Strategic Plan:

2025-2027

NORTH CENTRAL REGION

Emergency Medical Services & Trauma Care Council

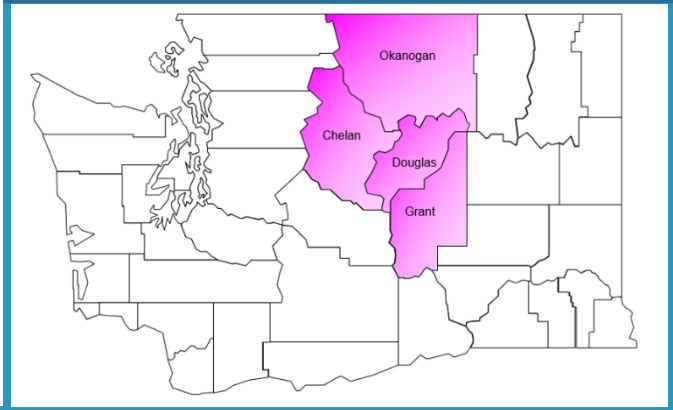

TABLE OF CONTENTS

INTRODUCTION

The North Central 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 Coalitions, Local Elected Official and Consumers. Council members are appointed volunteer representatives.

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

DBA Name: North Central Emergency Care Council
Mission Statement: To promote and support a comprehensive emergency care system.
Vision: Getting the Right Patient, to the Right Place in the Right Amount of Time.

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

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

- Training and Education Committee: Comprised of members of the Region Council, Local Councils, and Training Program Coordinators, review regional training needs, develop regional training programs, and improve patient outcomes.

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

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.

North Central 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 roles and responsibilities education required by the State of Washington for councils.
- Completed State Assessment Audits of financial accountability without findings.
- Provided leadership assistance to local councils addressing strategic planning, licensure, certification, financial documentation, and council structure.
- Provided training funds to local councils for provider requested training specific to their county needs that included ongoing training required for recertification, EMS training equipment, partial funding of Initial EMS Courses, EMS Evaluator renewal courses, SEI renewal course, agency leadership workshops.
- Provided virtual online format for EMS education, local council meetings, and MPD led meetings.
- Continued collaboration with regional MPD's on development of a regional set of MPD Protocols for ALS/ILS/BLS. This project benefits the providers who work in more than one county within the region and provides consistent patient care across Chelan, Douglas, Okanogan, and Grant Counties.
- Maintained status of the Department of Health approved Training Program for initial EMS courses and EMS course support to Instructors. The training program works closely with the Senior EMS Instructors, EMS Evaluators, Lead Instructors, and MPD's to ensure quality courses are provided consistently with National Education Standards and WAC.
- Provided funding to Injury Prevention Partners for continuation of programs that address senior falls, bicycle safety, child passenger safety, distracted driving, driving under the influence, Public First Aid/CPR training AHA CPR/First Aid, and AED training, Lifejacket loaner boards, and babysitting safety for the child and sitter.
- Participated in the Regional Advisory Committee, Prehospital TAC, Rule Making, EMS Education Workgroup, and attended State Steering Committee meetings.
- Continued Administrative Services contract with East Region EMS & Trauma Care Council, decreasing administrative cost and allowing more funding towards program work.
- The Region received an EMSC grant from the Department of Health for pediatric advanced airway train-the-trainers in the Region.

- Received funding for opioid naloxone leave-behind and buprenorphine programs and community education for naloxone administration.

The North Central Region ongoing challenges during the 2023-2025 plan cycle:

- EMS Agencies have experienced a decline in EMS personnel that has created challenges in their ability to staff ambulances and placed a burden on the neighboring agencies to assist in response.
- Hospital staffing challenges 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 of personnel to cover the response area.
- Increased wall times at facilities outside of the region place a burden on resources within the region.

The North Central Region is comprised of Chelan, Douglas, Grant, and Okanogan Counties, including the Colville Tribal Nations. The region covers 12,779 square miles with a population of approximately 269,150 residents. The region is rural in nature, with the Greater Wenatchee and Moses Lake areas being the largest population demographic. The major things that draw people to our Region and Counties are the lakes, rivers, wilderness, and the 6th Largest dam in the world.

There are 49 Licensed and Trauma Verified aid, ambulance, and Emergency Service Support Organization (ESSO) response agencies within North Central Region; the region has 924 certified EMS providers, with 41% of those being volunteers.

The North Central 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. https://www.ncecc.net/

CHELAN COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	66,616	72,453	79,074	79,997	
Income and Poverty	(2020) Median household income: $76,722 Poverty rate: 8.8%				
Health	(2020) 11.9% - without health care coverage 17.2% - disabled				
Description of county	2,924 sq m; on the eastern slopes of the Cascade Mountain range. It is the third largest county by area in WA State with 5 cities, 4 census-designated places, and 16 unincorporated communities. Two major highways run through the county; U.S Route 2 and U.S Route 97/97A. Notable geographic features are the Cascade, Chiwaukum, Entiat, Wenatchee, Chelan Mountains, and The Enchantments. Lake Chelan, Columbia, Entiat, and Wenatchee Rivers are known for fishing, rafting, and boating activities.				

