West Region Emergency Medical Services
& Trauma Care System Strategic Plan

July 1, 2025 – June 30, 2027

West Region Emergency Medical Services & Trauma Care Council

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Introduction to Plan

Mission Statement - To assist and guide local EMS and trauma care providers in the coordination and improvement of emergency medical services and injury/illness prevention and public education in the West Region.

Vision Statement - We envision a tenable regional EMS and Trauma Care System with a plan that:

- Keeps patient care and interest the number one priority.
- Recognizes the value of prevention and public education to decrease trauma/cardiac/stroke-related morbidity and mortality.
- Preserves local integrity and authority in coordination with inter/intra-regional agreements.

Through this strategic plan, the West Region EMS and Trauma Care Council (WREMS-TC) will work as a non-partisan facilitator, coordinator, and resource for regional EMS issues to achieve the Council mission:

West Region Council Structure

The WREMS-TC accomplishes comprehensive planning through a committee structure with final approval by the Council. The WREMS-TC meets quarterly, with 49 Council positions representing local healthcare providers, local government agencies, and consumers from areas as metropolitan as Tacoma and as remote as the rainforest on the Olympic Peninsula.

The Council benefits from a diverse representation of dedicated decision-makers, many of whom are also regular contributors at state Technical Advisory Committee (TAC) meetings where they share expertise.

The Council includes an Executive Board comprised of eight members, plus an Executive Director. The Executive Director is the only paid employee of the West Region and is not a voting member. Three of the Executive Board members are officers, including Chair, Vice-Chair and Secretary/Treasurer. The Executive Board and its officers are elected by a majority of the Council for a two-year term. No more than two of the officers may be from the same county. The Executive Board meets monthly and has fiduciary oversight of the Council's regional plan, budget, finances, contracts, as well as administrative policies and procedures. The Executive Board is responsible for developing recommendations to the full Council with any action being subject to review and ratification by the full Council.

West Region Subcommittees

There are several committees which undertake the core work of the Council including:

- Injury and Violence Prevention
- Training, Education and Development
- Cardiac QIF
- Stroke QIF

- Trauma QIF
- MPD, Planning and Standards Committees

These subcommittees receive administrative support from the Executive Director (meeting planning, meeting announcements, confirming speakers and presenters, transcribing meeting minutes, tracking meeting attendance, etc.). At least one Council member must be a member of each committee and shall, at the minimum, give written quarterly reports on committee activities to the full Council.

The Injury and Violence Prevention (IVP) Committee is dedicated to supporting the prevention of the leading causes of injury and death in the West Region which are unintentional poisoning, unintentional falls, unintentional motor vehicle crashes, Suicide with firearms, Homicide with firearms, Suicide by suffocation, unintentional suffocation, Suicide by poisoning, and Adverse Medical conditions. IVP meetings are held five times per year, and they engage participants from all West Region counties. Meetings provide opportunities for building partnerships, sharing best practices, and learning about resources and prevention programs in the region and at the state level. This committee also has the responsibility to announce and review all applications for the annual IVP Grant program. It is also a chance for grantees to share their work and outcomes with the region and prevention partners.

The Training, Education and Development (TED) Committee makes recommendations to the Executive Board and Council on the use of available EMS training funds in the West Region. The TED Committee is also engaged in year-long planning of the regional council's annual EMS conference, which provides high quality EMS education and training opportunities not only to the West Region but also open to all Washington State providers. When a regional conference cannot be undertaken due to exceptional circumstances, such as a pandemic, the TED Committee plans regional prehospital education alternatives. This committee typically meets monthly.

The MPD, Joint Standards and Planning Committee has the responsibility of developing and updating regional patient care procedures, overseeing updates to the strategic plan on issues related to prehospital patient care delivery, and reviewing recommended changes to the minimum/maximum numbers and levels of trauma designated services and verified prehospital services. They also review input from the Trauma QIF, Cardiac QIF, and Stroke QIF ensuring all pertinent information is provided throughout the West Region. Likewise, they are responsible for continuing overview and updating their local Protocols. All four MPDs (N. Pacific County operates under the Grays Harbor MPD) participate in this committee as well as WREMS-TC members. The committee convenes directly following each WREMS-TC meeting, four times annually.

