Strategic Plan:

2025-2027

NORTHWEST REGION

Emergency Medical Services & Trauma Care Council

Submitted: 3/3/25

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INTRODUCTION

The Northwest Region's Strategic EMS & Trauma Care System Plan is made up of goals adapted from the State Strategic EMS & Trauma Care System Plan. The objectives and strategies are further developed by the local councils and then approved by the Regional Council and its stakeholders of the Northwest Region.

Mission: It is the Mission of NWREMS to promote and support a coordinated system for local Emergency Medical Services.

Core Values: Accountability, Honesty, Integrity, Trustworthy, Diligence, High Quality Patient Care, Fortitude, Unity, Respect, Focus, Service before self. While Services are unique all are imperative to mission.

Vision: Excellence through integrity and honesty, leader in the state for patient care delivery.

Background

In accordance with RCW 70.168.010 – RCW 70.168.130 and Washington Administrative Code (WAC 246.976.960) the EMS and Trauma Care Regional Council and County Councils are required to 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 (DOH).

The Northwest Region is located on the Olympic Peninsula of Washington State. It is one of eight Regional Councils statewide composed of appointed volunteer representatives and funded primarily by the Washington State Department of Health (DOH). The Region is comprised of the following Counties: Clallam, Jefferson, Kitsap, and Mason. Due to demographics Northwest Region recognizes the West Olympic Peninsula - which includes West Clallam and West Jefferson Counties as a separate Council and they operate as such. As a result, we recognize 5 local EMS & Trauma Care Councils; Clallam, Jefferson, Kitsap, Mason and West Olympic Peninsula. The Region recognizes that the unique geographical features of the Region with one road leading in and out to some areas, one bridge that crosses Hood Canal, and a National Forest in the NW Corner of the Region can cause challenges in transport of patients. There are thirty-two (32) EMS licensed & trauma verified aid and ambulance services within the Northwest Region and two ESSOs. There are currently 20 SEI's, 0 SEIC's, 261 ESE's and 5 Approved Training Programs within the Northwest Region as of January 14, 2025. There are five (5) trauma services designated and five (5) Emergency Cardiac and Stroke System Hospitals within the Northwest Region.

Clallam County Overview												
Clallam County is located on the north side of the Region and is classified as Rural. Largest city is Port Angeles. Comprised of 2,671sq. miles. Clallam County is the westernmost point in both Washington and the US. Clallam County shares borders with Canada, the Pacific Ocean, and the Strait of Juan de Fuca. Also contains part of the Olympic National Park, and can be reached by US Hwy 101.												
	2023 estimate		**Rural population**			**% in poverty**			**% of population 65+**			
Population	77,616		35.5%			11.8			33%			
	# of EMR		**# of EMT**		**# of AEMT**		**# of Paramedic**					
	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Total Paid	Total Volunteer	% Volunteer	
EMS Providers	0	0	93	95	9	4	66	1	168	100	37.3%	
	SEI		5		**SEIC**		0		**ESE**		88	
	AID BLS		**AID ILS**		**AID ALS**		**AMB BLS**		**AMB ILS**	**AMB ALS**	**ESSO**	
EMS Agencies	1		0		0		3		1	4	0	
	Trauma Level		**Rehabilitation Level**			**Pediatric Level**			**Cardiac Level**		**Stroke Level**	
Olympic Medical Center	III								II		III	
Forks Community Hospital	IV								II		III	
Air Medical Base	Life Flight has a Rotor Wing base in Port Angeles, WA											

Jefferson County												
Jefferson County is in the middle of the Region, just below Clallam County and is classified as Rural. The largest city is the only incorporated city of Port Townsend. Comprised of 2,183sq. miles the Olympic Mountains and Olympic National Park/Forest make up 60% of the county. Eastern Jefferson County sits along the strait of Juan de Fuca, Admiralty Inlet, Puget Sound and the Hood Canal. Western Jefferson County borders sit along the Pacific Ocean. Because of the mountainous barrier, there is no road lying entirely within Jefferson County that connects the eastern and western parts. The most direct land route between the two ends of the county involves a drive of approximately 100 miles (160 km) along U.S. Route 101 through neighboring Clallam County. Can also be accessed 2 State Hwys or by Ferry from Coupeville.												
	2023 estimate		**Rural population**			**% in poverty**			**% of population 65 years and over**			
Population	33,714		57.5%			11.2%			42.1%			
	# of EMR		**# of EMT**		**# of AEMT**		**# of Paramedic**					
	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Total Paid	Total Volunteer	% Volunteer	
EMS Providers	0	0	48	50	4	1	21	0	73	51	41.1%	
	SEI		3		**SEIC**		0		**ESE**		21	
	AID BLS		**AID ILS**		**AID ALS**		**AMB BLS**		**AMB ILS**	**AMB ALS**	**ESSO**	
EMS Agencies	0		0		0		3		0	2		

							1
	Trauma Level	**Rehabilitation Level**	**Pediatric Level**	**Cardiac Level**	**Stroke Level**		
Jefferson Healthcare	IV			II	III		

Kitsap County Statistics and Resources											
Kitsap County is located on the eastern side of the Region and is classified as Urban. This is the 7th largest County in the State by population and the 3rd smallest in square miles. Bremerton is the largest city. The United States Navy is the largest employer in the county, with installations at Puget Sound Naval Shipyard, Naval Undersea Warfare Center Keyport, and Naval Base Kitsap (which comprises former NSB Bangor and NS Bremerton).Comprised of 566sq. miles, Kitsap County has 250 miles of saltwater shoreline and 2 islands, Bainbridge Island and Blake Island, which is a Marine State Park with 1,127 acres and 5 miles of saltwater beach shoreline and is an unserved area. Kitsap County is connected to the eastern shore of Puget Sound by 4 Ferry routes and Highway routes connect Kitsap to the mainland via the Tacoma Narrows Bridge to the I-5 corridor, and to the neighboring Olympic Peninsula via the Hood Canal Bridge.										
	2023 estimate		**Rural population**		**% in poverty**		**% of population 65+**				
Population	277,658		16.7%		9.5%		20.3%				
	# of EMR		**# of EMT**		**# of AEMT**		**# of Paramedic**				
	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Total Paid	Total Volunteer	% Vol.
EMS Providers	0	0	370	44	4	0	122	0	496	44	8.1%
	SEI		8		**SEIC**		0		**ESE**		109
	AID BLS	**AID ILS**	**AID ALS**	**AMB BLS**	**AMB ILS**	**AMB ALS**	**Licensed**	**ESSO**			
EMS Agencies	0	0	0	1	0	7	0	0			
	Trauma Level	**Rehabilitation Level**	**Pediatric Level**	**Cardiac Level**	**Stroke Level**						
St. Michael Medical Center	III			I	II						
Air Medical Base	Airlift NW has a Rotor Wing base in Bremerton, WA on the border of Mason & Kitsap Counties										

Mason County Statistics and Resources											
Mason County is located on the south-eastern side of the Region and is classified as Rural. The only incorporated city is Shelton. Comprised of 1,051sq. miles, 9% of which is water and 2 islands. Mason County encompasses the southern reach of Hood Canal and many bays and inlets of southern Puget Sound. Mason county can be reached by 3 State Routes or US Hwy 101.											
	2023 estimate		**Rural population**		**% in poverty**		**% of population 65+**				
Population	68,389		63.7%		11.4%		25.0%				
	# of EMR		**# of EMT**		**# of AEMT**		**# of Paramedic**				
	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Total Paid	Total Volunteer	% Volunteer
EMS Providers	1	5	73	78	5	3	52	1	131	87	39.9%
	SEI		4		**SEIC**		0		**ESE**		43

	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed	ESSO
EMS Agencies	3	0	0	4	0	3	0	1

	Trauma Level	Rehabilitation Level	Pediatric Level	Cardiac Level	Stroke Level
Mason General Hospital	IV			II	III

https://www.census.gov/quickfacts
https://en.wikipedia.org/wiki

Regional Council Members

Regional Council membership is made up of representatives from private and public healthcare providers across the EMS and Trauma Care System. As of February 2025, we have 25 active members including all 3 MPD's. Local Councils are given reports by their Executive Board member. County reports are given at each Region meeting. Local Councils help to write the biennial strategic plan as well. The Council meets virtually 5 times per year on the 2nd Thursday in January, March, May, September and November. See website for meeting details.