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.				
CHELAN COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 382	ILS - 2	ALS - 47		
	Verified	**Licensed**	**ESSO**		
EMS Agencies	12	1	3		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	4	1	1	2	3

DOUGLAS COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	32,603	38,431	42,938	44,798	
Income and Poverty	(2020) Median household income: $80,374		Poverty rate: 7.9%		
Health	(2020) 12.4% - without health care coverage		17.0% - disabled		
Description of county	1,849 sq m; located near the geographic center of WA state with 3 cities, 3 towns, and 6 unincorporated communities. Two major highways run through the county: US Route 2 and US Route 97. Notable geographic features are the Columbia River known for fishing, rafting, and boating activities.				
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.				
DOUGLAS COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 39	ILS - 0	ALS - 0		
	Verified	**Licensed**	**ESSO**		
EMS Agencies	5	0	0		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	1	0	0	1	1

GRANT COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	74,698	89,120	99,123	102,678	
Income and Poverty	(2020) Median household income: $75,586		Poverty rate: 16.7%		
Health	(2020) 15.0% - without health care coverage		16.3% - disabled		
Description of county	2,791 sq mi; with 10 cities, 5 towns, 11 census-designated places, and 10 unincorporated communities. Five major highways run through the county: I-90, I-90 BL, U.S. Route 2, State Route 17, and State Route 28. Notable geographic features are the Columbia River, Soap Lake, Potholes Reservoir, and Moses Lake known for fishing and boating activities. Grant county is also home of the Grand Coulee Dam, “A Man-Made Marvel” which was the key to the development of power on the Columbia River and forms Lake Roosevelt extending 151 miles upstream to the Canadian border				

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.				
GRANT COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 268	ILS - 11	ALS - 36		
	Verified	**Licensed**	**ESSO**		
EMS Agencies	17	1	0		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	4	0	0	3	3

OKANOGAN COUNTY					
	2000	**2010**	**2020**	**2023**	
Population	39,564	41,120	42,104	43,712	
Income and Poverty	(2020) Median household income: $60,293 Poverty rate: 18.5%				
Health	(2020) 13.9% - without health care coverage 16.4% - disabled				
Description of county	5,215 sq mi; is the largest county in WA State for square miles, located along the Canada – US Border, with 6 cities, 7 towns, and 11 unincorporated communities. Three major highways run through the county: U.S. Route 97, State Route 20, and State Route 153. Notable geographic features are the Cascade and North Gardner Mountains. The Columbia and Okanogan Rivers, and Beaner Lake which are known for fishing and boating activities.				
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.				
OKANOGAN COUNTY RESOURCE STATISTICS					
EMS Providers	BLS - 91	ILS - 34	ALS - 12		
	Verified	**Licensed**	**ESSO**		
EMS Agencies	8	1	1		
	Designated Trauma	**Designated Rehabilitation**	**Designated Pediatric**	**Categorized Cardiac**	**Categorized Stroke**
Hospitals	3	0	0	1	1

*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, Regional QI Committee, and Trauma Service Assessment workgroup will review data from trauma services, Department data, population growth, transfer patterns, and EMS status, to determine the minimum and maximum numbers of

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
		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 will submit the current Department list of categorized cardiac and stroke services to the Regional QI Committee with request for review and status of each facility in the region.
	2	**Strategy 2.** By August 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.
	3	**Strategy 3.** 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.
	4	**Strategy 4**. 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.
	5	**Strategy 5.** By July 2026, the Region Council will distribute Department approved Regional PCPs to system partners, local councils, and Medical Program Directors.

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
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.
Objective 8: By February 2027, the Region Council will distribute Behaviors Health facilities and treatment program information to region stakeholders.	**1**	**Strategy 1:** By December 2026, the Region Council will identify Behavior Health facilities and treatment programs
	2	**Strategy 2:** By February 2027, the Region Council will distribute Behavior Health facilities and treatment programs list of services to EMS, MPDs, healthcare facilities, law enforcement, and local councils.

GOAL 2 INTRODUCTION

SUPPORT EMERGENCY PREPAREDNESS ACTIVITIES

The North Central Region participates with Emergency Response Coalitions, Local Healthcare Alliances, 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 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 North Central Region promotes programs and policies to prevent and reduce the incidence and impact of injuries, violence, and illness.

Programs supported by the North Central Region include Senior Falls/Fall Risk, Safe Kids for bicycle safety and helmet fittings, Child Passenger Safety, Public Automated External Defibrillator training, AHA First Aid and CPR Courses, Safe Sitter babysitting classes, Life jacket Loaner Boards, 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 North Central 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 based on the identification of data-driven priorities for the region.
	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 North Central 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.
Objective 2: During July 2025-June 2027, the Region Council will support MPDs in	**1**	**Strategy 1.** By October 2025, the Region Council will request MPDs assess the opportunity to collaborate on a regional set of KPIs.

