Council, Executive Director, will maintain a current roster with Regional Council membership positions, appointment expirations, and maintain records of all Council appointments and reappointments.
	3	**Strategy 3.** On an ongoing basis, the Region Council, Executive Director, will maintain a current roster with Regional Council member compliance with the Open Public Meeting Act and other pertinent council member training.
Objective 3: By May 2027, the Region Council will develop a 2027-2029 Strategic Plan.	**1**	**Strategy 1.** By August 2026, the Region Executive Director will provide a review of the Regional Planning guidance documents provided by the Department to Council members for the 2027-2029 planning cycle.
	2	**Strategy 2.** By October 2026, the Regional Executive Director will establish regional planning workshops/meetings and invite council members, MPDs, Local Councils, and other system stakeholders to participate.
	3	**Strategy 3.** By December 2026, the Region Council and Executive Director will perform an assessment of each county's demographics, infrastructure, and EMS resources, to update statistical information in the 2027-2029 strategic plan.
	4	**Strategy 4.** By February 2027, the Region Council will develop goals, objectives, and strategies, using the strategic planning guidance document, for the 2027-2029 strategic plan.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
	5	**Strategy 5.** By May 2027, the Region Council will approve the 2027-2029 strategic plan for presentation to the State Steering Committee for approval.
	6	**Strategy 6.** By June 2027, the Region Council Executive Director will distribute the 2027-2029 Strategic Plan to all council members, Local Councils, MPD's, and other system stakeholders.
Objective 4: Annually, by June, the Region Council will enhance workforce development, and support training and education for prehospital providers and educators.	**1**	**Strategy 1.** Annually, By February, the Regional Training and Education Committee will assist Local Councils in developing and distributing a Training and Education Survey to EMS Agencies, providers, and Medical Program Directors.
	2	**Strategy 2.** Annually, by April, the Regional Training and Education Committee will provide the results of the Training and Education survey to the Local Councils and MPDs.
	3	**Strategy 3.** Annually by June, the Local Councils may utilize the results of the Training and Education Survey to determine a training plan specific to the needs of their county council area providers and MPDs.
	4	**Strategy 4.** Annually, by June, the Regional Training and Education Committee will submit a proposed fiscal year training plan and program budget that supports the SEI, EMS providers, and MPD needs, to the Region Council for approval.
	5	**Strategy 5.** Annually, by June, the Region Council will submit the compiled results of the Training and Education Survey to the Department.
Objective 5: During July 2025-June 2027, the Region Council will promote opportunities to improve sustainable practices for rural EMS services.	**1**	**Strategy 1.** On an ongoing basis, the Region Council will distribute the Rural EMS Sustainability Project and the Quality Improvement Project documents completed by the Department as part of the FLEX EMS Grants to EMS services.
	2	**Strategy 2.** On an ongoing basis the Region Council will provide opportunities at the Region council meetings for updates and information on the 2024-2029 Workforce Project.

APPENDICES

APPENDIX 1:

Adult and Pediatric Trauma Designated Hospitals and Rehab Facilities

WA Department of Health Trauma Designated Services					
REGION	Trauma Designation			Facility	City
	Adult	Pediatric	Rehab		
EAST	II	II P		Providence Sacred Heart Medical Center & Children's Hospital	Spokane
	III			MultiCare Deaconess Hospital	Spokane
	III			MultiCare Valley Hospital	Spokane Valley
	III			Providence Holy Family Hospital	Spokane
	III			St. Joseph Regional Medical Center	Lewiston, ID
	IV			Newport Hospital & Health Services	Newport
	IV			Providence Mount Carmel Hospital	Colville
	IV			Providence St. Joseph's Hospital	Chewelah
	IV			Pullman Regional Hospital	Pullman
	IV			Tri-State Memorial Hospital	Clarkston
	V			East Adams Rural Healthcare	Ritzville
	V			Ferry County Memorial Hospital	Republic
	V			Garfield County Memorial Hospital	Pomeroy
	V			Lincoln Hospital	Davenport
	V			Odessa Memorial Healthcare Center	Odessa
	V			Othello Community Hospital	Othello
	V			Whitman Hospital & Medical Center	Colfax
			1 PR/1 R	Providence St. Luke's Rehabilitation Medical Center	Spokane

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	
EAST	I	0	0	0
	II	1	3	1
	III	3	4	4
	IV	4	7	5
	V	3	9	7
	* I P	0	0	0
	* II P	1	2	1
	* III P	1	2	0

* Pediatric

Numbers are current as of August 2023

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	
EAST	I R	1	1	1
	II R	1	2	0
	IR (P)	1	1	1

Numbers are current as of August 2023

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 and Stroke System Hospitals

Washington State
Emergency Cardiac and Stroke System
Participating Hospitals by Region

REGION	Categorization Level		Facility	City	County
	Cardiac	Stroke			
EAST	II	III	East Adams Rural Healthcare	Ritzville	Adams
	II	III	Ferry County Memorial Hospital	Republic	Ferry
	II	III	Odessa Memorial Hospital	Odessa	Lincoln
	II	III	Othello Community Hospital	Othello	Adams
	I	II	St. Joseph Regional Medical Center	Lewiston, Idaho	Nez Perce, ID
	II	II	Tri-State Memorial Hospital	Clarkston	Asotin
	II	III	MultiCare Valley Hospital	Spokane Valley	Spokane
	II	III	Whitman Hospital	Colfax	Whitman
	I	II	MultiCare Deaconess Hospital	Spokane	Spokane
	II	III	Garfield County Hospital District	Pomeroy	Garfield
	II	III	Lincoln Hospital District 3	Davenport	Lincoln
	II	III	Newport Hospital & Health Services	Newport	Pend Oreille
	II	II	Providence Holy Family Hospital	Spokane	Spokane
	II	III	Providence Mount Carmel Hospital	Colville	Stevens
	I	I	Providence Sacred Heart Medical Center and Children's Hospital *	Spokane	Spokane
	II	III	Providence St. Joseph's Hospital	Chewelah	Stevens
	II	III	Pullman Regional Hospital	Pullman	Whitman