The Cardiac Quality Improvement Forum uses data and presentations of case histories to evaluate and improve cardiac patient care. They analyze patterns and trends and compare similarities and differences between West Region and other regional, state and national models. Additionally, they compare similar outcomes through case reviews and when available, the outcomes are provided to the Region to help inform planning and determine the need to fill care gaps. Finally, when case reviews are provided and

Lessons Learned, the key teaching points are then disseminated to the Council and other QIF committees as appropriate.

The Stroke Quality Improvement Forum also uses data and presentations of case histories to evaluate and improve stroke patient care. They analyze patterns and trends and compare similarities and differences between West Region and other regional, state and national models. Additionally, they compare similar outcomes through case reviews and when available, the outcomes are provided to the Region to help inform planning and determine the need to fill care gaps. Finally, when case reviews are provided and Lessons Learned, the key teaching points are then disseminated to the Council and other QIF committees as appropriate.

The Trauma Quality Improvement Forum continuously strives to optimize Trauma EMS patients care and outcomes through the continuum of care. They also use data and presentations of case histories to evaluate and improve trauma patient care. They analyze patterns and trends and compare similarities and differences between West Region and other regional, state and national models. Additionally, they compare similar outcomes through case reviews and when available, a benchmarking is used to which comparisons can be made. The analysis, when pertinent, is then provided to the DOH for consideration. Finally, when case reviews are provided and Lessons Learned, the key teaching points are then disseminated to the Council and other QIF committees as appropriate.

The WREMS-TC representatives collaboratively assist with the independent regional quality improvement (QI) work of the region's Quality Improvement Forums (QIF). The Council administratively supports the Trauma, Cardiac and Stroke QIF responsibilities to improve patient outcomes, identify areas for improvement, educate providers and build coordination between services. The Trauma QIF meets five times a year and the Cardiac and Stroke QIF's meets quarterly.

Profile of the region.

The 2025-2027 WREMS-TC Strategic Plan applies to the five-county area of Grays Harbor, Lewis, North Pacific, Pierce, and Thurston Counties. The purpose is two-fold:

1. Sustain a robust continuum of care that effectively reduces injuries and fatalities.
2. Maintain a continuum of care which treats and rehabilitates victims of trauma and medical emergencies.

The WREMS-TC is empowered by legislative authority (RCW 70.168.100-70.168.130) and Washington Administrative Code (WAC 246.976.960) to plan, develop, and administer the EMS and trauma care system in the five counties that make up the Region. It is composed of appointed volunteer representatives and funded primarily by the Washington State Department of Health (WA DOH).

WREMS-TC is one of eight EMS and trauma care regions in Washington State. Each region is responsible for developing an in-depth strategic plan every two years with input from their respective local councils, county medical program directors (MPDs), and stakeholders. These plans are the cornerstone in the maintenance, improvement, and sustainability of Washington state's EMS and trauma care system. Based on plan guidance and a basic format template from the Washington State Department of Health (WA DOH), the regional plans focus on the work each council will accomplish. These regional plans align with the Washington State goals in the EMS and Trauma System Strategic Plans and are specific to the unique needs of each region. Goals are defined, objectives stated, strategies described, and tools outlined for measuring progress—these are the heart of each plan.

To provide the 1,433,925 citizens (Appendix 12), (up 31,272 from previous plan or 2.22%), and additional visitors with appropriate and timely EMS, medical and trauma care, the WREMS-TC focuses its efforts on the following issues:

- Prevention education and medical training of EMS, hospital and trauma care personnel
- Trauma level designations of hospitals
- Trauma verification and licensing of prehospital agencies
- Cardiac and stroke level-categorizations of hospitals
- All-hazards preparedness
- Improved data collection
- Regional quality evaluation and improvement
- Regional resources to support high quality trauma rehabilitation.

West Region Counties

The five-county West Region is not only a major population, manufacturing, transportation, and shipping corridor, it is a tourist center of the state. The large urban and rural geography (over 7,765 square miles) means the population density centers are spread out and also increases the challenges for emergency medical service (EMS) response and treatment. The region serves an estimated 1,433,925 citizens. All Medical facilities in the West Region, since the COVID pandemic, have reported excessive delays in patient care, long wall times, excessive wait times for Ambulances and shortages of trained personnel.