GOAL 4: ASSESS WEAKNESSES AND STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS IN THE REGION		
establishing a regional set of KPIs for system monitoring to determine training, education, and patient care protocol compliance.	**2**	**Strategy 2.** By December 2025, the Region Council will coordinate with MPDs to establish a method of tracking and submission of KPIs from EMS agencies.
	3	**Strategy 3.** By February 2026, the Region Council will provide a repository for EMS agencies to submit KPI data to.
	4	**Strategy 4.** On an ongoing basis, the Region Council will collate and distribute KPI data to MPDs.
	5	**Strategy 5.** 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.

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

The North Central Region EMS TCC maintains quality assurance of initial EMS courses by monitoring Instructors, participants success with National Registry Testing, and providing reports to County Medical Program Directors.

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 North Central 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 North Central 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.

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 work, of the Regional Council.	**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.
	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.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
	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.
	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: During July 2025-June 2027, the Region Council will maintain a DOH approved EMS Training Program.	**1**	**Strategy 1.** By August 2026, the Training and Education Committee will update the North Central Region EMS Training Program Policy and Procedures and submit to the Department of Health.
	2	**Strategy 2.** Annually, by June, the EMS Training Program Coordinator will provide a DOH Approved SEI workshop.
	3	**Strategy 3.** Biannually, by January, the EMS Training Program Coordinator will provide a DOH Approved EMS Instructor Methodology Course.
Objective 5: 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.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
	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 Local Councils, SEI, 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 6: During July 2025-June 2027, the Region Council will assist Medical Program Directors with EMS projects.	**1**	**Strategic 1.** On an ongoing basis, the Region Council Executive Director will assist in the review, revision, distribution of, and education for the MPD Patient Care Protocols.
	2	**Strategy 2.** On an ongoing basis, the Region Council Executive Director will assist EMS agencies and MPDs in the development and implementation of updated agency OTEP Plans.
	3	**Strategy 3.** On an ongoing basis, the Region Council Executive Director will assist the EMS provider in verification of education met for initial and renewal EMS Certification.
Objective 7: 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 Rehabilitation Facilities

WA Department of Health Trauma Designated Services					
REGION	Trauma Designation			Facility	City
	Adult	Pediatric	Rehab		
NORTH CENTRAL	III	III P		Central Washington Hospital	Wenatchee
	III			Samaritan Healthcare	Moses Lake
	IV			Lake Chelan Health	Chelan
	IV			Mid-Valley Hospital	Omak
	IV			North Valley Hospital	Tonasket
	IV			Coulee Medical Center	Grand Coulee
	IV			Three Rivers Hospital	Brewster
	V			Cascade Medical Center	Leavenworth
	V			Columbia Basin Hospital	Ephrata
	IV			Quincy Valley Medical Center	Quincy
			II R	Confluence Health Wenatchee Valley Hospital	Wenatchee

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	
NORTH CENTRAL	I	0	0	0
	II	1	1	0
	III	2	2	2
	IV	4	7	6
	V	3	3	2
	* I P	0	0	0
	* II P	1	1	0
	* III P	1	1	1

* 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	
NORTH CENTRAL	I R	1	1	1
	II R	0	0	0

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 Cardiac and Stroke System Categorized Hospitals

Washington State
Emergency Cardiac and Stroke System
Participating Hospitals by Region

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

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

Information is current as of October 2024

REF: DOH 345-299 / October 2024

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

APPENDIX 5

Appendix 5A: EMS Agency Report/Data

NORTH CENTRAL REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Chelan	AIDV.ES.61171887	Chelan Fire and Rescue	Chelan	AIDV	BLS	0	8	16	0	8
Chelan	ESSO.ES.61444609	Mission Ridge Ski Area	Wenatchee	ESSO		0	0	0	0	0
Chelan	AIDV.ES.61369174	Wenatchee Valley Fire Department	Wenatchee	AIDV	BLS	0	27	79	0	0
Chelan	AIDV.ES.00000030	Chelan County Fire District 3	Leavenworth	AIDV	BLS	0	2	2	0	0
Chelan	AIDV.ES.00000042	Chelan County Fire District 6	Monitor	AIDV	BLS	0	6	1	0	0
Chelan	AIDV.ES.60449836	Lake Wenatchee Fire and Rescue	Leavenworth	AIDV	BLS	0	2	31	0	0
Chelan	AMBV.ES.00000032	Chelan County Fire District 8	Entiat	AMBV	BLS	1	1	11	0	1
Chelan	AMBV.ES.00000039	Cashmere Fire Department	Cashmere	AMBV	BLS	1	3	10	0	0
Chelan	AMBV.ES.00000047	Ballard Ambulance	Wenatchee	AMBV	BLS	11	0	30	1	16
Chelan	AMBV.ES.00000048	Cascade Medical	Leavenworth	AMBV	ALS	5	1	45	1	8
Chelan	AMBV.ES.00000049	Lake Chelan Community Hospital Emergency Medical Services	Chelan	AMBV	ALS	7	1	15	0	14
Chelan	AMBV.ES.00000051	Lifeline Ambulance	Wenatchee	AMBV	ALS	4	1	23	0	4
Chelan	AMBV.ES.60358237	Chelan County Fire Protection District 5	Manson	AMBV	BLS	1	2	11	0	0
Chelan	ESSO.ES.60343761	Chelan County Public Utility District	Wenatchee	ESSO		0	0	19	0	0
Chelan	AID.ES.60958997	Stevens Pass Mountain Resort	Leavenworth	AIDV	BLS	0	0	20	0	0
Chelan	ESSO.ES.60427779	Holden Mine Remediation Clinic	Anchorage-Holden	ESSO		0	0	0	0	3
Douglas	AIDV.ES.61369157	Wenatchee Valley Fire Department	East Wenatchee	AIDV	BLS	0	0	3	0	0
Douglas	AIDV.ES.00000118	Douglas County Fire District 4	Orondo	AIDV	BLS	0	1	11	0	0
Douglas	AMBV.ES.00000120	Bridgeport Volunteer Fire	Bridgeport	AMBV	BLS	1	1	7	0	0
Douglas	AMBV.ES.00000121	Mansfield Ambulance	Mansfield	AMBV	BLS	2	2	13	0	0
Douglas	AMBV.ES.00000122	Waterville Ambulance Service	Waterville	AMBV	BLS	2	1	2	0	0