* 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 October 2024

REF: DOH 345-299 / October 2024

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

APPENDIX 5: EMS Resources, Prehospital Verified Services

Appendix 5A: EMS Agency Report/Data

EAST REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Adams	AMBV.ES.00000001	East Adams Rural Healthcare	Ritzville	AMBV	ALS	4	0	11	0	4
Adams	AMBV.ES.00000002	Othello Ambulance Service	Othello	AMBV	BLS	3	0	3	5	0
Asotin	AIDV.ES.00000004	Clarkston Fire Department	Clarkston	AIDV	ILS	0	4	4	0	7
Asotin	AMB.ES.60115262	Clarkston Fire Department	Clarkston	AMB	ALS	4	0	5	0	5
Asotin	AMB.ES.60534793	PACT EMS	Genesee	AMB	ALS	4	0	1	0	0
Asotin	AMBV.ES.00000904	Lewiston Fire Department	Lewiston	AMBV	ALS	8	0	25	6	28
Asotin	AMBV.ES.60444690	Fire Protection District 1 Asotin County	Clarkston	AMBV	BLS	3	2	18	5	1
Asotin	AIDV.ES.61585797	City of Asotin Fire Department	Asotin	AIDV	BLS	0	2	3	0	0
Ferry	AMBV.ES.00000123	North Ferry County Ambulance	Curlew	AMBV	BLS	2	0	5	1	1
Ferry	AMBV.ES.00000126	Ferry County Emergency Medical Services District 1	Republic	AMBV	BLS	3	0	23	0	1
Garfield	AMBV.ES.00000137	Garfield County Fire District 1	Pomeroy	AMBV	BLS	3	0	22	1	0
Lincoln	AIDV.ES.00000412	Lincoln County Fire Protection District 4	Reardan	AIDV	BLS	0	3	14	0	0
Lincoln	AMBV.ES.00000410	Lincoln County Fire Protection District 1	Sprague	AMBV	BLS	2	1	5	2	0
Lincoln	AMBV.ES.00000413	Lincoln County Fire Protection District 6	Harrington	AMBV	BLS	1	0	9	0	0
Lincoln	AMBV.ES.00000416	Creston Ambulance Service	Creston	AMBV	BLS	1	0	6	5	0
Lincoln	AMBV.ES.00000417	Wilbur Ambulance	Wilbur	AMBV	BLS	1	1	5	0	0
Lincoln	AMBV.ES.00000420	Odessa Ambulance	Odessa	AMBV	BLS	3	0	4	0	0
Lincoln	AMBV.ES.60456753	Davenport Ambulance	Davenport	AMBV	BLS	2	0	13	2	0
Lincoln	AMBV.ES.60744082	Lincoln County Fire District 8	Almira	AMBV	BLS	1	0	3	3	0
Pend Oreille	AIDV.ES.00000471	Pend Oreille County Fire District 5	Cusick	AIDV	BLS	0	3	3	0	0
Pend Oreille	AMBV.ES.00000468	Pend Oreille County Fire District 2	Ione	AMBV	ALS	17	6	26	1	11
Pend Oreille	AMBV.ES.60620522	Kalispel Tribal Fire Department	Usk	AMBV	BLS	2	3	7	1	1
Pend Oreille	AMBV.ES.60683795	Pend Oreille Co Fire District 4	Newport	AMBV	BLS	3	8	8	0	0

EAST REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Pend Oreille	AMBV.ES.60720550	South Pend Oreille Fire and Rescue	Newport	AMBV	ALS	5	13	27	1	2
Spokane	AID.ES.60352468	Kalispel Tribal EMS	Airway Heights	AID	ALS	0	1	7	1	3
Spokane	AIDV.ES.00000663	Spokane Valley Fire Department	Spokane Valley	AIDV	ALS	0	22	143	1	57
Spokane	AIDV.ES.00000665	Spokane County Fire District 3	Cheney	AIDV	BLS	0	16	84	4	5
Spokane	AIDV.ES.00000667	Spokane County Fire Protection District 5	Nine Mile Falls	AIDV	BLS	0	4	6	0	0
Spokane	AIDV.ES.00000669	Spokane County Fire Protection District 8	Valleyford	AIDV	ALS	0	13	36	0	19
Spokane	AIDV.ES.00000670	Spokane County Fire District 9	Mead	AIDV	ALS	0	22	65	1	31
Spokane	AIDV.ES.00000671	Spokane County Fire District 10	Airway Heights	AIDV	BLS	0	12	44	4	0
Spokane	AIDV.ES.00000672	Spokane County Fire Protection District 11	Rockford	AIDV	BLS	0	2	11	0	0
Spokane	AIDV.ES.00000673	Spokane County Fire District 12	Waverly	AIDV	BLS	0	2	3	0	0
Spokane	AIDV.ES.00000674	Newman Lake Fire and Rescue	Newman Lake	AIDV	BLS	0	2	18	1	1
Spokane	AIDV.ES.00000691	Airway Heights Fire Department	Airway Heights	AIDV	BLS	0	7	17	3	0
Spokane	AIDV.ES.00000692	City of Cheney Fire Department	Cheney	AIDV	BLS	0	7	15	3	2
Spokane	AIDV.ES.00000697	Spokane Fire Department	Spokane	AIDV	ALS	0	61	241	4	80
Spokane	AIDV.ES.60424330	Spokane International Airport Fire Department	Spokane	AIDV	BLS	0	1	10	1	0
Spokane	AIRV.ES.60019210	Life Flight Network LLC	Aurora	AIRV	ALS	0	0	1	0	13
Spokane	AMB.ES.60661477	Life Flight Network LLC	Aurora	AMB	ALS	3	0	9	0	98
Spokane	AMB.ES.61435748	Advanced Life Systems Inc	Yakima	AMB	ALS	3	1	13	0	4
Spokane	AMB.ES.61484639	Pend Oreille County Fire District 2	Ione	AMB	ALS	1	0	0	0	0
Spokane	AMBV.ES.00000664	Fairfield Ambulance Service	Fairfield	AMBV	BLS	1	0	9	0	0
Spokane	AMBV.ES.00000709	American Medical Response	Spokane	AMBV	ALS	56	10	158	12	100
Spokane	AMBV.ES.00000712	Deer Park Volunteer Ambulance	Deer Park	AMBV	ALS	5	2	1	0	0
Spokane	AMBV.ES.61436200	Spokane County Fire District 4	Deer Park	AMBV	ALS	3	32	70	4	14
Spokane	ESSO.ES.60285027	Goodrich Corporation	Spokane	ESSO		0	0	2	0	0

EAST REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Spokane	ESSO.ES.60451728	Spokane County Sheriff's Office	Spokane	ESSO		0	0	3	1	0
Stevens	AIDV.ES.00000722	Stevens County Fire Protection District 1	Loon Lake	AIDV	BLS	0	8	28	15	0
Stevens	AIDV.ES.00000723	Stevens County Fire District 4	Valley	AIDV	BLS	0	10	8	0	0
Stevens	AIDV.ES.00000725	Joint Fire Protection District 3 and 8	Kettle Falls	AIDV	BLS	0	4	8	2	0
Stevens	AIDV.ES.00000726	Stevens County Fire Protection District 12	Rice	AIDV	BLS	0	4	5	0	0
Stevens	AIDV.ES.00000730	Northport Fire Department 1st Response	Northport	AIDV	BLS	0	2	7	0	0
Stevens	AIDV.ES.60019790	Stevens County Fire District 5	Addy	AIDV	BLS	0	3	9	0	0
Stevens	AIDV.ES.60839524	Stevens County Fire District 13	Evans	AIDV	BLS	0	2	5	0	0
Stevens	AMB.ES.61250408	Pend Oreille County Fire District2	Ione	AMB	ALS	0	0	1	0	1
Stevens	AMBV.ES.00000733	Stevens County Sheriffs Ambulance	Colville	AMBV	ALS	6	0	9	3	7
Stevens	AMBV.ES.00000734	Chewelah Rural Ambulance Association	Chewelah	AMBV	BLS	3	0	21	6	0
Stevens	AMBV.ES.60448538	Spokane Tribal Emergency Response	Wellpinit	AMBV	BLS	3	0	7	4	0
Stevens	AMBV.ES.60800657	Deer Park Volunteer Ambulance	Deer Park	AMBV	ALS	1	0	19	8	11
Stevens	AMBV.ES.61227432	Stevens County Fire District 7/Arden Fire Department	Colville	AMBV	BLS	5	5	11	0	0
Stevens	ESSO.ES.61511763	49 Degrees North Ski Area	Chewelah	ESSO		0	0	6	0	1
Whitman	AIDV.ES.00000835	Palouse EMS	Palouse	AIDV	BLS	0	1	8	0	0
Whitman	AIDV.ES.00000836	Whitman County FP District 5	Lamont	AIDV	BLS	0	3	2	0	0
Whitman	AIDV.ES.00000838	Steptoe Fire Department	Steptoe	AIDV	BLS	0	2	2	1	0
Whitman	AIDV.ES.00000840	Whitman County Fire Protection District 14	Colton	AIDV	BLS	0	1	14	0	0
Whitman	AIDV.ES.00000845	Whitman County Fire District 10	Oakesdale	AIDV	BLS	0	2	3	0	0
Whitman	AIDV.ES.00000848	St. John Volunteer Fire Department	Saint John	AIDV	BLS	0	2	8	0	0
Whitman	AIDV.ES.60340004	Whitman County Fire District 6	Endicott	AIDV	BLS	0	1	5	0	0
Whitman	AIDV.ES.60506154	Pullman-Moscow Regional Airport Fire Department	Pullman	AIDV	BLS	0	1	9	0	0