Grays Harbor County

Gateway to the Pacific Ocean and Olympic Peninsula, Grays Harbor County has a landscape which varies from coastline to rainforest. Total square mileage is 2,224; 1,902 is land and 322 is water. As of April 1, 2024, the Appendix 12 shows the following information for the population of Grays Harbor County:

	CENSUS 2024	CENSUS 2022	% change	# change
Grays Harbor	**77,400**	**76,400**	**1.3%**	**1,000**
Unincorporated	29,420	29,125	**1.0%**	**295**
percentage of total	38%	38%		
Incorporated	47,980	47,275	**1.5%**	**705**
percentage of total	62%	62%		

County Resources						
# AMB	**# AID**	**# FIXED**	**# Rotary**	**#BLS**	**# ILS**	**#ALS**
44	**24**	**0**	**0**	**178**	**1**	**78**

Due to its coastal location, Grays Harbor County has tourism throughout the year, and specialized EMS responses (such as ocean rescues) are common. Two Indian tribes have territories bordering Grays Harbor County: The Confederated Tribes of the Chehalis Reservation, and the Quinault Indian Nation. A vast portion north of the county is the Quinault Indian Nation's territory and the Olympic National Forest.

Lewis County

Lewis County is split by the 1-5 corridor, with a total square mileage of 2,436; of that 2,403 is land and 33 is water. The geography varies from the mountain views of Packwood to the east, to the agricultural

landscapes of the west. Fire and EMS respond to emergencies frequently along the corridor. As of April 1, 2024, current data shows the following information for the population of Lewis County:

	CENSUS	CENSUS	% change	# change
	2024	2022		
LEWIS	**84,950**	**83,400**	**1.01%**	**1,550**
Unincorporated	50,550	50,185	**1.48%**	**365**
percentage of total	60%	60%		
Incorporated	34,400	33,215	**1.42%**	**1,185**
percentage of total	40%	40%		

County Resources						
Ground Vehicles		**Aircraft**		**Personnel**		
# AMB	**# AID**	**# FIXED**	**# Rotary**	**#BLS**	**# ILS**	**#ALS**
46	**21**	**0**	**0**	**164**	**16**	**75**

Pacific County, North

The As of April 1, 2024, current data (appendix #12) shows the following information for HALF the population of Pacific County[1]:

	CENSUS	CENSUS	% change	# change
	2024	2022		
Pacific (represents 50% for WREMS)	**11,975**	**11,800**	**1.48%**	**175**
Unincorporated	8,093	7,980	**1.42%**	**113**
percentage of total	68%	68%		

[1] Pacific County is divided into two separate regions for the purpose of EMS transport to healthcare locations: the northern half of Pacific is in the West Region and southern half of the county is in the Southwest Region; a portion of the natural line of division is the Grays River along State Route 4. The two North Pacific County EMS agencies work under the guidance of the Grays Harbor/North Pacific EMS Medical Program Director (MPD).

Incorporated	3,883	3,820	**1.65%**	**63**
percentage of total	32%	32%		

Population numbers listed in this chart are for just the northern portion of the county, which are approximately half of the total. The population density is 22 people per square mile or an estimate of 11,9754.

North Pacific County Resources						
# AMB	**# AID**	**# FIXED**	**# Rotary**	**#BLS**	**# ILS**	**#ALS**
4	4	-	-	13	-	6

Pierce County

Pierce County's total area is 1806 square miles, of which 1669 is land and 137 is water. It is notable for being home to Mount Rainier, the tallest mountain in the Cascade Range (14,410 feet) and a volcano, too. The most recent recorded eruption was between 1820 and 1854. There is no imminent risk of eruption, but geologists expect that the volcano will erupt again. If this should happen, parts of Pierce County and the Puyallup Valley would be at risk from lahars, lava, or pyroclastic flows.[2] The Mount Rainier Volcano Lahar Warning System was established in 1998 to assist in the evacuation of the Puyallup River valley in case of eruption, and sirens in that valley continue to be tested monthly. There are three rivers that run through the county, and six islands in the Pierce County portion of Puget Sound. As of April 1, 2024, current data (appendix #12) shows the following information for the population of Pierce County:

	CENSUS	**CENSUS**	**% change**	**# change**
	2024	**2022**		
Pierce	**952,600**	**930,553**	**2.37%**	**22,047**

[2] A **lahar** is a violent type of mudflow or debris flow composed of a slurry of pyroclastic material, rocky debris and water. The material flows down from a volcano, typically along a river valley. A **pyroclastic flow** is a dense, fast-moving flow of solidified lava pieces, volcanic ash, and hot gases; extremely hot, burning anything in its path.