Executive Committee

The Executive Committee consists of the Chairperson, Vice-Chairperson, Secretary/Treasurer, most recent past Chairperson and two At-Large members. With representation from each of the local councils, this committee fulfills a decision-making role on behalf of the Northwest Region EMS and Trauma Care Council to help move forward the goals and objectives of the Regional Plan. Executive Committee members report to the local councils and keeps them apprised of region happenings. The Executive Committee meets in the off months of the Council meetings and additionally when there is pressing business to discuss. The Executive Committee is also tasked with the creating and maintaining operations budget.

Training Education Development (TED) Committee

The Regional Councils TED Committee has representatives from prehospital agencies and the Medical Program Directors. They assist in the development and revisions of Northwest Region Protocols, Ongoing Training and Education Program (OTEP) and Patient Care Procedures. The TED Committee makes recommendations to the Council on the use of available EMS grant training funds, the review of annual training requests, as well as other training related matters, addressing areas of need and future direction of prehospital training for the region. Training opportunities are posted on the Region's website and are frequently updated. The Committee meets prior to the Regional Council meetings in May and September or when necessary.

QI Committee

This committee consists of representatives from each of the five trauma designated hospitals within the Region, includes MPD's and pre-hospital providers. This group serves as the core group that conducts Quality Improvement reviews and participates in the ongoing process of updating Patient

Care Procedures. This committee is organized and run by the highest-level Designated Trauma Centers and Categorized Cardiac and Stroke Facilities in the Region. The QI Committee is the venue where information from various data sources may be shared to inform and promote quality improvement. The Committee meets prior to the Regional Council meetings.

Injury & Violence Prevention (IVP) Committee

The IVP Committee is dedicated to preventing the leading causes of injury and death in the region which have consistently been Unintentional Falls, Unintentional Poisoning, Suicide by Firearm, and Unintentional Motor Vehicle crashes. When funds allow, mini-grants are awarded to evidence-based injury prevention projects in Northwest Region that support data-driven projects in the leading causes of injury and death. In this effort the region has recently funded fall prevention materials, bike helmets, and Narcan leave-behind kit supplies. The committee meets prior to the Regional Council meetings when necessary.

Protocol Committee

Committee is made up of the NW Regions' MPD's and designated providers tasked with the review and updating of our Regional Protocols. They make recommendations for improvements and submit for approval. The committee meets whenever Protocol review is open and is done as needed.

Historical Snapshot

Accomplishments and outcomes from 2023-2025 strategic plan are as follows but not limited to;

- The Region transitioned staff with a new Executive Director. The position was vacant for a short amount of time. With the help of the Executive Board of Directors, the group collectively continues to improve administrative functions & processes.
- The Region hosted a WEMSIS workshop. This effort helped to provide an overview and answer some questions. This has facilitated ongoing, continued efforts to improve data collected and meaningful output.
- DMCC workgroup has been formed and continues to meet regularly. Work on the DMCC will remain ongoing, aiming to maintain momentum and focus.
- A First Responder Wellness Workshop. This opportunity was open to all first responders in the region, the Council hosted a virtual wellness workshop led by a licensed psychologist.
- The Region conducted a survey of workforce around the topics of recruitment and retention. This survey highlighted the anecdotal challenges that are experienced. The information gathered supports efforts to increase and expand educational opportunities and other strategies for retention going forward.
- The Regional Council members and staff continue to support efforts to increase training opportunities and aim to continue collaboration cross region.
- Expansion of Naloxone leave-behind program by partnering with the DOH and supporting creation of kits to be distributed throughout the region.
- Mitigation of crowded ED's and hospitals by collaborating with both hospitals as well as individual agencies. EMS providers are involved in Pre-Hospital hand-offs and staffing the ER

waiting rooms to make sure patients with changing conditions are monitored and prioritized. These are EMS providers registered as Nursing Assistants. Four new community based or mobile integrated health programs in Jefferson, Mason & Kitsap Counties.

- Development and implementation of Behavioral Health Patient Care Protocols and Training to ensure safe and timely care of patients in Behavioral Health Crisis.
- Despite challenges and restrictions, The Region has successfully developed and adhered to an operating budget that fits within DOH standards.
- Partnering with Central Region has enabled the consolidation of some administrative costs, and will look into this further when feasible.

Challenges and Priorities

Challenges and Priorities are as follows but not limited to;

- Funding. The Region is currently limited by the allowable administrative budget. The Regional Council would benefit by improving accounting software and taking on additional assistance of an accountant. Current operating budget is at the maximum of its allowable administrative categories, while the costs of goods & services continue to increase. The Region aims to think creatively to continue to support the functions of the Regional Council if current trends continue with a static budget that has seen only a decrease in funding since 2008.
- Change in Regional Council staff: catching up and prioritizing administrative functions to keep the organization compliant and efficient.
- Behavioral health and substance abuse population continues to challenge existing resources. With few places to transport these patients and increasingly long transport times having a great impact, the vast majority of patients are transported outside of the Region. Lack of adequate facilities and resources to address this population continues to be one of the largest challenges.
- In the aftermath of the COVID-19 pandemic, the Northwest Region continues to work with emergency preparedness partners to develop a DMCC network and plan for the Region. This is now a standing agenda item and discussed at every meeting with a workgroup meeting bimonthly. There is much work to be done in this area.
- In NW Region there is a lack of clinical ride sites. This creates great challenge within the Region in training and onboarding new EMTs and paramedics. Across the Region we've seen great collaboration and willingness to help others. The programs continue working to collaborate and develop a best practice to standardize field internship student participation.
- NW Region has a large percentage of EMS volunteers. This can be a challenge to properly train and maintain skills of EMS volunteers, and also impacts transport of patients in a timely manner.
- In NW Region there is a shortage of Paramedics. This is due to promotions within merging agencies, retirement, and not enough training programs available to them. The training programs are too limited to the number of providers it can hold thus making it challenging to fulfill openings within the Region.

GOAL 1 - MAINTAIN, ASSESS AND INCREASE EMERGENCY CARE RESOURCES

This goal addresses the equitable distribution and accessibility of services across the system of care. By working collaboratively with partners—including the Department of Health, Local Councils, EMS agencies, and hospitals—the Region aims to ensure resources are sufficient, accessible, and reflective of the diverse communities we serve. Promoting health and equity through training opportunities will be integrated into this effort, emphasizing multicultural health awareness alongside other critical training priorities. Data-driven assessments and stakeholder input will guide decisions and improvements to the system, addressing underserved areas and supporting regional preparedness.

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
Objective 1: By June 2027, the NWREMS Council will follow recommendations and methodology from the Washington State Department of Health to recommend minimum and maximum numbers and levels of trauma designated services. Include the identification of any unserved or underserved areas.	**1**	**Strategy 1.** By January 2027, the Regional Council will review trauma data including population demographics and solicit input to determine recommended min/max number and levels of trauma designated facilities in Northwest Region.
	2	**Strategy 2.** By March 2027, the Regional Council will share results of data collected for discussion and catalog any potential unserved or underserved areas.
	3	**Strategy 3.** By May 2027, the Regional Council will make recommendations to the Washington State Department of Health and EMS & Trauma Steering Committee regarding the numbers and levels of trauma designated services.
Objective 2: By March 2027, determine min/max numbers for verified prehospital services.	**1**	**Strategy 1.** By September 2026, the Regional Council will request each county council review the verified prehospital services min/max numbers.
	2	**Strategy 2.** By November 2026, The Regional Council will guide the county councils through the process of evaluating and/or making changes by providing DOH guidance and training as needed.
	3	**Strategy 3.** By January 2027, the Regional Council will review and consider any recommendation to change the min/max numbers.
	4	**Strategy 4.** Throughout the plan cycle, the Regional Council will review current verified prehospital services min/max numbers in the region plan for accuracy and help resolve any discrepancies.