EAST REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Whitman	AMBV.ES.00000846	Pullman Fire Department	Pullman	AMBV	ALS	6	9	27	2	22
Whitman	AMBV.ES.00000852	Garfield-Farmington EMS	Garfield	AMBV	BLS	2	1	2	0	0
Whitman	AMBV.ES.00000853	Tekoa Community Ambulance Association	Tekoa	AMBV	BLS	2	0	3	0	0
Whitman	AMBV.ES.00000854	Volunteer Firemen Inc	Colfax	AMBV	BLS	3	0	31	2	0
Whitman	AMBV.ES.60044365	Whitman County Fire District 8	Lacrosse	AMBV	BLS	1	0	8	0	0
Whitman	AMBV.ES.60679634	Whitman County Fire District 7	Rosalia	AMBV	BLS	2	3	14	2	0
Whitman	AMBV.ES.60858728	Whitman County Rural FP District 12	Pullman	AMBV	BLS	2	4	15	3	0

Numbers are current as of April 2025

Appendix 5B: Verified Services by County

Total Prehospital Verified Services by County						
COUNTY	AMBV - ALS	AMBV - ILS	AMBV - BLS	AIDV - ALS	AIDV -ILS	AIDV - BLS
Adams	1	0	1	0	0	0
Asotin	1	0	1	0	1	0
Ferry	0	0	2	0	0	0
Garfield	0	0	1	0	0	0
Lincoln	0	0	7	0	0	2
Pend Oreille	2	0	1	0	0	1
Spokane	3	0	1	4	0	9
Stevens	2	0	3	0	0	7
Whitman	1	0	6	0	0	8

Numbers are current as of February 2025

Appendix 5C: Non-Verified Services by County

Total Prehospital Non-Verified Services by County							
COUNTY	AMB - ALS	AMB - ILS	AMB - BLS	AID - ALS	AID -ILS	AID - BLS	ESSO
Adams	0	0	0	0	0	0	0
Asotin	2	0	0	0	0	0	0
Ferry	0	0	0	0	0	0	0
Garfield	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0
Pend Oreille	0	0	0	0	0	0	1
Spokane	3	0	0	1	0	2	2
Stevens	1	0	0	0	0	0	1
Whitman	0	0	0	0	0	0	0

Numbers are current as of February 2025

Appendix 5D (OPTIONAL): East Region Personnel: Paid & Volunteer by County

	# of EMR		# of EMT		# of AEMT		# of Paramedic	
COUNTY	**Paid**	**Volunteer**	**Paid**	**Volunteer**	**Paid**	**Volunteer**	**Paid**	**Volunteer**
Adams	0	0	13	5	5	0	4	0
Asotin	0	0	35	22	7	4	41	3
Ferry	0	0	1	26	0	1	0	2
Garfield	0	4	2	16	1	0	0	0
Lincoln	0	0	12	58	1	11	0	0
Pend Oreille	0	0	22	57	0	3	13	2
Spokane	2	16	743	295	43	2	441	4
Stevens	0	18	32	122	19	17	11	5
Whitman	2	22	31	94	4	6	20	0

Numbers are current as of February 2025

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)**
ADAMS	AIDV	BLS	0	0	0
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	2	2	1
		ILS	0	0	0
		ALS	1	2	1
ASOTIN	AIDV	BLS	1	1	1
		ILS	1	1	1
		ALS	0	0	0
	AMBV	BLS	1	1	1
		ILS	0	0	0
		ALS	1	1	1 (Idaho)
FERRY	AIDV	BLS	0	0	0
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	2	2	2
		ILS	1	1	0
		ALS	0	0	0
GARFIELD	AIDV	BLS	0	0	0
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	1	1	1
		ILS	0	0	0
		ALS	0	0	0
LINCOLN	AIDV	BLS	2	3	2
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	6	8	7
		ILS	0	0	0

		ALS	0	0	0
PEND OREILLE	AIDV	BLS	6	7	2
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	2	7	3
		ILS	0	0	0
		ALS	0	2	2
SPOKANE	AIDV	BLS	12	12	9
		ILS	0	0	0
		ALS	4	4	4
	AMBV	BLS	1	1	1
		ILS	0	0	0
		ALS	2	3	3
STEVENS	AIDV	BLS	4	9	7
		ILS	0	2	0
		ALS	0	0	0
	AMBV	BLS	3	5	3
		ILS	0	2	0
		ALS	1	2	2
WHITMAN	AIDV	BLS	10	13	8
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	8	13	9
		ILS	1	5	0
		ALS	1	1	1

Numbers are current as of February 2025

APPENDIX 6 – AIR AMBULANCE

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 of Verified Services in TRA**	**Level of Verified Services in TRA**
ADAMS	**101**	East Adams Rural Hospital	AMBV	ALS
	102	East Adams Rural Hospital	AMBV	ALS
	103	Odessa Ambulance	AMBV	BLS
	104	East Adams Rural Hospital	AMBV	ALS
	105	East Adams Rural Hospital	AMBV	ALS
	106	Othello Ambulance Service	AMBV	BLS
ASOTIN	**201**	Asotin County FD 1	AMBV	BLS
	202	Asotin County FD 1	AMBV	BLS
	203	Asotin County FD 1 Lewiston FD Clarkston FD	AMBV	BLS ALS
FERRY	**1001**	Ferry County EMS District 1	AMBV	BLS
	1002	North Ferry County Ambulance	AMBV	BLS
	1003	Joint Fire Protection District 3 & 8	AMBV	BLS
	OCCT	Ferry County EMS District 1 Colville Tribal EMS	AMBV	BLS
GARFIELD	**1**	Garfield County FD 1	AMBV	BLS
LINCOLN	**2201**	Lincoln County FD 4	AIDV	BLS
	2202	Lincoln County FD 4	AIDV	BLS
	2203	Lincoln County FD 4	AIDV	BLS
	2204	NONE		
	2205	NONE		
	2206	Odessa Ambulance	AMBV	BLS
	2207	Almira Fire and Rescue	AMBV	BLS
	2208	Lincoln County FD 1	AMBV	BLS
	2209	Lincoln County FD 1	AMBV	BLS
	2210	Lincoln County FD 6	AMBV	BLS
	2211	Lincoln County FD 4	AIDV	BLS
	2212	Davenport Ambulance	AMBV	BLS
	2213	Creston Ambulance Service	AMBV	BLS
	2214	Wilbur Fire Department	AMBV	BLS
	2215	Davenport Ambulance	AMBV	BLS
	2216	Lincoln County FD 4	AIDV	BLS