Unincorporated	447,645	440,800	**1.55%**	**6,845**
percentage of total	47%	47%		
Incorporated	504,955	496,600	**1.65%**	**8,355**
percentage of total	53%	53%		

Pierce County Resources						
Ground Vehicles		**Aircraft**		**Personnel**		
# AMB	**# AID**	**# FIXED**	**# Rotary**	**#BLS**	**# ILS**	**#ALS**
134	**165**	**0**	**0**	**1,521**	**1**	**480**

Tacoma-Pierce County Health Department conducted a Community Health Assessment to determine some of the barriers to healthy lives. The following key factors are among the findings:

- Access to healthcare—especially mental health and substance abuse services,
- People are dying before their time—premature death from injuries,
- Access to healthy food,
- Safe, reliable and affordable housing, and
- ways to get around (transportation).

Income, education, housing and transportation can create opportunities for, or barriers to, optimal health. With a focus on equality, health should not be dependent upon zip code, income, race, or any other socioeconomic factor. Safe and affordable housing and reliable ways to get around should be available for everyone in Pierce County.

Seven particular health needs were selected as the focus of the next three-year implementation period by the healthcare systems in Pierce County:

- Access to Care,
- Obesity,
- Behavioral Mental Health and substance use disorders,
- Maternal and Child Health,
- Injury & Violence Prevention,
- Cancer, and
- Food insecurity

The top issues facing children and youth include exposure to behavioral health, youth obesity, crime and violence, poverty and lack of positive relationships.

5. Thurston County

As of April 1, 2024, current data (appendix # 12) shows the following information for the population of Thurston County:

	CENSUS	CENSUS	% change	# change
	2024	2022		
Thurston	**307,000**	**300,500**	**2.16%**	**6,500**
Unincorporated	145,735	143,760	**1.38%**	**1,975**
percentage of total	47%	48%		
Incorporated	161,265	156,740	**2.89%**	**4,525**
percentage of total	53%	52%		

Thurston County Resources							
	Ground Vehicles		Aircraft		Personnel		
Care Level	# AMB	# AID	# FIXED	# Rotary	#BLS	# ILS	#ALS
Totals:	**72**	**99**	**0**	**1**	**617**	**1**	**81**

Thurston County is the eighth most populated county among Washington State's 39 counties. EMS in Thurston County is overseen by Thurston County Medic One. The pre-hospital ALS service is funded by a tax on the citizens of Thurston County and carried out through a partnership between Thurston County Medic One and 3 of the local fire departments: Olympia Fire Department, Lacey Fire District 3, and Tumwater Fire Department. Each of the three ALS departments staff dual medic units and carry out ALS 911 transports in their response area, as well as in the areas immediately surrounding them. BLS pre-hospital transports are carried out by a combination of the local fire departments and by local private ambulance providers.

These particular health needs were selected as the focus of the next three-year implementation period by the healthcare systems in Thurston County:

Access to Care,
Behavioral Health,
Immunizations,
Maternal and Child Health

Emergency Care System Resources

Trauma Verified Prehospital Resources

Identification of need and distribution of verified aid and ambulance services is facilitated by local county EMS councils in Grays Harbor/North Pacific, Lewis, Pierce and Thurston Counties. Local councils also identify where those services operate within their county's unique Trauma Response Areas.

For an extensive GIS map[3] of West Region Trauma Response Areas available please go to: **https://fortress.wa.gov/doh/ems/index.html**

There are currently 77 prehospital trauma-verified aid and ambulance agencies within the West Region (up by 10), providing 300 AMB units down by 19) and 308 AID units (up by 13). We also have a total of 3,011 EMS providers which is up by 93 (3% increase). Of these, 2,731 are paid and 626 are volunteers.