NORTH CENTRAL REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Grant	AID.ES.60356927	Reclamation Fire Dept	Grand Coulee	AID	BLS	0	1	7	2	0
Grant	AIDV.ES.00000138	Grant County Fire District 3	Quincy	AIDV	BLS	0	12	17	0	1
Grant	AIDV.ES.61243994	Grant County Fire Protection District 7	Soap Lake	AMBV	BLS	2	0	12	1	0
Grant	AIDV.ES.00000146	Grant County Fire District 13	Ephrata	AIDV	BLS	0	4	8	0	0
Grant	AIDV.ES.60053432	Grant County Fire Protection District 12	Wilson Creek	AIDV	BLS	0	1	10	0	0
Grant	AIDV.ES.60795718	Centerra Fire Department	Moses Lake	AIDV	BLS	0	2	7	1	0
Grant	AID.ES.61023441	Boeing Fire Department	Seattle Moses Lake	AIDV	BLS	0	1	0	0	0
Grant	AMBV.ES.00000140	Grant County Fire District 5	Moses Lake	AMBV	BLS	1	5	26	0	1
Grant	AMBV.ES.00000141	Grant County Fire District 6	Hartline	AMBV	BLS	1	0	8	0	0
Grant	AMBV.ES.00000143	Grant County Fire District 8	Mattawa	AMBV	BLS	4	0	19	0	0
Grant	AMBV.ES.00000144	Royal Slope EMS	Royal City	AMBV	BLS	3	2	16	3	0
Grant	AMBV.ES.00000147	Coulee City Fire Department	Coulee City	AMBV	BLS	2	0	5	0	0
Grant	AMBV.ES.00000148	Grand Coulee Volunteer Ambulance	Grand Coulee	AMBV	BLS	3	0	21	3	0
Grant	AMBV.ES.00000149	Moses Lake Fire Department	Moses Lake	AMBV	ALS	5	5	31	0	18
Grant	AMBV.ES.00000155	Ephrata Fire Department	Ephrata	AMBV	BLS	1	3	14	0	0
Grant	AMBV.ES.61449602	Lifeline Ambulance	Wenatchee	AMBV	ALS	4	1	7	7	14
Grant	AMBV.ES.60231631	Columbia EMS	Quincy	AIDV	ALS	4	3	14	7	5
Grant	AMBV.ES.60642727	Grant County Fire District 4	Warden	AMBV	BLS	1	2	12	0	0
Okanogan	AID.ES.60875601	Okanogan County Fire District 12	Tonasket	AIDV	BLS	0	2	3	0	0
Okanogan	AIDV.ES.00000446	Conconully Fire and Rescue	Conconully	AIDV	BLS	0	1	3	0	0
Okanogan	AIDV.ES.60310971	Okanogan County Fire Protection District 16	Tonasket	AIDV	BLS	0	1	3	1	0
Okanogan	AIDV.ES.60483069	Okanogan County Fire District 3	Okanogan	AIDV	BLS	0	3	8	0	0
Okanogan	AMBV.ES.00000443	Douglas Okanogan County Fire District 15	Brewster	AMBV	ILS	4	2	9	5	1
Okanogan	AMBV.ES.00000453	Aero Methow Rescue Service	Twisp	AMBV	ALS	5	6	23	15	6

NORTH CENTRAL REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Okanogan	AMBV.ES.00000454	Colville Tribal Emergency Services	Nespelem	AMBV	BLS	7	0	19	7	0
Okanogan	AMBV.ES.00000456	Lifeline Ambulance	Omak	AMBV	ALS	9	2	23	8	5
Okanogan	ESSO.ES.60291376	North Cascades Smokejumper Base	Winthrop	ESSO		0	0	1	0	0
Okanogan	AMBV.ES.60922878	Grant Coulee Volunteer Ambulance	Grand Coulee	AIDV	BLS	1	0	0	0	0

Numbers are current as of January 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
Chelan	4	0	3	0	0	5
Douglas	0	0	3	0	0	2
Grant	3	0	9	0	0	5
Okanogan	2	1	2	0	0	3

Numbers are current as of January 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
Chelan	0	0	0	0	0	1	3
Douglas	0	0	0	0	0	0	0
Grant	0	0	0	0	0	1	0
Okanogan	0	0	0	0	0	1	1