		Davenport Ambulance	AMBV	
	2217	Lincoln County FD 4 Davenport Ambulance	AIDV AMBV	BLS
	2218	Lincoln County FD 7 Creston Ambulance Service Davenport Ambulance	AIDV AMBV	BLS
	2219	Lincoln County FD 6 Lincoln County FD 7 Davenport Ambulance	AIDV AMBV	BLS
	2220	Lincoln County FD 6 Wilbur Fire Department Odessa Ambulance	AMBV	BLS
	2221	Lincoln County FD 8 Almira Fire and Rescue	AMBV	BLS
	2222	Lincoln County FD 7 Wilbur Fire Department	AIDV AMBV	BLS
	2223	Lincoln County FD 7 Wilbur Fire Department	AIDV AMBV	BLS
	2224	Davenport Ambulance	AMBV	BLS
	2225	Lincoln County FD 7 Creston Ambulance Service	AIDV AMBV	BLS
PEND OREILLE	**2601**	Kalispell Tribal FD	AMBV	BLS
	2602	Pend Oreille County FD 2 Ione Fire Department	AMBV	ALS
	2603	South Pend Oreille Fire and Rescue	AMBV	BLS
	2604	Cusick Fire Department Pend Oreille County FD 4	AMBV	BLS
	2605	Pend Oreille County FD 5	AIDV	BLS
	2606	Pend Oreille County FD 6	AMBV	BLS
	2608	Pend Oreille County FD 8	AIDV	BLS
	2609	Pend Oreille County FD 9 Pend Oreille County FD 5	AIDV AMBV	BLS
	2610	Pend Oreille EMS Pend Oreille County FD 5 South Pend Oreille Fire and Rescue Pend Oreille County FD 4	AIDV AMBV	BLS
	3201	South Pend Oreille Fire and Rescue	AMBV	BLS
SPOKANE	**3201**	Spokane County FD 4 Deer Park Ambulance	AIDV AMBV	BLS ALS
	3202	Spokane County FD 9 City of Spokane FD	AIDV	ALS
	3203	Newman Lake Fire and Rescue	AIDV	BLS
	3204	Spokane County FD 5	AIDV	BLS
	3205	Spokane County FD 5 Spokane Fire Department American Medical Response	AIDV AMBV	BLS ALS
	3206	Newman Lake Fire and Rescue	AIDV	BLS

		Spokane Valley FD Spokane County FD 8		ALS
	3207	Spokane County FD 10 Spokane International Airport FD	AIDV	BLS
	3208	Spokane County FD 10 Airway Heights FD	AIDV	BLS
	3209	Spokane County FD 8	AIDV	ALS
	3210	Spokane County FD 3	AIDV	BLS
	3211	Spokane County FD 8 Spokane County FD 11	AIDV	BLS ALS
	3212	Spokane County FD 3	AIDV	BLS
	3213	Cheney Fire Department Spokane County FD 3	AIDV	BLS
	3214	Spokane County FD 8 Spokane County FD 11	AIDV	BLS ALS
	3215	Spokane County FD 11	AIDV	BLS
	3216	Spokane County FD 3	AIDV	BLS
	3217	Spokane County FD 12	AIDV	BLS
STEVENS	**3301**	Stevens County FD 1 Deer Park Ambulance	AIDV AMBV	BLS ALS
	3302	Spokane Tribal Emergency Response	AMBV	BLS
	3303	Joint Fire Protection 3 and 8 Stevens County Sheriffs Ambulance	AIDV AMBV	BLS ALS
	3304	Stevens County Sheriffs Ambulance Northport Fire Department 1st Response	AIDV AMBV	BLS ALS
	3305	Stevens County FD 12		BLS
	3306	Stevens County Sheriffs Ambulance	AMBV	ALS
	3307	Stevens County Sheriffs Ambulance Stevens County FD 7	AIDV AMBV	BLS ALS
	3308	Stevens County FD 5 Stevens County FD 7 Stevens County Sheriffs Ambulance	AIDV AMBV	BLS ALS
	3309	Not listed		BLS
	3310	Stevens County Sheriffs Ambulance	AMBV	ALS
	3311	Stevens County Sheriffs Ambulance Stevens County FD 5	AIDV AMBV	BLS ALS
	3312	Stevens County Sheriffs Ambulance	AMBV	ALS
	3313	Stevens County Sheriffs Ambulance Stevens County FD 5	AIDV AMBV	BLS ALS
	3314	Chewelah Rural Ambulance Association	AMBV	BLS
	3315	Chewelah Rural Ambulance Association	AMBV	BLS
	3316	Stevens County Sheriffs Ambulance Stevens County FD 5	AIDV AMBV	BLS ALS
	3317	Stevens County FD 5 Chewelah Rural Ambulance Association	AIDV AMBV	BLS ALS
	3318	Stevens County FD 5 Chewelah Rural Ambulance Association	AIDV AMBV	BLS

	3319	Stevens County FD 1 Deer Park Ambulance	AIDV AMBV	BLS ALS
	3320	Stevens County FD 4 Chewelah Rural Ambulance Association	AIDV AMBV	BLS
	3321	Stevens County FD 4 Chewelah Rural Ambulance Association	AIDV AMBV	BLS
	3322	Stevens County FD 1 Deer Park Ambulance	AIDV AMBV	BLS ALS
	3323	Chewelah Rural Ambulance Association	AMBV	BLS
	3324	Stevens County FD 4 Chewelah Rural Ambulance Association	AIDV AMBV	BLS
	3325	Stevens County FD 4 Chewelah Rural Ambulance Association	AIDV AMBV	BLS
	3326	Stevens County FD 4 Chewelah Rural Ambulance Association	AIDV AMBV	BLS
	3327	Stevens County FD 4 Chewelah Rural Ambulance Association	AIDV AMBV	BLS
	3328	Stevens County FD 4 Chewelah Rural Ambulance Association	AIDV AMBV	BLS
WHITMAN	**3801**	Whitman County FD 5	AIDV	BLS
	3802	Saint John FD 2	AIDV	BLS
	3803	None indicated		
	3804	Whitman County FD 6	AIDV	BLS
	3805	Whitman County FD 7	AMBV	BLS
	3806	Whitman County FD 8	AMBV	BLS
	3807	Palouse EMS	AIDV	BLS
	3808	None indicated		
	3809	Whitman County FD 10	AIDV	BLS
	3810	Tekoe Community Ambulance Association	AMBV	BLS
	3811	Garfield-Farmington EMS Whitman County FD 10 Palouse EMS	AIDV AMBV	BLS
	3812	Palouse EMS	AIDV	BLS
	3813	Garfield-Farmington EMS Steptoe Fire Department	AIDV AMBV	BLS
	3814	Whitman County FD 10	AIDV	BLS
	3815	Whitman County FD 7	AMBV	BLS
	3816	None indicated		
	3817	Volunteer Firemen Inc.	AMBV	ALS
	3818	Garfield-Farmington EMS	AMBV	BLS
	3819	Whitman County FD 7	AMBV	BLS
	3820	None indicated		
	3821	None indicated		
	3822	Garfield-Farmington EMS	AMBV	BLS
	3823	Whitman County FD 10 Garfield-Farmington EMS	AIDV AMBV	BLS

	3824	Whitman County FD 10 Tekoe Community Ambulance Association	AIDV AMBV	BLS
	3825	Whitman County FD 12 Pullman-Moscow Regional Airport FD	AIDV AMBV	BLS
	3826	Whitman County FD 14	AIDV	BLS
	3827	Pullman FD Pullman-Moscow Regional Airport FD Whitman County FD 12	AIDV AMBV	BLS ALS