GOAL 1: Maintain, Assess and Increase Emergency Care Resources		
	5	**Strategy 5.** Annually, Staff will ensure that county councils inform the Regional council when there is a change in a prehospital service (merger, closure, or addition) by conducting a survey after receiving Agency Resource Report from DOH.
Objective 3: Throughout the planning cycle, the Regional Council will review the Patient Care Procedures (PCPs) and participate in statewide standardization	**1**	**Strategy 1.** Throughout the planning cycle, the NWREMS Council will review currently categorized trauma designations and cardiac & stroke centers and update PCPs to accurately reflect current state.
	2	**Strategy 2.** Throughout the planning cycle, the NWREMS Council will consider and review additional PCPs to be added or amended.
	3	**Strategy 3.** Throughout the planning cycle, the NWREMS Council will submit revisions to Region PCPs to the Washington Department of Health Office of Community Health Systems and EMS & Trauma Steering Committee, as appropriate.
Objective 4. By May 2026 and throughout the plan, NWREMS will identify and communicate specific challenges as they relate to pre-hospital services.	**1**	**Strategy 1.** By January 2027, the NWREMS Council will identify & monitor issues that affect EMS services. Truth out and summarize challenges. Prioritize and suggest solutions. This will be reported to DOH as part of contract deliverables.
	2	**Strategy 2.** By May 2027, the NWREMS Council will prioritize and suggest solutions to identified challenges. This will be reported to DOH as part of contract deliverables.

GOAL 2 - SUPPORT EMERGENCY PREPAREDNESS, RESPONSE, AND RESILIENCE ACTIVITIES

The Northwest Region EMS and Trauma Care Council will continue to collaborate with emergency preparedness partners to facilitate the smooth functioning of the EMS and Trauma system in the event of an emergency. The Region aims to create sustainable and resilient systems. Work in the 2025-2027 planning period builds upon ongoing efforts and includes, disaster planning, training/exercises, DMCC planning, and response plans.

GOAL 2: Support Emergency Preparedness Activities		
Objective 1: By January 2027, identify activities, strategies, goals, to improve emergency care system preparedness, response and resilience, to public health emergencies, all-hazards incidents, planning and exercise activities to the extent possible with existing resources.	**1**	**Strategy 1:** Throughout the plan, the Council and workgroups will identify ways to improve coordination with local, state, regional public health, healthcare coalitions, local emergency managers. This includes identifying relevant partners, developing relationships, identifying activities where regional EMST council participation will improve emergency preparedness, response and resiliency of the emergency care system.
	2	**Strategy 2.** By January 2026, the Region will collaborate and facilitate with emergency preparedness partners to draft a DMCC plan for the Region.
	3	**Strategy 3.** By May 2026, the Region will socialize the DMCC plan draft to all relevant partners for feedback and input.
	4	**Strategy 4.** By September 2027, the Region will coordinate and facilitate with partners to finalize a DMCC plan for the Region.
	5	**Strategy 5.** By November 2027, the Region will incorporate the DMCC plan into the Regional Plan and patient care procedures.
Objective 2: By November 2026, monitor for disaster, MCI, and special pathogens related drills and exercises, advocate for EMS to be included in exercises and drills, communicate opportunities for EMS to participate.	**1**	**Strategy 1.** Throughout the plan, the Regional Council will invite emergency preparedness representatives to participate on county and region councils.
	2	**Strategy 2.** Throughout the plan, the Regional Council will encourage participation in disaster planning & training opportunities by sharing information on upcoming events (training classes, full scale drills, tabletop exercises).
Objective 3: By November 2026 Work with partners to make available a situational awareness report that can be used to help inform partners of EMS situational awareness during surge events.	**1**	**Strategy 1.** By November 2026, the Region will work with NWHRN to share Regional and local healthcare situational awareness provided by the Coalition. This information will be shared at a localized level with the Council.

GOAL 2: Support Emergency Preparedness Activities		
Objective 4: Throughout the plan, NWREMS Council will coordinate with and participate in emergency preparedness and response to all-hazards incidents, patient transport, and plan initiatives to the extent possible of existing resources.	**1**	**Strategy 1.** Throughout the plan cycle, the Regional Council will encourage participation in disaster planning & training opportunities by sharing information on upcoming events. (training classes, full scale drills, tabletop exercises).
	2	**Strategy 2.** Throughout the plan cycle, the Region staff will distribute pre-hospital Emergency Preparedness information on the Region website and via email distributions.

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

The Northwest Region utilizes data provided from DOH to identify injury prevalence and prioritize prevention needs. Injury Prevention grants awarded to the local County EMS & Trauma Care Councils will support projects aimed at addressing leading causes of injury, hospitalizations, and death. In the 2023-2025 planning period the top causes included overdoses, falls, suicide, and motor vehicle accidents. The opioid epidemic continues to impact the region significantly. Working with various partners the Region continues to support naloxone leave-behind programs, fall prevention programs, mobile integrated healthcare, and other efforts that address the top causes of injury and illness.

GOAL 3: PLAN, IMPLEMENT, MONITOR AND REPORT OUTCOMES OF PROGRAMS TO REDUCE THE INCIDENCE AND IMPACT OF INJURIES, VIOLENCE AND ILLNESS IN THE REGION		
Objective 1: By March 2026, promote best available or promising practices and programs.	**1**	**Strategy 1.** By January 2026, the Regional Council, with the help of Council representatives, will collect and aggregate all activities and programs provided by member agencies that impact the occurrence of and/or reduce the incidence of injuries, violence and illness within the Region.
	2	**Strategy 2.** Throughout the plan, the Regional Council will request injury and violence prevention (IVP) information and resources from the IVP TAC to post on the Region Website.

GOAL 3: PLAN, IMPLEMENT, MONITOR AND REPORT OUTCOMES OF PROGRAMS TO REDUCE THE INCIDENCE AND IMPACT OF INJURIES, VIOLENCE AND ILLNESS IN THE REGION		
	3	**Strategy 3.** By March 2026, The Regional Council Staff will request fatal and nonfatal hospitalization data from DOH to share at the QI committee meeting and will post on the Region Website.
Objective 2: Annually, seek to understand and document interventions and outcomes that are providing meaningful & positive impacts in the system	**1**	**Strategy 1.** By November 2026, NWREMS Council will provide outreach and invitation to community groups aimed at addressing leading causes of injury and hospitalization.
	2	**Strategy 2.** By March 2027, identify activities and programs that demonstrate a positive impact on patient outcomes.
	3	**Strategy 3.** By March 2027, activities and programs with measurable positive impacts shall be promoted within the Region through the implementation of ongoing educational activities.
	4	**Strategy 4.** By May 2027, create a report or presentation to be distributed amongst member agencies and DOH to share activities and programs that have proven most effective at addressing leading causes of injuries, violence and illness.

GOAL 4 - ASSESS WEAKNESSES AND STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS

The Northwest Region EMS & Trauma Care Council has an active Quality Improvement Committee that meets five times per year. This group collectively presents data on various topics including trauma, cardiac, stroke, behavioral health, substance use, and burns. Much of the data used by the QI committee and the Council are derived from the WEMSIS data collection system and the Trauma Registry, for this reason work within this goal aims to support this statewide effort. In the 2023-2025 planning period the Region accomplished much in this area. The Council collaborated to improve WEMSIS data quality and continues efforts to improve quality data input and obtain meaningful output.