Numbers are current as of January 2025

Appendix 5D: North Central Region Personnel: Paid & Volunteer by County

	# of EMR		# of EMT		# of AEMT		# of Paramedic	
COUNTY	**Paid**	**Volunteer**	**Paid**	**Volunteer**	**Paid**	**Volunteer**	**Paid**	**Volunteer**
Chelan	0	0	251	131	2	0	46	1
Douglas	0	3	5	31	0	0	0	0
Grant	1	5	121	141	4	7	36	0
Okanogan	0	5	44	42	24	12	11	1

Numbers are current as of February 2025

APPENDIX 6

Approved Minimum and Maximum 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)**
CHELAN	AIDV	BLS	4	6	5
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	3	3	3
		ILS	0	0	0
		ALS	4	4	4
DOUGLAS	AIDV	BLS	1	2	2
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	3	3	3
		ILS	0	0	0
		ALS	0	0	0
GRANT	AIDV	BLS	4	11	5
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	4	9	9
		ILS	0	5	0
		ALS	1	4	3
OKANOGAN	AIDV	BLS	1	5	3
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	3	4	2
		ILS	1	2	1
		ALS	1	2	2

Numbers are current as of January 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**
CHELAN	**1**	Wenatchee Valley Fire Department Ballard Ambulance Lifeline Ambulance	AIDV AMBV	BLS ALS
	2	Lake Wenatchee Fire and Rescue Cascade Medical	AIDV AMBV	BLS ALS
	3	Lake Wenatchee Fire and Rescue Cascade Medical	AIDV AMBV	BLS ALS
	4	Chelan County FD6 Cashmere Cascade Medical	AIDV AMBV	BLS ALS
	5	Chelan County FD8 Ballard Ambulance	AMBV	BLS ALS
	6	Lake Chelan Community Hospital EMS Chelan Fire & Rescue	AIDV AMBV	BLS ALS
	7	Chelan County FD6 Cashmere FD	AIDV AMBV	BLS
	8	Wenatchee Valley Fire Department Ballard Ambulance Lifeline Ambulance	AIDV AMBV	BLS ALS
	9	Lake Chelan Community Hospital EMS	AMBV	ALS
	U-1	Chelan County FD6 Cascade Medical	AIDV AMBV	BLS ALS
	U-2	Chelan County FD3 Lake Wenatchee Fire and Rescue Cascade Medical	AIDV AMBV	BLS ALS
	U-3	Chelan County FD6 Cascade Medical	AIDV AMBV	BLS ALS
	U-4	Lake Wenatchee Fire and Rescue Cascade Medical	AIDV AMBV	BLS ALS
	U-5	Chelan County FD3 Cascade Medical	AIDV AMBV	BLS ALS
	U-6	Lake Chelan Community Hospital EMS Chelan Fire & Rescue	AIDV AMBV	BLS ALS
	U-7	Lake Chelan Community Hospital EMS Chelan Fire & Rescue	AIDV AMBV	BLS ALS
	U-8	Chelan County FD8 Ballard Ambulance	AMBV	BLS ALS

		Lifeline Ambulance		
	U-9	Lake Wenatchee Fire and Rescue Cascade Medical Chelan County FD8 Lake Chelan Community Hospital EMS	AIDV AMBV	BLS ALS
	U-10	Chelan County FD6 Cascade Medical	AIDV AMBV	BLS ALS
	U-11	Chelan County FD6 Cascade Medical	AIDV AMBV	BLS ALS
	U-12	Chelan County FD8 Ballard Ambulance Lifeline Ambulance	AMBV	BLS ALS
	U-13	Lake Chelan Community Hospital EMS Chelan Fire & Rescue Chelan County FD8	AIDV AMBV	BLS ALS
	U-14	Lake Chelan Community Hospital EMS Chelan Fire & Rescue	AIDV AMBV	BLS ALS
	U-15	Lake Chelan Community Hospital EMS Chelan County FD5	AMBV	BLS ALS
	U-16	Lake Chelan Community Hospital EMS Chelan Fire & Rescue	AIDV AMBV	BLS ALS
	U-17	Cashmere FD Chelan County FD6 Ballard Ambulance Lifeline Ambulance	AIDV AMBV	BLS ALS
	U-18	Cashmere FD Chelan County FD6 Ballard Ambulance Lifeline Ambulance	AMBV	BLS ALS
	U-19	Wenatchee Valley Fire Department Ballard Ambulance Lifeline Ambulance	AIDV AMBV	BLS ALS
DOUGLAS	**1**	Waterville Ambulance	AMBV	BLS
	2	Waterville Ambulance Ballard Ambulance Lifeline Ambulance	AMBV	BLS ALS
	3	Bridgeport VFD & EMS	AMBV	BLS
	4	Douglas County FD4 Lake Chelan Health EMS Ballard Ambulance	AIDV AMBV	BLS ALS
	5	Douglas County FD4 Mansfield Ambulance Lake Chelan Health EMS	AIDV AMBV	BLS ALS