APPENDIX 8: Educators and Training Programs

Appendix 8A: Approved Training Programs

(Identify) REGION TRAINING PROGRAMS APPROVED BY WASHINGTON STATE DEPARTMENT OF HEALTH					
Credential #	**Status**	**Expiration Date**	**Facility Name**	**Site City**	**Site County**
TRNG.ES.60136631-PRO	APPROVED	08/31/2027	Clarkston Fire Department	Clarkston	Asotin
TRNG.ES.61220146-PRO	APPROVED	08/31/2027	Ferry County EMS & Trauma Care Council	Republic	Ferry
TRNG.ES.60114491-PRO	APPROVED	08/31/2027	Lincoln County Fire District 4	Reardan	Lincoln
TRNG.ES.60128950-PRO	APPROVED	08/31/2027	Pend Oreille County Fire District 2	Cusick	Pend Oreille
TRNG.ES.60128965-PRO	APPROVED	08/31/2027	South Pend Oreille Fire and Rescue	Newport	Pend Oreille
TRNG.ES.60136352-PRO	APPROVED	08/31/2027	Deer Park Volunteer Ambulance	Deer Park	Spokane
TRNG.ES. 60136352-PRO	APPROVED	08/31/2028	Eastern Washington University	Spokane	Spokane
TRNG.ES.61384953-PRO	APPROVED	08/31/2028	EMS Connect LLC	Spokane	Spokane
TRNG.ES.61337625-PRO	APPROVED	08/31/2027	Providence Health & Services-Washington	Spokane	Spokane
TRNG.ES.60136378-PRO	APPROVED	08/31/2027	Spokane Community College	Spokane	Spokane
TRNG.ES.60122894-PRO	APPROVED	08/31/2027	Spokane County Fire District 4	Chattaroy	Spokane
TRNG.ES.60136371-PRO	APPROVED	08/31/2028	Spokane County Fire District 3 Station 31	Cheney	Spokane
TRNG.ES.60122524-PRO	APPROVED	08/31/2028	Spokane County Fire District 9	Mead	Spokane
TRNG.ES.61411339-PRO	APPROVED	08/31/2028	Spokane Valley Fire Department	Spokane	Spokane
TRNG.ES.60136464-PRO	APPROVED	08/31/2029	Chewelah Rural Ambulance Asso.	Chewelah	Stevens
TRNG.ES.60115682-PRO	APPROVED	08/31/2027	Stevens County Sheriffs Ambulance	Colville	Stevens
TRNG.ES.60122828-PRO	APPROVED	08/31/2027	Pullman Fire Department	Pullman	Whitman
TRNG.ES.60136612-PRO	APPROVED	08/31/2028	Whitman County Emergency Medical Services Council	Colfax	Whitman

Information is current as of February 2025

WA State approved Training Programs list

Appendix 8B: Approved EMS Educators by County

ESE			
County	2023	2024	Change
Adams	4	6	2
Asotin	5	0	-5
Ferry	12	10	-2
Garfield	4	3	-1
Lincoln	34	34	0
Pend Oreille	25	25	0
Spokane	229	273	
Stevens	52	56	4
Whitman	42	36	-6
TOTALS:	407	443	36

SEIC			
County	2023	2024	Change
Adams	0	0	0
Asotin	0	0	0
Ferry	0	0	0
Garfield	1	0	0
Lincoln	0	0	0
Pend Oreille	3	0	-3
Spokane	1	0	-1
Stevens	1	4	3
Whitman	0	0	0
TOTALS:	6	4	2

SEI			
County	2023	2024	Change
Adams	1	1	0
Asotin	0	0	0
Ferry	1	0	0
Garfield	0	1	1
Lincoln	4	4	0
Pend Oreille	3	4	1
Spokane	17	14	-3
Stevens	3	4	1
Whitman	3	6	3
TOTALS:	32	34	2

Total EMS educators in the East Region = 481

Numbers are current as of February 2025

Appendix 9:

Local Health Jurisdictions

LOCAL HEALTH JURISDICTIONS		
Agency/Organization Name	**City**	**County**
Adams County Health Department	Othello	Adams
Asotin County Health District	Asotin	Asotin
Garfield County Health District	Pomeroy	Garfield
Northeast Tri County Health District	Colville	Stevens
Northeast Tri County Health District	Republic	Ferry
Northeast Tri County Health District	Newport	Pend Oreille
Spokane Regional Health District	Spokane	Spokane
Lincoln County Health Department	Davenport	Lincoln
Whitman County Public Health	Pullman	Whitman

Information is current as of February 2025

Appendix 10:

Local Department of Emergency Management Offices

LOCAL DEPARTMENT OF EMERGENCY MANAGEMENT OFFICES		
Agency/Organization Name	**City**	**County**
Adams County LEPC	Othello	Adams
Asotin County Emergency Services	Asotin	Asotin
Ferry County Emergency Management	Republic	Ferry
Garfield County Emergency Management	Pomeroy	Garfield
Lincoln County Emergency Management	Davenport	Lincoln
Pend Oreille County Emergency Management	Newport	Pend Oreille
Spokane County Emergency Management	Spokane	Spokane
Stevens County Emergency Management	Colville	Stevens
Whitman County Emergency Management	Colfax	Whitman

Information is current as of February 2025

Appendix 11:

Regional Preparedness Coalitions

REGIONAL PREPAREDNESS COALITIONS		
Agency/Organization Name	**City**	**County**
Northwest Healthcare Response Network	Statewide	Statewide

Information is current as of February 2025

EAST 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 East 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 East Region 2025-2027 Strategic Plan. The East Region will continue to follow the website posting and distribution requirements for the regional plan.

CONTENTS:

PATIENT CARE PROCEDURES:

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
  - WAC 246-976-910 – Regional Quality Assurance and Improvement Program

1.1. DISPATCH OF MEDICAL PERSONNEL

Effective Date: 4/11/2012
Revised: 6/2012

1. PURPOSE:

A. To provide timely care to all emergency medical and trauma patients as identified in the *Current WAC*.
B. To minimize "System Response Time" in order to get certified personnel to the scene as quickly as possible.
C. To minimize "System Response Time" in order to get licensed and or verified aid and ambulance services to the scene as quickly as possible.
D. To establish uniformity and appropriate dispatch of response agencies.

2. **SCOPE**:

A. Licensed aid and/or licensed ambulance services shall be dispatched to all emergency medical incidents by the appropriate 911 center.
B. Verified aid and/or verified ambulance services shall be dispatched to all known injury incidents, as well as unknown injury incidents.
C. All licensed and verified aid and licensed and verified ambulance services shall operate 24 hours a day seven days a week. (Current WAC)
D. All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services **shall use appropriate Washington State EMD Guidelines.**

3. **GENERAL PROCEDURES:**

A. Following the Region's plan to promote the concept of tiered response, an appropriate licensed or verified service shall be dispatched per the above Standards.
B. Dispatcher shall determine appropriate category of call using established Washington State EMD Guidelines.
C. Response shall be pre-planned by EMD response protocol. (See County Specific Operating Procedures and East Region Response Area Maps.)

4. DEFINITIONS:

"System Response Time" for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:

- Discovery Time": The interval from injury to discovery of the injury;
- "System Access Time": The interval from discovery to call received;
- "911 Time": The interval from call received to dispatch notified, including the time it takes the call answerer to:
    - Process the call, including citizen interview; and

    - Give the information to the dispatcher;
- "Dispatch Time": The interval from the call received by the dispatcher to agency notification;
- "Activation Time": The interval from agency notification to start of response;
- "Enroute Time": The interval from the end of activation time to the beginning of on-scene time;
- "Patient access time**":** The interval from the end of enroute time to the beginning of patient care;
- "On Scene Time": The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;
- "Transport Time": The interval from leaving the scene to arrival at the health care facility.

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

*Reformatted 11/6/2020 with no changes

1.2. RESPONSE TIMES

Effective Date: 9/2010

1. PURPOSE:

A. To provide trauma patients with appropriate and timely care.
B. To establish a baseline for data requirements needed for System Quality Improvement.

2. SCOPE:

All verified ambulance and verified aid services shall respond to trauma incidents in a timely manner in accordance with current WAC.

3. GENERAL PROCEDURES:

A. The Regional Council shall work with all Prehospital providers and Local Councils to identify response areas as urban, suburban, and rural or wilderness.
B. Verified ambulance and verified aid services shall collect and submit documentation to ensure the following system response times are met 80% of the time as defined in the current WAC 246.976.390.