GOAL 4: ASSESS WEAKNESSES AND STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS		
Objective 1: The NWREMS Council will coordinate with regional partners to	**1**	**Strategy 1.** By September 2025 and annually, the Region will plan, schedule and hold QI Committee meetings; addressing topics that are impactful and timely.

GOAL 4: ASSESS WEAKNESSES AND STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS		
continually improve QI Committee meetings and the data that supports quality improvement.	**2**	**Strategy 2.** By November 2025, the Region will request and analyze WEMSIS data quality and identify common errors or omissions most consistent throughout the region.
	3	**Strategy 3.** By February 2026 and throughout the plan cycle, the Region will maintain and promote attendance and participation by hospitals and EMS for well-rounded attendance and participation.
Objective 2: During the 25-27 plan, the Regional Council will support EMS agency participation and data quality in WEMSIS.	**1**	**Strategy 1.** Throughout the plan, the Region will review and share reports related to data quality and completeness in WEMSIS.
	2	**Strategy 2.** By May 2026, NWREMS Council will work to utilize WEMSIS data to support regional quality improvement and planning efforts.
Objective 3: The Quality Improvement Committee will consider strategies to improve emergency care systems performance in areas highlighted by data analysis and reports presented at EMS & Trauma Care Steering Committee meetings.	**1**	**Strategy 1.** By May 2027, the Quality Improvement Forum will seek out opportunities to further utilize data and reports shared at other settings and from other sources.
	2	**Strategy 2:** Throughout the plan cycle, the Chair of QI Forum and Chair of the Board will consider if any data and reports from Steering Committee could be further utilized at local and regional levels.
Objective 4. Enhance training and capacity building to improve data accuracy & quality improvement processes.	**1**	**Strategy 1.** By September 2025 and annually, the Council will organize a regional workshop focused on WEMSIS data input, report interpretation, and practical applications for quality improvement.
	2	**Strategy 2.** Throughout the 2025-2027 plan, the Council will encourage EMS agencies and hospitals to assign dedicated staff members as quality improvement liaisons, ensuring continuous learning and data management oversight.
	3	**Strategy 3.** By May 2027, the Council will help facilitate mentorship programs to connect experienced EMS data managers with agencies needing additional support, focusing on rural and under-resourced areas.

GOAL 5 - PROMOTE REGIONAL SYSTEM SUSTAINABILITY

The work within goal 5 is to monitor and complete the work required by the DOH contract. This captures administrative functions as required by DOH, State Auditor, and as outlined in the fiscal accounting polies and procedure manual. This includes attendance at Local and State DOH meetings, TAC's and disseminate information to the Regional Council partners.

The Region will continue to support and fund educational programs within the region and establish Program grant contracts addressing both Prehospital Training and Injury Prevention. Rural educational programs will also continue to be our focus as we explore hosting a leadership Course and EMS instructor development.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
Objective 1: By June 2027, support education for EMS providers. Prioritize initial education programs particularly in rural communities.	**1**	**Strategy 1.** Annually in September, each county council will conduct a county-wide training needs assessment to identify training needs of all EMS agencies within their county.
	2	**Strategy 2.** By September 2025, the Training and Education Committee will review the submitted requests and make a recommendation to the Region Council for approval.
	3	**Strategy 3.** By November 2025, the Regional Council will establish prehospital training grant contracts with each County Council.
		Strategy 4. By March 2027, the Region will review and reallocate grant funds when grant awarded planned training does not occur within the grant period.
		Strategy 5. By June 15, 2027, grant funds are distributed throughout the contract as the training occurs and complete reimbursement and course outcome documentation is submitted to the region council office.
		Strategy 6. Throughout the plan period, the Regional Council will continue to post training opportunities on the Region website along with sharing at Council meetings.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
Objective 2: By June 2027, support education and development of providers in the system.	**1**	**Strategy 1.** By June 2027, the Region will explore opportunities to host a leadership course for providers.
	2	**Strategy 3.** By May 2027, the Region will explore opportunities to host and support EMS instructor development.
Objective 3: By June 2027, promote opportunities to improve sustainable practices for rural EMS systems. Consider using DOH education materials that have been developed to support rural EMS sustainability.	**1**	**Strategy 1**. Throughout the plan cycle, the Region will work with the DOH/RAC to support sustainable practices as available.
	2	**Strategy 2.** As needed, staff will continue to communicate information and opportunities from the DOH Rural EMS Workgroup with the Membership and throughout the Region.
	3	**Strategy 3.** By September 2026, The Region will appoint a council member to attend Rural EMS meetings and report back to the Council.
Objective 4: Throughout the plan period Manage regional council membership to ensure all medical, and other partners and stakeholders, are represented.	**1**	**Strategy 1.** Throughout the plan period, the region council will work with stakeholders to identify and fill gaps in membership.
	2	**Strategy 2.** Throughout the plan period, the Regional Council will provide new council members orientation and information such as the region council handbook & bylaws.
	3	**Strategy 3.** Throughout the plan period, as needed, region staff will ensure that Council members are current with required OMPA training.
	4	**Strategy 4.** By September annually, the Regional Council will work with council members to ensure reappointment applications are submitted to the DOH prior to the September expiration.
Objective 5: Throughout the plan period, NWREMS Council and staff will manage work and deliverables required by the DOH contract.	**1**	**Strategy 1.** The Regional Council will submit deliverables and supplemental documents per DOH contract requirements.
	2	**Strategy 2.** Throughout the plan period, the Regional Council will maintain a website with pertinent Regional and county council information per DOH requirements and beyond.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY		
	3	**Strategy 3.** By March 2027, the Regional Council will write Objectives and Strategies for the subsequent Strategic Plan per DOH guidelines.
	4	**Strategy 4.** Throughout the plan period, the Region Staff, will coordinate and hold regularly scheduled meetings for the Council, subcommittees and workgroups.
	5	**Strategy 5.** Throughout the plan period, the Region will ensure that County Councils coordinate and hold regularly scheduled meetings. Region staff or Executive Board member will attend meetings for bidirectional communications.
	6	**Strategy 6.** Throughout the plan period, a Regional Council representative will participate in EMS & Trauma related meetings, committees, and workgroups and TACS including; County Council meetings, State EMS Steering Committee, Regional Advisory Committee (RAC), DOH Office of Community Health meetings, WAC revision, and Regional QI meeting, Regional IVP, and others as applicable.
	7	**Strategy 7.** On a monthly basis, all NWREMS Council financial transactions will be conducted in accordance with the council fiscal accounting policies and procedures.
	8	**Strategy 8.** By May each year, the NWREMS Council will create and approve an annual budget for the following fiscal year.
	9	**Strategy 9.** On an annual basis, the NWREMS Council will complete all necessary administrative tasks to keep the organization in good standing, including but not limited to the federal IRS filings, Secretary of State reports, Department of Revenue and State Auditor's Office.
	10	**Strategy 10.** Biennially, the Regional Council will cooperate with the State Auditor's Office to facilitate the audit process.