	6	Bridgeport VFD & EMS	AMBV	BLS
	U-1	Waterville Ambulance	AMBV	BLS
	U-2	Bridgeport VFD & EMS Mansfield Ambulance	AMBV	BLS
	U-3	Douglas Okanogan County FD 15	AMBV	ILS
	U-4	Coulee City Fire Department	AMBV	BLS
	U-5	Grant County FD3 Coulee City Fire Department Lifeline Ambulance	AIDV AMBV	BLS ALS
	U-6	Waterville Ambulance Ballard Ambulance Lifeline Ambulance	AMBV	BLS ALS
	U-7	Ballard Ambulance Lifeline Ambulance	AMBV	ALS
Unable to locate on DOH GIS map	**U-8**			
	U-9	Coulee City Fire Department	AMBV	BLS
	U-10	Okanogan Douglas County FD15	AMBV	ILS
GRANT	**1**	Grant County FD3 Protection-1, LLC	AIDV AMBV	BLS ALS
	2	Grant County FD4 Lifeline Ambulance	AMBV	BLS ALS
	3	Grant County FD5 Lifeline Ambulance	AMBV	BLS ALS
	4	Grant County FD6 Coulee City FD	AMBV	BLS
	5	Grant County FD7 Coulee City FD Lifeline Ambulance	AIDV AMBV	BLS ALS
	6	Grant County FD8	AMBV	BLS
	7	Grant County FD10	AMBV	BLS
	8	Grant County FD10	AMBV	BLS
	9	Grant County FD12 Coulee City FD Lifeline Ambulance	AIDV AMBV	BLS ALS
	10	Grant County FD13 Lifeline Ambulance	AMBV	BLS ALS
	11	Grand Coulee Volunteer Ambulance	AMBV	BLS
	12	Grant County FD5 Lifeline Ambulance	AMBV	BLS ALS
	13	Coulee City FD	AMBV	BLS
	14	Ephrata FD Lifeline Ambulance	AMBV	BLS ALS
	15	Grand Coulee Volunteer Ambulance	AMBV	BLS
	16	Moses Lake FD	AMBV	BLS

				ALS
	17	Centerra FD Boeing FD Grant County FD5 Lifeline Ambulance	AIDV AMBV	BLS ALS
	U-1	Grand Coulee Volunteer Ambulance Grant County FD6	AMBV	BLS
	U-2	Grand Coulee Volunteer Ambulance	AMBV	BLS
	U-3	Coulee City FD	AMBV	BLS
	U-4	Coulee City FD	AMBV	BLS
	U-5	Coulee City FD	AMBV	BLS
	U-6	Grant County FD3 Lifeline Ambulance	AIDV AMBV	BLS ALS
	U-7	Grant County FD12 Lifeline Ambulance	AIDV AMBV	BLS ALS
	U-8	Grant County FD7 Lifeline Ambulance	AMBV	BLS ALS
	U-9	Grant County FD12 Lifeline Ambulance	AIDV AMBV	BLS ALS
	U-10/10A	Lifeline Ambulance	AMBV	ALS
	U-11	Lifeline Ambulance	AMBV	ALS
OKANOGAN	**1**	Lifeline Ambulance	AMBV	ALS
	2	Grand Coulee Volunteer Ambulance	AMBV	BLS
	3	Grand Coulee Volunteer Ambulance	AMBV	BLS
	4	Lifeline Ambulance	AMBV	ALS
	5	Douglas Okanogan FD15	AMBV	ILS
	6	Aero Methow Rescue Service	AMBV	ALS
	7	Lifeline Ambulance	AMBV	ALS
	8	Colville Tribal EMS Lifeline Ambulance	AMBV	BLS ALS
	9	Conconully Fire and Rescue Lifeline Ambulance	AIDV AMBV	BLS ALS
	10	Lifeline Ambulance	AMBV	ALS
	11	Lifeline Ambulance	AMBV	ALS
	12	Lifeline Ambulance	AMBV	ALS
	13	Colville Tribal EMS Grand Coulee Volunteer Ambulance Lifeline Ambulance	AMBV	BLS ALS
	U-1	Lifeline Ambulance	AMBV	ALS
	U-2	Lifeline Ambulance	AMBV	ALS
	U-3	Okanogan County FD6 Lifeline Ambulance	AIDV AMBV	BLS ALS
	U-4	Lifeline Ambulance	AMBV	ALS

	U-5	Lifeline Ambulance	AMBV	ALS
	U-6	Lifeline Ambulance	AMBV	ALS
	U-7	Unknown	AMBV	ALS
	U-8	Lifeline Ambulance	AMBV	
	U-9	Aero Methow Rescue Service	AMBV	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.60850963-PRO	APPROVED	10/31/2028	Lifeline Ambulance	Omak	Okanogan
TRNG.ES.60119536-PRO	APPROVED	10/31/2028	North Central Region EMSTCC	Wenatchee	Chelan
TRNG.ES.60119457-PRO	APPROVED	10/31/2027	Wenatchee Valley College	Wenatchee	Chelan
TRNG.ES.60124290-PRO	APPROVED	10/31/2027	Grant County Fire District 5	Moses Lake	Grant
TRNG.ES.60751916-PRO	APPROVED	10/31/2028	Moses Lake Fire Department	Moses Lake	Grant