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

C. Verified ambulance and verified aid services shall collect and submit documentation to show wilderness system response times are "as soon as possible."

4. DEFINITIONS:

- **Urban**: An unincorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 and a population density over 2,000 per square mile.
- **Suburban**: An incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of 1,000 to 2,000 per square mile.
- **Rural**: Incorporated or unincorporated areas with total populations less than 10,000, or with a population density of less than 1,000 per square mile.
- **Wilderness**: Any rural area not readily accessible by public or private road.
- **"System Response Time"** for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:
    - Discovery Time": The interval from injury to discovery of the injury;
    - "System Access Time": The interval from discovery to call received;

- "911 Time": The interval from call received to dispatch notified, including the time it takes the call answerer to:
  - Process the call, including citizen interview; and
  - Give the information to the dispatcher;
- "Dispatch Time": The interval from the call received by the dispatcher to agency notification;
- "Activation Time": The interval from agency notification to start of response;
- "Enroute Time": The interval from the end of activation time to the beginning of on-scene time;
- "Patient access time**":** The interval from the end of enroute time to the beginning of patient care;
- "On Scene Time": The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;
- "Transport Time": The interval from leaving the scene to arrival at the health care facility.

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

*Reformatted 11/6/2020 with no changes

3. AIR MEDICAL SERVICES - ACTIVATION AND UTILIZATION

Effective Date: September 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:
    a. Night; 100 ft. x 100 ft.
    b. 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	6/10/2020	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.1. TRAUMA TRIAGE AND DESTINATION PROCEDURE

Effective Date: 9/2010
Reviewed: 10/2024
Revised: 04/2025

PURPOSE
To provide guidance to prehospital providers, decreasing the amount of decision making in the field necessary, to ensure patients are delivered to the most appropriate trauma center equipped to minimize death and disability.

SCOPE
This PCP was created for prehospital EMS providers to use in the field when responding to victims of traumatic injury. It should be utilized in conjunction with COP and Protocol to make decisions about patient destination based upon **WA State Trauma Triage and Destination Guidelines for Prehospital Providers**

GENERAL PROCEDURES

EMS dispatch and response to traumatic injury in the East region will be consistent with guidelines set forth in "PCP 1.1 Dispatch of EMS to the Scene" of this document. Currently dispatch and response PCPs are specific to and defined by each Local Council area. MOUs for mutual aid and rendezvous are set forth in each county and dispatch cards/criteria and set by user groups and reviewed annually to ensure the highest level of response possible is afforded each trauma response area.

Triage is performed by the first arriving EMS unit using the **WA State Trauma Triage and Destination Guidelines for Prehospital Providers**.

Activation of the trauma system is done through early notification of Medical Control at the receiving trauma center. This can be done via radio notification through dispatch, HEAR radio contact or via phone. COPs further define mode of activation by providers based upon destination facility preference and internal procedures. Providers must provide activation at the earliest possible moment to ensure adequate resources are available at the receiving trauma center.

Transport of ***High-Risk*** patients, meeting any RED criteria, should be transported to the closest level I or II trauma service within 30 minutes transport time (air or ground). Transport times greater than 30 minutes, take to the closest most appropriate trauma service. There are NO Level I or II facilities in the North Central Region. Refer to the table in the appendices for Designated Trauma Centers in the North Central Region.

Transport of *Moderate Risk* patients meeting YELLOW criteria, WHO DO NOT MEET THE RED CRITERIA, should be transported to a designated trauma service, it need not be the highest level. Refer to the table in the appendices for Designated Trauma Centers in the North Central Region.

Interfacility transport of patients requiring additional definitive care not available at the primary trauma center after stabilization will be coordinated by the primary trauma center and be consistent with transfer procedures in RCW 70.170.

Specialty Care Services such as pediatric trauma patients, burn patients and obstetrical patients will be triaged and transported in the same manner as all other trauma patients using the **WA State Trauma Triage and Destination Guidelines for Prehospital Providers,** where secondary triage and stabilizing care can take place, and the patient then transferred to the most appropriate trauma center capable of definitively managing their injuries.

Quality Measures are monitored by the Regional Quality Assurance Committee. Quarterly data will be reviewed to determine the following system components.

- Adherence to the WA State Trauma Triage and Destination Guidelines for Prehospital Providers
- Adequacy of system resources
    - EMS Response
        - Level/adequacy of response
        - Request for ALS rendezvous
        - Use of air medical services
    - Initial stabilization by primary trauma centers
    - Transfers from primary trauma center for definitive care
    - System barriers to optimal care and outcome

APPENDICES

DESIGNATED TRAUMA FACILITIES IN THE EAST REGION

Facility	Location (City/County)	Designation Level
Providence Sacred Heart Medical Center & Children's Hospital	Spokane	II II/P
MultiCare Deaconess Hospital	Spokane	III
MultiCare Valley Hospital	Spokane Valley	III
Providence Holy Family Hospital	Spokane	III
St. Joseph Regional Medical Center	Lewiston, ID	III
Newport Hospital & Health Services	Newport	IV

Providence Mounty Carmel Hospital	Colville	IV
Providence St. Joseph's Hospital	Chewelah	IV
Pullman Regional Hospital	Pullman	IV
Tri-State Memorial Hospital	Clarkston	IV
East Adams Rual Healthcare	Ritzville	V
Ferry County Memorial Hospital	Republic	V
Garfield County Memorial Hospital	Pomeroy	V
Lincoln Hospital	Davenport	V
Odessa Memorial Healthcare Center	Odessa	V
Othello Community Hospital	Othello	V
Whitman Hospital & Medical Center	Colfax	V
Providence St. Luke's Rehabilitation Medical Center	Spokane	IPR/IR

*DOH 530-101, July 2024

ASSOCIATED COUNTY OPERATING PROCEDURES (COPs) AND MPD PROTOCOLS

https://www.eastregion-ems.org/

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council		04/11/2025	☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.2. CARDIAC TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/01/2018

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:

For cardiac patients follow the State of Washington Prehospital Cardiac Triage Destination Procedure.

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	10/11/2017	☐ Major ☒ Minor
			☐ Major ☐ Minor

5.3. STROKE TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/01/2018

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:

For stroke patients follow the State of Washington Prehospital Stroke Triage Destination Procedure

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	10/11/2017	☐ Major ☒ Minor
			☐ Major ☐ Minor

5.4. EMS TRANSPORT TO BEHAVIORAL HEALTH FACILITIES

Effective Date: 11/01/2018
Revised: 04/2025

PURPOSE

To operationalize licensed and verified EMS services who may transport patients from the field to behavioral health facilities; to include mental health services, chemical dependency services, and 23-hour crisis centers.

SCOPE

Licensed and verified EMS services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170, and to 23-hour crisis relief centers in accordance with RCW 71.24.916, with approval from the county Medical Program Director (MPD).

GENERAL PROCEDURES

1. Facility participation is voluntary.
2. Facilities and agencies must adhere to the Facilities and agencies must adhere to the Washington State Department of Health, EMS Guideline, Transport to Behavioral Health.
3. Facilities that participate will work with the county Medical Program Director (MPD) and EMS services to establish criteria that all participating facilities and EMS entities will follow for accepting patients.
4. The MPD and Local EMS and Trauma Care Council must develop and establish a county operating procedure (COP) inclusive of the standards recommended by the Washington State Department of Health, EMS Guideline, EMS Transport to Behavioral Health and regional PCP, to include dispatch criteria, response parameters and other local nuances to operationalize the program. The MPD must develop and implement department approved education for EMS personnel in accordance with the training requirements of the guideline. (educational programs must be approved by the department)

MONITORING

Biannually the Regional Council will review and update the behavioral health facilities identified in the appendices below. System partners: to include Medical Program Directors, Local Council members, Regional QI Committee members, and behavioral health facility representatives, will review PCP 5.4 to evaluate relevance and intent.