APPENDICES

APPENDIX 1:

Adult and Pediatric Trauma Designated Hospitals & Rehab Facilities

Trauma Designation			Facility	City
Adult	Pediatric	Rehab		
III			St. Michael Medical Center	Silverdale
III			Olympic Medical Center	Port Angeles
IV			Forks Community Hospital	Forks
IV			Jefferson Healthcare Hospital	Port Townsend
IV			Mason General Hospital	Shelton

APPENDIX 2

Approved Minimum/Maximum Numbers of Designated Trauma Care Services

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

* Pediatric

APPENDIX 3

Approved Minimum/Maximum Numbers of Designated Rehabilitation Trauma Care Services

Level	State Approved		Current Status (#)
	MIN	MAX	
I R	0	0	0
II R	0	0	0

Numbers are current as of XXXX XX, XXXX

REF: DOH 689-163

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

APPENDIX 4

Washington State Emergency Care Categorized Cardiac and Stroke System Hospitals

Washington State Emergency Cardiac and Stroke System Categorized Hospitals				
Categorization Level		Hospital	City	County
Cardiac	Stroke			
II	III	Olympic Medical Center	Port Angeles	Clallam
II	III	Forks Community Hospital	Forks	Clallam
II	III	Jefferson Healthcare Hospital	Port Townsend	Jefferson
I	II	St. Michael Medical Center	Silverdale	Kitsap
II	III	Mason General Hospital	Shelton	Mason

Information is current as of March 2025

REF: DOH 345-299 / March 2024

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

APPENDIX 5: EMS Resources, Prehospital Verified Services

Appendix 5A: EMS Agency Report/Data

NORTHWEST REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Clallam	AID.ES.60704710	Norpoint Medical	Port Angeles	AID	BLS	0	3	5	0	0
Clallam	AMBV.ES.00000055	Clallam 2 Fire Rescue and Clallam County Fire District No. 2	Port Angeles	AMBV	ALS	4	0	27	0	5
Clallam	AMBV.ES.00000056	Clallam County Fire District #3	Sequim	AMBV	ALS	6	4	55	0	29
Clallam	AMBV.ES.00000057	Clallam 4 Fire and Rescue	Joyce	AMBV	BLS	2	0	14	2	3
Clallam	AMBV.ES.00000058	Clallam County Fire District 5	Clallam Bay	AMBV	BLS	2	0	5	0	0
Clallam	AMBV.ES.00000060	Port Angeles Fire Department	Port Angeles	AMBV	ALS	2	5	18	1	17
Clallam	AMBV.ES.00000066	Forks Community Hospital	Forks	AMBV	ILS	3	1	12	6	0
Clallam	AMBV.ES.00000067	Olympic Ambulance Service Inc	Sequim	AMBV	ALS	10	0	46	1	11
Clallam	AMBV.ES.00000068	Neah Bay Ambulance Service	Neah Bay	AMBV	BLS	3	0	4	3	1
Jefferson	AMBV.ES.00000209	East Jefferson Fire and Rescue	Port Townsend	AMBV	ALS	11	13	64	3	18
Jefferson	AMBV.ES.00000212	Brinnon Fire Department	Brinnon	AMBV	BLS	2	3	11	1	1
Jefferson	AMBV.ES.00000213	Discovery Bay Fire and Rescue	Port Townsend	AMBV	BLS	2	4	6	1	0
Jefferson	AMBV.ES.60404294	Quilcene Fire Rescue	Quilcene	AMBV	BLS	2	0	15	0	1
Jefferson	AMBV.ES.61461679	Olympic Ambulance Service Inc	Sequim	AMBV	ALS	1	0	0	0	0
Jefferson	ESSO.ES.60487425	Jefferson Search and Rescue	Port Hadlock	ESSO		0	0	1	0	0
Kitsap	AMBV.ES.00000320	Central Kitsap Fire and Rescue	Silverdale	AMBV	ALS	8	0	82	0	28
Kitsap	AMBV.ES.00000321	Bainbridge Island Fire Department	Bainbridge Island	AMBV	ALS	5	0	47	0	7

Kitsap	AMBV.ES.00000324	South Kitsap Fire and Rescue	Port Orchard	AMBV	ALS	8	0	82	0	25
Kitsap	AMBV.ES.00000326	North Kitsap Fire and Rescue	Kingston	AMBV	ALS	6	0	37	0	12
Kitsap	AMBV.ES.00000330	Bremerton Fire Department	Bremerton	AMBV	ALS	7	0	49	1	17
Kitsap	AMBV.ES.00000332	Poulsbo Fire Department	Poulsbo	AMBV	ALS	6	23	44	2	19
Kitsap	AMBV.ES.00000342	Olympic Ambulance Service Inc	Sequim	AMBV	ALS	8	0	62	1	12
Kitsap	AMBV.ES.00000343	Bremerton Ambulance	Bremerton	AMBV	BLS	3	0	9	0	2
Mason	AIDV.ES.00000430	Mason County Fire District # 12	Matlock	AIDV	BLS	0	1	0	0	0
Mason	AIDV.ES.00000431	Mason County Fire District #13	Elma	AIDV	BLS	0	3	8	0	0
Mason	AIDV.ES.00000434	Mason County Fire District #17	Lilliwaup	AIDV	BLS	0	2	8	0	0
Mason	AMBV.ES.00000424	Mason County Fire District #4	Shelton	AMBV	BLS	2	2	20	0	1
Mason	AMBV.ES.00000425	Central Mason Fire and EMS	Shelton	AMBV	ALS	10	0	48	4	29
Mason	AMBV.ES.00000426	Mason County Fire District #6	Union	AMBV	BLS	2	7	9	1	0
Mason	AMBV.ES.00000435	Fire Dist #18 Mason County	Hoodsport	AMBV	BLS	3	3	17	2	2
Mason	AMBV.ES.60231480	West Mason Fire	Shelton	AMBV	BLS	2	0	14	0	0
Mason	AMBV.ES.60437165	North Mason Regional Fire Authority	Belfair	AMBV	ALS	6	0	24	0	11
Mason	AMBV.ES.60920474	Olympic Ambulance Service Inc	Sequim	AMBV	ALS	2	0	0	0	7
Mason	ESSO.ES.60336509	Mason County Sheriff's Office	Shelton	ESSO		0	0	0	0	2

Numbers are current as of January 2025

APPENDIX 6

Approved MIN and MAX Numbers for Trauma Verified EMS Services

Approved Minimum and Maximum of Verified Prehospital Trauma Services by Level and Type by County

COUNTY	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
CLALLAM	AIDV	BLS	1	2	0
		ILS	0	0	0
		ALS	1	2	0
	AMBV	BLS	5	6	3
		ILS	0	0	1
		ALS	3	4	4
JEFFERSON	AIDV	BLS	1	2	0
		ILS	0	1	0
		ALS	0	0	0
	AMBV	BLS	5	5	3
		ILS	1	2	0
		ALS	2	2	2
KITSAP	AIDV	BLS	2	4	0
		ILS	0	1	0
		ALS	0	0	0
	AMBV	BLS	5	6	1
		ILS	0	1	0
		ALS	5	7	7
MASON	AIDV	BLS	6	7	3
		ILS	0	0	0
		ALS	1	1	0
	AMBV	BLS	6	8	5
		ILS	0	0	0
		ALS	3	3	3