Information is current as of January 2025
WA State approved Training Programs list

Appendix 8B: Approved EMS Educators by County

ESE			
County	2023	2024	Change
Chelan	77	77	0
Douglas	30	28	-2
Grant	73	82	+9
Okanogan	33	36	+3
			0
TOTALS:	213	223	10

SEIC			
County	2023	2024	Change
Chelan	0	2	0
Douglas	0	0	0
Grant	0	0	0
Okanogan	2	2	0
			0
TOTALS:	2	0	0

SEI			
County	2023	2024	Change
Chelan	6	6	0
Douglas	4	4	0
Grant	8	7	-1
Okanogan	7	8	+1
			0
TOTALS:	25	25	0

Total EMS educators in the North Central Region = 240

Numbers are current as of January 2025

Appendix 9:

Local Health Jurisdictions

LOCAL HEALTH JURISDICTIONS		
Agency/Organization Name	City	County
Chelan-Douglas Health District	East Wenatchee	Chelan-Douglas
Grant County Public Health	Moses Lake	Grant
Okanogan County Public Health	Okanogan	Okanogan

Information is current as of January 2025

Appendix 10:

Local Department of Emergency Management Offices

LOCAL DEPARTMENT OF EMERGENCY MANAGEMENT OFFICES		
Agency/Organization Name	**City**	**County**
Chelan County Emergency Management	Wenatchee	Chelan
Grant County Emergency Management	Moses Lake	Grant
Okanogan County Emergency Management	Okanogan	Okanogan
Douglas County Emergency Management	East Wenatchee	Douglas

Information is current as of January 2025

Appendix 11:

Regional Preparedness Coalitions

REGIONAL PREPAREDNESS COALITIONS		
Agency/Organization Name	**City**	**County**
Region 7 Healthcare Alliance	East Wenatchee	Chelan-Douglas
		Okanogan-Grant
		Kittitas
Northwest Healthcare Response Network	Statewide	Statewide

Information is current as of January 2025

NORTH CENTRAL REGION - PATIENT CARE PROCEDURES

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

The following PCPs are approved with the 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.

PATIENT CARE PROCEDURES:

- **1.1** Dispatch of Agencies
- **1.2** Timely & Appropriate EMS Response
- **1.3** Response Times
- **3**. Air Medical Services Activation and Utilization
- **5.** Prehospital Triage and Destination Procedure
- **5.2** Cardiac Triage and Destination Procedure
- **5.3** Stroke Triage and Destination Procedure
- **5.4** EMS Transport to Behavioral Health Facililities
- **5.5** Identification of Major Trauma & Medical Patients
- **7**. Hospital Diversion
- **9**. Inter-Facility Transfer
- **10.1** Mass Casualty Incident
- **10.2** All Hazards

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 AGENCIES

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

1. PURPOSE:

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

2. SCOPE:

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

3. GENERAL PROCEDURES:

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

4. DEFINITIONS:

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

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

1.2. TIMELY & APPROPRIATE EMS RESPONSE

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

1. PURPOSE:

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

2. SCOPE:

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

3. GENERAL PROCEDURES:

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

4. DEFINITIONS:

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

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

1.3. RESPONSE TIMES

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

1. PURPOSE:

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

2. SCOPE:

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

3. GENERAL PROCEDURES:

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

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

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

4. DEFINITIONS:

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

- ***"Urban"*** an incorporated area over thirty thousand; or an incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square mile.

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

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

3. AIR AMBULANCE SERVICES – ACTIVATION AND UTILIZATION

Effective Date: 9/1/ 2020

1. PURPOSE:

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

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

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

4. TRANSPORT CONSIDERATIONS:

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

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

5. CONSIDERATIONS FOR AIR AMBULANCE TRANSPORT:

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

a. Hazardous materials exposure
b. Highly infectious disease (such as Ebola)
c. Inclement weather

d. Patient weight and size

If any of the conditions above are present:

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

6. SAFETY OF GROUND CREWS AROUND AIRCRAFT

To promote safety of all personnel, ground crews must:

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

7. LANDING ZONE CONSIDERATIONS:

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

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

A. Select a location for the landing zone that is at least:
    b. Night; 100 ft. x 100 ft.
    c. Daytime: 75 ft. x 75 ft.
B. Assure the landing zone location is free of loose debris.
C. Assure the approach and departure paths are free of obstructions, and identify to the pilot hazards such as wires, poles, antennae, trees, wind speed and direction, etc.
D. Provide air ambulance services with the latitude and longitude of the landing zone. Avoid using nomenclature such as "Zone 1."
E. Mark night landing zones with lights. Cones may be used if secured or held down. Do not use flares.
F. Establish security for the landing zone for safety and privacy.
G. Avoid pointing spotlights and high beams towards the aircraft. Bright lights should be dimmed as the aircraft approaches.
H. Do not approach an aircraft unless escorted by an aircrew member.
I. Consult with aircrew members before loading and unloading. Loading and unloading procedures will be conducted under the direction of the flight crew.