Continuous system monitoring is to be performed at the local level. Local EMS Councils must work with EMS Medical Program Directors to establish Quality Assurance Processes to monitor programs that are operating in their county.

APPENDICES

The Department of Health (DOH) licenses and regulates inpatient and outpatient Behavioral Health Agencies that may be certified to provide mental health, substance use disorder (SUD), problem gambling and gambling disorder services, or any combination of these types of services.

In developing County Operating Procedures and Patient Care Protocols; access the Department of Health website for "EMS Guidelines for EMS Transport to Behavioral Health Facilities", and "Find a BHA" with a downloadable pdf., Behavioral Health Agencies (BHA)

ASSOCIATED COUNTY OPERATING PROCEDURES (COPs) AND PATIENT CARE PROTOCOLS

Accessible in the document vault on https://www.eastregion-ems.org/

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	02/07/2018	☒ Major ☐ Minor
Regional Council	Updated	04/11/2025	☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.5. TRAIGE TRANSPORT OF MEDICAL AND NON-TRAUMA

Effective Date: 10/2002

1. PURPOSE:

A. To implement regional policies and procedures for all ***medical and non-major trauma patients who do not meet the criteria for trauma system activation*** as described in the Washington Prehospital Trauma Triage Tool.
B. To ensure that all medical and/or non-major trauma patients are transported to the most appropriate facility.

2. **SCOPE**:

All licensed ambulance services shall transport patients to the most appropriate facility in accordance with County Operating Procedures (COPs).

3. **GENERAL PROCEDURES:**

Patients not meeting Prehospital trauma triage criteria for activation of the trauma system, and all other patients will be transported to facilities based on County Operating Procedures (COPs).

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

*Reformatted 11/6/2020 with no changes

5.6. PEDIATRIC TRAUMA TRIAGE TRANSPORT

Effective Date: 10/2002

1. PURPOSE:

To ensure that consideration is given to early transport of a child to the regional pediatric trauma center(s) when required surgical or medical subspecialty care of resources are unavailable.

2. **SCOPE**:

A. All verified ambulance, verified aid services, and affiliated agencies shall comply with the Washington Prehospital Trauma Triage Procedures as defined in current WAC. All verified ambulance services shall transport patients to the most appropriate designated facility.
B. All verified ambulance and verified aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7 - if beyond the 30-minute transport time to a designated facility OR if transport time to the appropriate facility may be reduced by more than 15 minutes.
C. Each trauma-designated facility will determine when it is appropriate to alert verified ambulance services to divert to another trauma designated facility.

3. **GENERAL PROCEDURES:**

A. The provider must determine if primary resuscitation is needed for the patient and apply per level of training.
B. The first certified EMS/TC provider determines that a pediatric patient:
    A. Needs definitive trauma care
    B. Meets the trauma triage criteria
    C. Presents the factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure
    D. Determine if patient meets Patient Care Procedure #8 for All Hazards Mass Casualty
C. Take the pediatric patient to the highest-level pediatric trauma center within 30 minutes transport time via ground or air transport according to Department Of Health approved regional patient care procedures and approved County Operating Procedures (COPs).
D. If a pediatric designated facility is not available within 30 minutes, take the patient to the highest adult designated facility within 30 minutes.

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

*Reformatted 11/6/2020 with no changes

6. EMS MEDICAL CONTROL

Effective Date: 10/2002

1. PURPOSE:

To define methods of expedient communications between Prehospital personnel and receiving facilities.

2. **SCOPE**:

Communications between Prehospital personnel and receiving facilities will utilize the most effective communications to expedite patient information exchange.

3. **GENERAL PROCEDURES:**

A. The preferred communications method should be direct between an EMS Prehospital provider and the facility. An alternative method of communications should be addressed in County Operating Procedures.
B. Local Medical Program Director, county councils and communications centers will be responsible for establishing communications procedures between the Prehospital provider(s) and the facility (ies).
C. The provider agencies will maintain communications equipment and training needed to communicate in accordance with WAC.
D. Problems with communications affecting patient care will be reviewed by the provider agency, county council, MPD, communications center, and if necessary, report to the Regional Communications Committee for review**.**
E. All patient information communicated between agencies shall be in compliance with current HIPAA Standards.

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

*Reformatted 11/6/2020 with no changes

9. INTERFACILITY TRANSFER OF PATIENTS

Effective Date: 10/2002

1. PURPOSE:

Provide a procedure that will facilitate the goal of transferring high-risk trauma and medical patients.

2. **SCOPE**:

A. All Interfacility transfers via ground or air shall be provided by the appropriate licensed and/or verified services with personnel and equipment to meet patient needs.
B. Immediately upon determination that the patient's needs exceed the scope of practice and/or their Medical Program Director (MPD) approved protocols, or physician standing orders for non-EMS personnel, the licensed and/or verified service personnel shall advise the facility personnel that they do not have the resources to do the transfer.

3. **GENERAL PROCEDURES:**

A. Medical responsibility during transport should be arranged at the time of initial contact between receiving and referring physicians. The transferring physician should write the transfer orders after consultation with the receiving physician. Facilities having transfer agreements for trauma patients are attached as a reference.
B. Prehospital MPD protocols shall be followed prior to and during transport.
C. While en-route, the transporting agency should communicate patient status and their estimated time of arrival (ETA) to the receiving facility per Medical Program Director (MPD) approved protocols or physician standing orders for non-EMS personnel.

DEFINITIONS:

- **"Scope of Practice**" Patient care within the scope of approved level of certification and/or specialized training.
- **"Facilities"** are Department Of Health designated trauma care services and licensed acute care hospitals.
- **"Non-EMS Personnel"** Licensed Health Care Professionals including Physicians, Physicians Assistants, Registered Nurses, and Advanced Registered Nurse Practitioners.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council			☐ Major ☐ Minor
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*Reformatted 11/6/2020 with no changes

10.1. ALL HAZARDS MCI

Effective Date: 9/2002
Revised: 4/2012

1. PURPOSE:

A. To develop and communicate the information of regional trauma plan section VII prior to an MCI.
B. To implement county MCI plans during an MCI.
C. **Severe Burns**: ***To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region***.
D. To provide safe mass transportation with pre-identified EMS personnel, equipment, and supplies per the approved County Disaster Plan and/or the Hazardous Mitigation Plan.

2. **SCOPE**:

EMS personnel, licensed ambulance and licensed aid services shall respond to a Mass Casualty Incident as identified in this document.

A. All verified ambulance and verified aid services shall respond to an MCI per the county MCI plans.
B. Licensed ambulance and licensed aid services shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and/or in support of verified EMS services.
C. EMS certified first response personnel shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and /or in support of verified EMS services.
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 or the Incident Command System (ICS) as identified in the jurisdiction that has authority, protocol and MCI plan.

3. **GENERAL PROCEDURES:**

A. Incident Commander (IC) shall follow the county MCI Plan to inform medical control and the disaster medical control hospital 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 meds, equipment, procedures, and/or protocols until delivery at the receiving facility has been completed.
C. EMS personnel may use the ***Prehospital Mass Casualty Incident (MCI) general Algorithm*** during the MCI incident (attached).

DEFINITIONS:

- **"CBRNE"** Chemical, Biological, Radiological, Nuclear Explosive
- **"County Disaster Plan"** Comprehensive Emergency Management Plan (CEMP)
- **"Medical Control"** MPD authority to direct the medical care provided by certified EMS personnel in the Prehospital EMS system.