Numbers are current as of January 2025

APPENDIX 7

Trauma Response Area and EMS Services

Trauma Response Area by County			
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Type & Level of Services in TRA**
Clallam	#1	Port Angeles Fire Department	1 AMBV-ALS
Clallam	#2	Clallam County Fire District #2	1 AMBV-LS
Clallam	#3	Clallam County Fire District #3	2 AMBV-ALS
Clallam	#4	Clallam County Fire District #4	1 AMBV-BLS
Clallam	#5	Clallam County Fire District #5	1 AMBV-BLS
Clallam	#6	Forks Community Hospital	1 AMBV-ILS
Clallam	#7	Neah Bay Ambulance	1 AMBV-BLS
Clallam Clallam Clallam	#A #B-O #B	Clallam County Fire District #2	1 AIDV-BLS 1 AMBV-BLS 4 AIDV-BLS
Jefferson	#1	Jefferson County Fire District #1	1 AMBV-ALS
Jefferson	#2	Quilcene Fire & Rescue	1 AMBV-BLS
Jefferson	#3	Jefferson County Fire District #3	1 AMBV-ALS
Jefferson	#4	Jefferson County Fire District #4	1 AMBV-BLS 1 AMBV-ALS
Jefferson	#5	Discovery Bay Volunteer Fire and Rescue	1 AMBV-BLS 1 AMBV-ALS
Jefferson	#7		1 AMBV-BLS 1 AMBV-ALS
Jefferson	#8		1 AMBV-BLS 1 AMBV-ALS
Jefferson	#A		1 AIDV-BLS
Jefferson	#B		
Jefferson	#C		
Jefferson	#D		
Kitsap	#1	Central Kitsap Fire and Rescue	1 AMBV-ALS
Kitsap	#1A	Central Kitsap Fire and Rescue	1 AMBV-ALS
Kitsap	#2	Bainbridge Island	1 AMBV-BLS 1 AMBV-ALS
Kitsap	#3	Bremerton Fire	2 AMBV-BLS 1 AMBV-ALS
Kitsap	#3A		2 AMBV-BLS

			1 AMBV-ALS
Kitsap	#5	Navy Region NW	1 AMBV-BLS
Kitsap	#7	South Kitsap Fire and Rescue	1 AMBV-ALS
Kitsap	#10	North Kitsap Fire and Rescue	1 AMBV-ALS
Kitsap	#18	Poulsbo Fire Department	1 AMBV-ALS
Kitsap	#18A	Poulsbo Fire Department	1 AMBV-ALS
Kitsap	#A		
Kitsap	#B		
Kitsap	#C		
Kitsap	#D		
Kitsap	#E		
Mason	#1	Fire Dist #18 Mason County	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#2	North Mason RFA	1 AMBV-ALS
Mason	#3	Central Mason Fire & EMS	1 AMBV-BLS 1 AMBV-ALS AIDV-ILS
Mason	#4	Mason County Fire District #4	1 AMBV-BLS 1 AMBV-ALS
Mason	#5	Central Mason Fire & EMS	1 AMBV-ALS
Mason	#6	Mason County Fire District #6	1 AMBV-BLS 1 AMBV-ALS
Mason	#8	North Mason RFA	1 AMBV-BLS 1 AMBV-ALS
Mason	#9	West Mason Fire	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#11	Central Mason Fire & EMS	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#12	Mason County Fire District #12	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#13	Mason County Fire District #13	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#16	Central Mason Fire & EMS	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#17	Mason County Fire District #17	1 AIDV-ALS 1 AMBV-BLS 1 AMBV-ALS
Mason	#18	Fire Dist #18 Mason County	1 AMBV-BLS 1 AMBV-ALS
Mason	#15	Central Mason Fire & EMS	1 AIDV-BLS

			1 AMBV-ALS
Mason	#A		1 AIDV-BLS
Mason	#B		
Mason	#C		
Mason	#D		

APPENDIX 8: Education and Training Programs and Testing Sites

Appendix 8A: Approved Training Programs

NORTHWEST REGION TRAINING PROGRAMS APPROVED BY WASHINGTON STATE DOH				
Credential #	**Status**	**Expiration Date**	**Facility Name**	**Site County**
TRNG.ES.60119539-PRO	APPROVED	05/31/2027	Clallam County EMS	Clallam
TRNG.ES.61447730-PRO	APPROVED	05/31/2028	West Olympic Peninsula EMS Council	Clallam
TRNG.ES.60101345-PRO	APPROVED	05/31/2028	Jefferson County EMS and Trauma Care Council	Jefferson
TRNG.ES.60113452-PRO	APPROVED	05/31/2028	Kitsap County EMS and Trauma Care Council	Kitsap
TRNG.ES.60126227-PRO	APPROVED	05/31/2027	Mason County EMS and Trauma Care Council	Mason

Information is current as of January 2025

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

CONTACTS:

Northwest Region EMS & Trauma Care Council Chair: Dr. Joseph Hoffman

Regional Executive Director: Randi Riesenberg

To request additional or updated copies: admin@nwrems.org

Regulations: Revised Code of Washington (RCW) AND Washington Administrative Code (WAC)
Anatomy of a PCP

PATIENT CARE PROCEDURES:

1. Level of Medical Care Personnel to be Dispatched to an Emergency Scene
2. Guidelines for Rendezvous with Agencies that Offer Higher Level of Care
3. Air Medical Services - Activation and Utilization
4. On Scene Command
5. Prehospital Triage and Destination Procedure
5.1 Trauma Triage and Destination Procedure
5.2 Cardiac Triage and Destination Procedure
5.3 Stroke Triage and Destination Procedure
5.4 Behavioral Health Facilities Destination Procedure
5.5 Prehospital Triage and Destination Procedure - Other
6. EMS/Medical Control Communications
7. Hospital Diversion
8. Cross Border Transport
9. Inter-Facility Transport Procedure
10. Procedures To Handle Types and Volumes of Patients that Exceed Regional Resources
11. MCI
12. All Hazards
13. Other
Region Specific Patient Care Procedures

Contacts: Northwest Region Patient Care Procedures

Clallam County EMS Council

Medical Program Director	Dr. Paul Craven
Chairperson	Tyler Gage

Jefferson County EMS Council

Medical Program Director	Dr. David Carlbom
Chairperson	Tim Manly

Kitsap County EMS Council

Medical Program Director	Dr. Joseph Hoffman
Chairperson	Jeff Faucett

Mason County EMS Council

Medical Program Director	Dr. Joseph Hoffman
Chairperson	Michael Sexton

West Olympic Peninsula EMS Council

Medical Program Director	Dr. Paul Craven
Chairperson	Tim Wade

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

Anatomy of a PCP

RCW 18.73.030 – Defines a "Patient Care Procedure".

Other helpful definitions when building the anatomy of the PCP:

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

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

Effective Date: 2015

PURPOSE

To guide EMS providers to initiate rendezvous with a higher level of care while en route to a receiving hospital based on patient needs and resource availability.

SCOPE

Provide timely care to all trauma patients so major trauma patients are provided appropriate medical treatment within the "golden hour" of trauma treatment.

As outlined in the Regional Trauma System Plan, "Dispatch Time" is defined as "the time from when the call is received by dispatch to the time the agency is notified" WAC 246-976-010

As outlined in the Regional Trauma System Plan, "Response Time" is measured from "the time the call is received by the trauma verified service to the time of arrival on-scene".

For major trauma patients, the following time guidelines are to be used (measured from the time the call is received by the trauma verified service to the time of arrival on-scene):

First Response (80 percent of the time)

Urban Areas	8 minutes
Suburban Areas	15 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

Transport Response Time (80 percent of the time)

Urban Areas	10 minutes
Suburban Areas	20 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

GENERAL PROCEDURES

A verified licensed ambulance and/or aid service shall be dispatched to all emergency and trauma incidents in the Northwest Region. The highest-level trauma verified ambulance in the response area should be dispatched to transport all known or suspected major trauma patients who meet, or are suspected to meet, the Prehospital Trauma Triage Destination Procedures.

APPENDICES

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	5/14/2015	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

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

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

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

2.1 Transport Guidelines

Effective Date:

PURPOSE

Provide guidance for transport from the emergency medical scene to the appropriate receiving facility.

SCOPE

All EMS Agencies should follow their Medical Program Director's patient care protocols and/or guidelines for the care and transport of medical and non-major trauma patients. If it is unclear as to where a medical or non-major trauma patient should be transported, contact medical control at your nearest resource hospital for directions; otherwise follow off-line medical control of patients as outlined in your standing orders, patient care protocols, and/or guidelines provided by your Medical Program Director. For the care and transport of identified Major trauma patients EMS Agencies should use the most current State of Washington Prehospital Trauma Triage (Destination) Procedures according to the Department of Health.