8. DEFINITIONS:

- ***"Standby"*** Upon receiving the request, dispatch will notify the pilot and crew of the possible flight. The crew will respond to the aircraft and ensure they are in a flight ready status. The crew will then remain at or near the aircraft until such time as they are launched or released from standby.
- ***"Launch time"*** launch time is the time the skids lift the helipad en route to the scene location.

- ***"Early activation"*** Departing for a requested scene prior to arrival of the first responders, based on a high index of suspicion that specialty services will be necessary.

9. APPENDICES

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

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

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

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

5.1 TRAUMA TRIAGE AND DESTINATION PROCEDURE

Effective Date: 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 North Central 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. ALL trauma patients shall be transported by a AMBV (trauma verified ambulance service) per WAC 246-976-700.

Specialty Care Services are not available in the North Central Region, therefore patients requiring specialty care 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 REGION

Facility	Location (City/County)	Designation Level
Confluence Health	Wenatchee	III III Pediatric
Samaritan Healthcare	Moses Lake	III
Lake Chelan Health	Chelan	IV
Mid-Valley Hospital	Omak	IV
North Valley Hospital	Tonasket	IV
Coulee Medical Center	Grand Coulee	IV
Three Rivers Hospital	Brewster	IV

Cascade Medical Center	Leavenworth	V
Columbia Basin Hospital	Ephrata	V
Quincy Valley Medical Center	Quincy	IV
Confluence Health Wenatchee Valley Hospital	Wenatchee	II Rehabilitation

*DOH 530-101, July 2024

ASSOCIATED COUNTY OPERATING PROCEDURES (COPs) AND MPD PROTOCOLS
https://www.ncecc.net/

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

5.2. CARDIAC TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/1/2018

1. PURPOSE:

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

2. SCOPE:

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

3. GENERAL PROCEDURES:

The first certified EMS provider determines that a patient:

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

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

4. APPENDICES:

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

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

5.3. STROKE TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/1/2018

1. PURPOSE:

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

2. SCOPE:

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

3. GENERAL PROCEDURES:

The first certified EMS provider determines that a patient:

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

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

4. APPENDICES:

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

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

5.4. EMS TRANSPORT TO BEHAVIORAL HEALTH FACILITIES

Effective Date: 11/1/2018
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

A. Facility participation is voluntary.
B. Facilities and agencies must adhere to the Washington State Department of Health, EMS Guideline, EMS Transport to Behavioral Health.
C. 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.
D. 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.
E. The MPD must establish a patient care protocol inclusive of the standards and screening criteria recommended by the guideline and PCP.
F. 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 Guideline, 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.ncecc.net/

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	02/07/2018	☒ Major ☐ Minor
Regional Council	Updated	4/11/2025	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.5. IDENTIFICATION OF MAJOR TRAUMA & EMERGENCY MEDICAL PATIENTS

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

1. PURPOSE:

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

2. SCOPE:

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

3. GENERAL PROCEDURES:

A. The first certified EMS provider will:

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

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

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

C. Whenever needed, BLS agencies may request ILS or ALS agencies be dispatched to the scene by ground or air.
D. In accordance with WAC 246-976-330 (2)(b); "Within twenty-four hours of arrival, a complete written or electronic patient care report……." Shall be provided to the receiving facility.

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

7. HOSPITAL DIVERSION

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

1. PURPOSE:

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

2. SCOPE:

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

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

3. GENERAL PROCEDURES:

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

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

9. INTERFACILITY TRANSFER

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

1. PURPOSE:

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

2. SCOPE:

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

a. Central Nervous System Injury
b. Head injury with any of the following
   - Open, penetrating, or depressed skull fracture
   - Severe coma (Glasgow Coma Score <10)
   - Lateralizing signs
   - Unstable spine or spinal cord injury
c. Chest Injury
   - Suspected great vessel or cardiac injuries
   - Major chest wall injury
   - Patients requiring prolonged ventilation
d. Pelvis Injury:
   - Pelvic ring disruption with shock requiring more than 5 units of blood transfusion
   - Evidence of continued hemorrhage
   - Compounded/open pelvic fracture or pelvic visceral injury
e. Multiple System Injury
   - Severe facial injury with head injury
   - Chest injury with head injury
   - Abdominal or pelvic injury with head injury
   - Burns with head injury
f. Specialized Problems
   - Burns > 20% BSA or involving airway

- Carbon Monoxide poisoning
- Barotrauma

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

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

3. GENERAL PROCEDURES:

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

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

F. MPD approved Prehospital Protocols will be followed during transport, unless direct medical orders are given to the contrary.
G. The transferring facility must arrange for the appropriate level of care during transport. For interfacility transfer of critical major trauma patients, trauma verified air or ground ALS transport services shall be used. Air or ground interfacility transport shall be based on patient acuity and consideration of total out of hospital time in consultation with the receiving physician.
H. Transport of patients out of region shall be consistent with these standards.

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

10.1. MASS CASUALTY INCIDENT (MCI)

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

1. PURPOSE:

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

2. SCOPE:

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

3. GENERAL PROCEDURES:

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

4. DEFINITIONS:

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

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

10.2. ALL HAZARDS

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

1. PURPOSE:

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

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

3. **GENERAL PROCEDURES:**

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

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