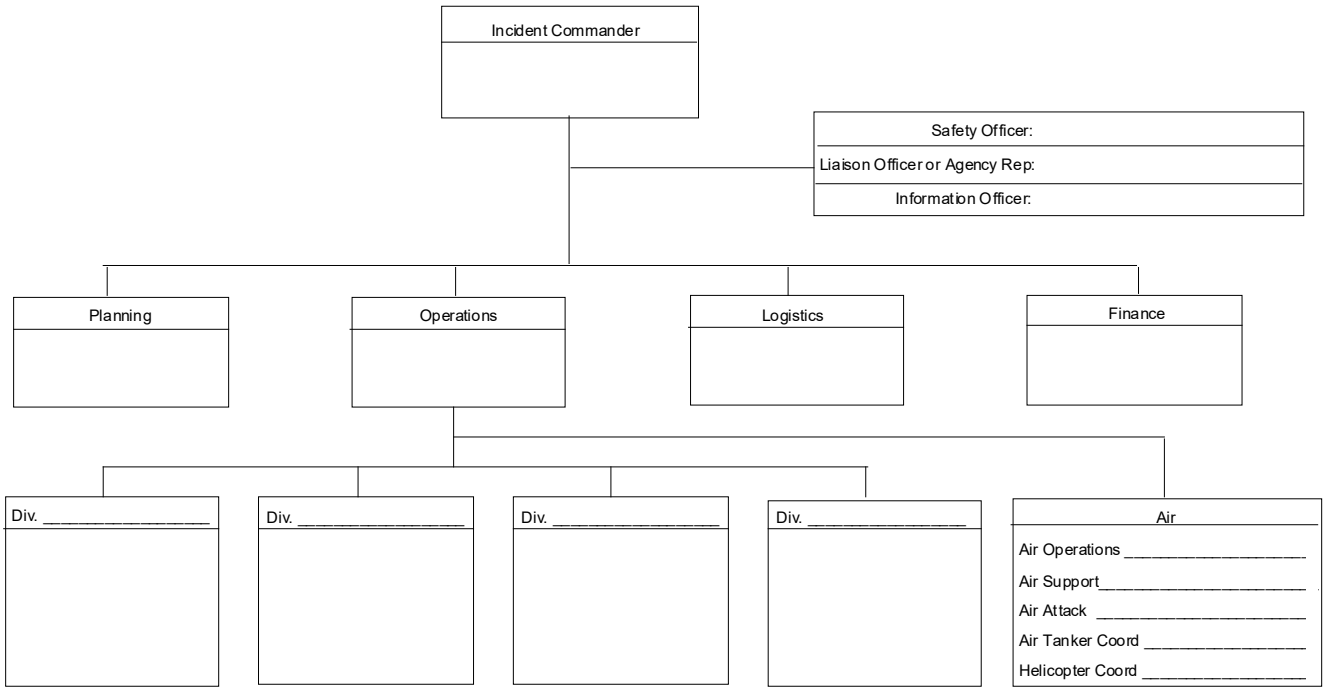
4. APPENDICES

Prehospital Mass Casualty Incident (IC) General Algorithm	*Once a command is established and a more thorough situation assessment/size up has been completed, Command shall provide an "updated report of conditions," confirm that a "Multi-Casualty Incident" exists and provide the following information: 1. Agency calling 2. Name and position of caller. 3. Type of incident (bus accident, aircraft accident, explosion, etc.) 4. Name of Incident 5. Confirmation of location of incident. 6. Approximate number of casualties by triage category (red, yellow, green, black) 7. Unusual circumstances or hazardous conditions, e.g., WMD 8. Command Post location. 9. Type and number of additional resources or special equipment needed 10. Best access and staging area(s) location. Note: *Blue does NOT indicate revision.
Receive dispatch Respond as directed Arrive at scene and Establish Incident Command (IC) Scene Assessment and size-up* *Report to Dispatch Determine if mass casualty conditions exist* Implement county MCI plan Request additional resources as needed The dispatch center shall coordinate notification and dispatch or required agencies and resources including notification of the Disaster Medical Coordination Control (DMCC). Identify hazards and determine needs to control or eliminate them. Take immediate action to isolate and deny access (Site Access Control) or mitigate the hazards as necessary to prevent additional injuries. Consider possibility of terrorist attack (WMD, secondary device) Initiate START Reaffirm additional resources Initiate ICS 201 or similar tactical worksheet (See attached) 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	

Incident Briefing	1. Incident Name	2. Date	3. Time

4. Map Sketch

5. Current Organization



Page 72 of	6. Prepared by (Name and Position)

6. Resources Summary			
Resources Ordered	Resource Identification	ETA On Scene	Location/Assignment
7. Summary of Current Actions			

Incident Name						**Date**
Pt #	**Tag Number and/or Name**	**Adult Pedi Sex**	**Triage Tag Color**	**Injuries by System: List most severe first**	**Transport Mode and Time**	**To Hospital**
1	# _____	A P M F	R Y G		AIR _____ AMB _____ BUS/OTR _____ TIME _____	DMC SHMC VHMC HF OTR_____
2	# _____	A P M F	R Y G		AIR _____ AMB _____ BUS/OTR _____ TIME _____	DMC SHMC VHMC HF OTR_____
3	# _____	A P M F	R Y G		AIR _____ AMB _____ BUS/OTR _____ TIME _____	DMC SHMC VHMC HF OTR_____
4	# _____	A P M F	R Y G		AIR _____ AMB _____ BUS/OTR _____ TIME _____	DMC SHMC VHMC HF OTR_____
5	# _____	A P M F	R Y G		AIR _____ AMB _____ BUS/OTR _____ TIME _____	DMC SHMC VHMC HF OTR_____
6	#	A	R		AIR _____	DMC SHMC

		P M F	Y G		AMB _____ BUS/OTR _____ TIME _____	VHMC HF OTR_____
7	# _____	A P M F	R Y G		AIR _____ AMB _____ BUS/OTR _____ TIME _____	DMC SHMC VHMC HF OTR_____

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

*Reformatted 11/6/2020 with no changes

10.2. ALL HAZARDS MCI DMCC

Effective Date: 4/2011
Revised: 4/2012

1. PURPOSE:

All Public Safety, EMS providers and dispatch centers in Region 9 shall have ***trigger points*** to assist in determining if the Disaster Medical Coordination Center (DMCC) should be notified of potential patient surge caused by a Mass Casualty Incident (MCI) or disaster.

2. **SCOPE**:

A. All Public Safety and EMS providers in Region 9 shall consider the capability of the community's local hospital(s) or clinic(s) prior to contacting the Disaster Medical Coordination Center (DMCC).

B. All dispatch centers in Region 9 shall coordinate with the Incident Commander at the scene and local hospital(s) or clinic(s) regarding how many potential patients will be transported prior to contacting the DMHC.

3. **GENERAL PROCEDURES:**

A. EMS providers or the dispatch center should contact DMCC immediately upon notification of any of the following triggers:

a. Multiple ambulances dispatched to one incident.
b. Multi-unit housing / hotel - structure fire – burns, smoke inhalation or injuries.
c. Motor Vehicle Accidents – multi car, buses or semi-trucks with Haz Mat on board.
d. Haz Mat incidents – natural gas leaks with evacuations, fuel farm fires or leaks, chlorine leaks, unknown substance exposure, train derailments with fire or Haz mat.
e. Public venues with multiple injuries or ill people.
f. Aircraft incident.
g. Explosions or building collapse.
h. Threat of IED or WMD
i. Multi agency response

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

*Reformatted 11/6/2020 with no changes