GENERAL PROCEDURES

MPD's, in the development of their patient care protocols and/or guidelines for the care and transport of medical and non-major trauma patients, who do not meet State of Washington Prehospital trauma Triage (Destination) Procedures shall consider:

A. Patient's desire or choice of medical facility within the region as to where they want to be transported and/or treated. Or, In the case of an unconscious patient, the wishes of the patient's family or personal physician.
B. The type of treatment and the ability of a receiving hospital to treat such medical or non-major trauma (i.e., high risk OB patients, potential ICU/CCU patients, unstable co-morbid medical patients, etc.).
C. Level, severity, and type of injuries.
D. Ability of the receiving hospital to adequately treat the medical or non-major trauma patient.

In all cases, unless proper medical care and resources dictate otherwise, the choice of the patient is paramount in the development of standing orders, patient care protocols, and/or guidelines for EMS transport agencies.

Data Collection: Trauma verified ambulance and aid services shall collect and leave documentation in the form of Northwest Region approved MIR forms or approved electronic computer submission to the Hospital the patient was transported.

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

2.2 Response Times

Effective Date:

PURPOSE

SCOPE

All verified licensed ambulance and aid services shall respond to emergency medical and trauma incidents in a timely manner in accordance with the Northwest Region Plan and State WAC 246-976-390(10) WAC 246-976-390(11) -Verification of Trauma Care Service.

The Northwest Region EMS Council has identified the following urban, suburban, rural-suburban, rural and wilderness/marine/frontier areas response times in the Northwest Region Trauma Plan.

First Response (80 percent of the time)

Urban Areas	8 minutes
Suburban Areas	15 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

Transport Response Time (80 percent of the time)

Urban Areas	10 minutes
Suburban Areas	20 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

GENERAL PROCEDURES

In all major trauma cases, the Golden Hour shall be a dispatch/response/transport goal whenever possible.

A trauma verified service should proceed in an emergency mode to all suspected major trauma incidents until which time they have been advised of injury status to the patients involved.

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

3. Air Medical Services - Activation and Utilization

Effective Date: 1/12/23

PURPOSE

To provide guidelines for those initiating the request for Air Ambulance Services.

SCOPE

Activation/Standby

Activation of Medevac service will generally occur on-scene after EMS personnel determine that the patient's condition warrants the use of air medical transport modality to prevent loss of life, limb, or vital tissue, and time is a critical factor.

Standby of a Medevac will generally occur when EMS personn6el recognize (On scene or en route to the scene.) the patient's potential condition warrants the use of air medical transport modality to prevent loss of life, limb, or vital tissue, and time is a critical factor. Placing a medevac on standby does not control the Medevac from self-deploying if they (The Medevac) so choose.

GENERAL PROCEDURES

EMS personnel shall call the communication center via Fire or Law Radio to request Medevac and any needed support from Law Enforcement or Fire Departments, for example. A cellular or landline phone may be used if unable to utilize radio communications. Incident Commanders may also utilize direct communications with medevac services during MCIs, area command, or when deemed appropriate. In addition to EMS personnel, 911 Dispatchers, Law Enforcement, or National Park Service, for example, may also activate a Medevac or place it on standby if, in their opinion, the above critical conditions and time criteria exist. Standing down a Medevac should only be directed by the highest medical personnel responsible for patient care on scene.

Medical Control should always be consulted when determining the need for a Medevac when a patient's condition falls outside expected norms, receiving hospital capabilities, or general consultation when uncertain.

APPENDICES

Prehospital Trauma Triage Destination Procedure

Prehospital Cardiac Triage Destination Procedure

Prehospital Stroke Triage Destination Procedure

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved	1/12/2023	☒ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

4. On Scene Command

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

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

5. Prehospital Triage and Destination Procedure

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

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

5.1 Prehospital Trauma Triage & Destination Procedure

Effective Date: TBD

PURPOSE: Provide guidance for transport destination decisions for patients from the emergency medical scene to the appropriate receiving facility.

SCOPE: All verified licensed ambulance/transport and aid services shall comply with the Northwest Region Trauma Triage Tool, a modification of the Washington State Trauma Triage and Destination Guidelines for Prehospital Providers. This represents current best practice for the triage and transport of trauma patients to the most appropriate designated trauma center.

When a destination facility is placed on divert status, field personnel shall transport to the next closest – equal or higher designated trauma facility.

GENERAL PROCEDURES: The first trauma care providing agency to determine that the patient needs definitive medical care or meets the Northwest Region Trauma Triage Tool criteria, shall ensure immediate contact with a Level I or Level II trauma designated facility or the agency's on-line medical control.

The triage procedure is described in Figure 1. consolidates triage criteria into two main categories based on risk of serious injury. High-Risk Criteria (red box) includes injury patterns, mental status, and vital signs. Moderate-risk Criteria (yellow box) includes Mechanism of Injury and EMS Judgement. Each risk category is aligned with recommendations for a destination trauma service. If unable to maintain a patent airway, consider rendezvous with an Advanced Life Support (ALS) unit or transport to the nearest facility capable of definitive airway management. Pediatric patients should be preferentially transported to a designated pediatric trauma service.

Hospitals activate their trauma team based on internal policies and procedures. The receiving facility must be provided with the following information:

1. Identification of the EMS agency;
2. Patient's age, if known (or approximate age);
3. Patient's chief complaint(s) or problem;
4. Identification of the biomechanics and anatomy of the injury;
5. Basic vital signs (palpable pulse, where palpable, and rate of respiration;
6. Level of consciousness (Glasgow Coma Score or other means);
7. Other factors that require consultation with the base station;
8. Number of patients (if known); and
9. Estimated time of transport of the patient(s) to the nearest and highest level of trauma designated facility.
10. Estimated time of transport of the patient(s) from the scene to the nearest Level I or II facility

An air ambulance transport should be considered for transport by agencies in the Northwest Region when transport by ground will be greater than 30 minutes, unless weather conditions do not allow for such use.

Figure 1: Trauma Triage Criteria and Categories

Red Criteria: High Risk for Serious Injury

Injury Patterns	Mental Status & Vital Signs
• Penetrating injuries to head, neck, torso, and proximal extremities • Skull deformity, suspected skull fracture • Suspected spinal injury with new motor or sensory loss • Chest wall instability, deformity, or suspected flail chest • Suspected pelvic fracture • Suspected fracture of two or more proximal long bones • Crushed, degloved, mangled, or pulseless extremity • Amputation proximal to wrist or ankle • Active bleeding requiring a tourniquet or wound packing with continuous pressure • Burns - Burn Center appropriate	**All Patients** • Unable to follow commands (motor GCS < 6) • RR < 10 or > 29 breaths/min • Respiratory distress or need for respiratory support • Room-air pulse oximetry < 90% **Age 0–9 years** • SBP < 70mm Hg + (2 x age in years) **Age 10–64 years** • SBP < 90 mmHg or • HR > SBP **Age ≥ 65 years** • SBP < 110 mmHg or • HR > SBP

Patients meeting any RED criteria should be transported to the 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.

Yellow Criteria: Moderate Risk for Serious Injury

Mechanism of Injury	EMS Judgement
• High-risk auto crash - Partial or complete ejection - Significant intrusion (including roof) ▪ >12 inches occupant site OR ▪ >18 inches any site OR ▪ Need for extrication for entrapped patient - Death in passenger compartment - Child (age 0-9 years) unrestrained or in unsecured child safety seat - Vehicle telemetry data consistent with severe injury • Rider separated from transport vehicle with significant impact (e.g., Motorcycle, ATV, horse, etc.) • Pedestrian/bicycle rider thrown, run over, or with significant impact • Fall from height > 10 feet (all ages)	**Consider risk factors, including:** • Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact • Anticoagulant use • Suspicion of child abuse • Special, high-resource healthcare needs • Pregnancy > 20 weeks • Children should be triaged preferentially to pediatric capable centers **If concerned, take to a trauma service**

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.

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Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
Regional Council	Updated	9/12/24	☒ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.2 Cardiac Triage and Destination Procedure

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

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

5.3 Stroke Triage and Destination Procedure

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

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

5.4 Behavioral Health Facilities Destination Procedure

Effective Date: 6/17/2021

PURPOSE

To establish policy and procedure for licensed EMS ambulance services within the Northwest EMS Region to allow for transport patients from the field to mental health or chemical dependency services as informed by the alternative facility guidelines adopted under RCW 70.168.170 and if approved by their county Medical Program Director (MPD).

SCOPE

SHB 1721 enacted into RCW 70.168.100 allows Emergency Medical Services (EMS) licensed ambulance services to transport patients from the field to mental health or chemical dependency services.

GENERAL PROCEDURES

A. Participation
   a. Prehospital EMS service participation is voluntary and as approved by the county MPD.
   b. Receiving mental health and/or chemical dependency facility participation is voluntary.

B. Participating services and facilities will adhere to the WA State Department of Health Guideline for Implementation of RCW 70.168.170.

C. Facilities that participate will work with the county MPD and EMS services to establish criteria that all participating facilities and EMS services will follow for accepting patients.

D. Prior to implementing and during ongoing operation of transport to alternate receiving facilities the following must be in place:
   a. County operating procedure;
   b. MPD patient care protocol
   c. DOH approved MPD specialized training for EMS providers participating in transport programs participating in transport programs operating under this procedure.

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Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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5.5. Prehospital Triage And Destination Procedure – Critically Ill & Injury Child Triage & Destination Procedure

Effective Date: 2015

PURPOSE

(Why is it needed, what is it trying to accomplish)

SCOPE

(Describes situations for which the PCP was created and the intended audience)

GENERAL PROCEDURES

(Adopted by the Governor's EMS & Trauma Care Steering Committee on July 19, 1995) Consideration should be given to early transfer of a child to the regional pediatric trauma center when required surgical or medical subspecialty care of resources are unavailable. These include, but are not limited to the following:

A. Hemodynamically stable children with documented visceral injury being considered for "observational" management. Although the efficacy of this approach in selected cases has been well documented, two significant caveats always apply:
   a. Hemodynamic instability mandates immediate operative intervention, and
   b. Non-operative care is safe only in an environment that provides both close clinical observation by a surgeon experienced in the management of childhood trauma and immediately available operative care.

B. Children with abnormal mental status. In all but the infant, outcome from closed head injury has been shown to be significantly better for the child than for the adult. Although the quality and timeliness of initial resuscitation are the most important determinants of outcome from brain injury, continued comprehensive management in specialized units with multi-disciplinary pediatric critical care teams may provide a more rapid and complete recovery.

C. Infants and small children. Severely injured infants and small children are the most vulnerable and, frequently, the least stable trauma victims, because they require the special resources and environment of a regional pediatric trauma center, transfer should occur as soon as safely feasible.

D. Children with injuries requiring complex or extensive reconstruction. These services are traditionally most available in hospitals capable of functioning as a regional pediatric trauma center. It is especially important that children with impairments requiring long-term follow-up and supportive care have this provided or at last coordinated by the regional pediatric trauma center. Longitudinal follow-up of the injury-related disability is an essential requirement of the regional pediatric trauma center's trauma registry.

E. Children with polysystem trauma requiring organ system support. This is especially important for those patients requiring ventilatory, cardiovascular, renal, or nutritional support. Because these problems usually occur synchronously and require precise interdisciplinary coordination, they are best managed in comprehensive facilities such as regional pediatric trauma centers.

After airway management and primary resuscitation, consider the following points for transfer guidelines. A collaborative discussion is required between the transferring and receiving attending physicians.

A. Altered level of consciousness, mental status or declining trauma score (after primary resuscitation and airway management);
B. Head injury requiring CT scan and/or neurosurgical consultation, for example: with lateralizing signs, seizures, loss of consciousness;
C. Major thoracic injury, e.g.: hemothorax, pulmonary contusion, possible great vessel injury, cardiac tamponade, flail chest;
D. Inability to evaluate abdomen due to mental status or lack of resources such as CT or peritoneal lavage;
E. Suspicion of foreign body in lower airway or main stem bronchi;
F. Unstable spinal fracture, suspected or actual spinal cord injury;
G. Primary accidental hypothermia with core temperature of 32 degrees C or less; or hypothermia with multi-system injury and core temperature of 34 degrees C or less;
H. High risk fractures such as: pelvic fracture, long bone injuries with neurovascular involvement (compromise);
I. Significant penetrating injuries to head, neck, thorax, abdomen or pelvis;
J. Need for mechanical ventilation;
K. Evidence of onset of organ failure, for example: acute respiratory distress syndrome, cardiac, renal or hepatic failure;
L. Cardiac dysrhythmias, cardiac pacing, superventricular tachycardia, or continuous infusion of one or more inotropic or cardiovascular agents, need for invasive monitoring;
M. Near drowning or asphyxiation with deteriorating mental status or progressive respiratory distress;
N. Burns of greater than 15% of the body (20% of age 10 or greater), 2nd degree or greater involving:
a. The face, mouth and throat;
b. Singed nasal hair;
c. Brassy or sooty cough;
d. Deep or excessive burns of the hands, feet, joints and/or perineum;
e. Electrical injury (including lightening); and/or
f. Chemical burns with threat of functional or cosmetic compromise. Should be transferred to a Regional Burn Center.

Referral to these centers must be protocol-driven and continuously monitored by the quality improvement process. Access to such care must be expeditious and must reflect ONLY medical need.

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

The Northwest Region EMS and Trauma Car Council does not have this patient care procedure.

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

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

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

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

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Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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			☐ Major ☐ Minor

9. Inter-Facility Transport Procedure

Effective Date:

PURPOSE

The appropriate level of emergency, BLS, ILS, ALS personnel, aid or ambulance services will be dispatched to the emergency incident scene to provide timely patient care.

SCOPE

BLS or ILS units may rendezvous with a higher level of care.

GENERAL PROCEDURES

This is part of the Trauma Center Designation process and is addressed in the designation application process. The Northwest Region will use the procedures outlined by each facility in their designation application.

Interfacility transfer of A major Trauma Patient

When a major trauma patient must be transferred from a lower level Trauma Center to a higher level center (Level IV to Level I, for example), the transferring physician must contact the receiving physician who must accept the transfer of the patient prior to the patient leaving the sending facility.

The transferring physician and facility will ensure the appropriate level of care during transport of the major trauma patient to the receiving Trauma Center.

The receiving facility must accept or be available to accept the major trauma patient prior to the patient leaving the sending facility.

The receiving facility will be given the following information on the patient by fax, phone, or other appropriate means:

a. Brief History
b. Pertinent physical
c. Summary of any treatment done prior to the transfer
d. Response to therapy and current condition

All appropriate documentation must be available at the receiving facility upon arrival of the patient to the receiving facility (it may be sent with the patient, faxed to the hospital, or relayed by other appropriate means).

The transferring physician's orders shall be followed during transport. Should the patient's condition change during transport the pre-determined on-line or off-line medical control for the transporting agency shall be utilized.

Further orders may be given by the receiving physician.

MPD approved protocols should be followed during transport, unless direct medical orders by the sending or receiving physician are given to the contrary.

All ground interfacility transports must be conducted by a trauma-verified service for trauma system patients.

APPENDICES

WAC 246-976-960, RCW 70.170.060

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10. Procedures To Handle Types and Volumes of Patients That Exceed Regional Resources

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

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11. MCI

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

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

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

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

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

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