Trauma-Designated Facilities

Fourteen designated trauma care services currently operate within the West Region. The following DOH chart shows the facility name, trauma designation level and city. (see also Appendix 1)

DESIGNATED TRAUMA FACILITIES IN THE REGION		
Facility	**Location (City/County)**	**Designation Level**
Madigan Army Medical Center	Tacoma	II
Mary Bridge Children's Hospital	Tacoma	IIP
St. Joseph Medical Center	Tacoma	II
Tacoma General Hospital	Tacoma	II
Harbor Regional Health	Aberdeen	III
MultiCare Good Samaritan	Puyallup	III & IR
Providence St. Peter	Olympia	III
MultiCare Allenmore	Tacoma	IV
Providence Centralia	Centralia	IV

[3] A *GIS map* is a computer-based system of software and hardware designed to link computer generated maps with information about the mapped entities, in this case different trauma and care services.

St. Anthony	Gig Harbor	IV
St. Clare	Lakewood	IV
Summit Pacific Med Ctr	Elma	IV
Arbor Health	Morton	V
Willapa Harbor Hospital	South Bend	V

Emergency Cardiac & Stroke Resources

Washington State's Emergency Cardiac and Stroke System saves lives and reduces disability from heart attack, cardiac arrest, and stroke, EMS will take patients directly to hospitals that meet care requirements and choose to participate in the system. Fourteen hospitals in the West Region are categorized as cardiac and stroke care facilities. The following DOH chart shows the facility name, cardiac & stroke designation level, city and county. (see also Appendix 4)

DESIGNATED CARDIAC AND STROKE FACILITIES IN THE WEST REGION			
Facility	**Location (City/County)**	**Designation Level**	
		ADULT	**PEDS**
Arbor Health	Morton	II	III
Harbor Regional Health	Aberdeen	II	II
Madigan Army Medical Center	Tacoma	I	II
Morton General Hospital	Lewis	II	III
MultiCare Allenmore	Tacoma	II	III
MultiCare Good Samaritan	Puyallup	I	II
Providence Centralia	Centralia	II	III
Providence St. Peter	Olympia	I	II
St. Anthony	Gig Harbor	II	II
St. Clare	Lakewood	II	III
St. Joseph Medical Center	Tacoma	I	I
Willapa Harbor Hospital	South Bend	II	III
Capital Medical Center	Olympia	I	NP
Summit Pacific Medical Center	McCleary	II	III

Note: A recent change in Thrombectomy availability at one of the Thurston County Hospitals continues to add extended transfer/care time for stroke patients. Also see 'Challenges' below.

Key Accomplishments from the West Region 2023-25 Strategic Plan

- Completed min/max review of Level III-V trauma designated hospitals.
- Completed min/max review of county prehospital agencies.
- Ten prevention grants were awarded in FY24, and seven in FY25, targeting the leading causes of injury and death in the region during each fiscal year. $19,503.26 was awarded in FY24 and we are expecting to awarded $23,500 in FY25 (see appendix 13 for additional details). The increase in Prevention Grant Funding for FY 25 was provided with dollars we received while investing in CD's. The Board recommended using $3,500.00 of this money to add to the Prevention Grants and the Council agreed unanimously.

FY 24

Safe Kids Thuston County – Safety Calendars: This year they increased the number of calendars printed and distributed from 1200 to 1500. This year, calendars were distributed to over 13 local agencies and directly to individual families.

Lewis County FD #2 – Water Rescue Equipment: Purchased PFD's, tethers, ropes, etc. for the Water rescue team. Trained additional personnel. A total of 12 water rescues were performed during the contract period.

South Bend Police – Safe School Zones using new radar product: With the new radar, no kids were hit or killed in or around the school zone during the grant period!

New Phoebe House – Rebuilding families going through trauma and violence: During the contract period, they provided 1,270 hours of parent coaching, 419 hours of child programming, 39 parenting classes and 1,284 hours of case management.

Northwest Infant Survival & SIDS Alliance – Unsafe infant sleep prevention and crib distribution: Purchase and deliver 20 cribs and sheets within the grant period. Hosted quarterly trainings for Crib Distribution partners in September and December 2023, and in January and March 2024. Crib Partners provided safe sleep education and a new, portable cribs to 133 families in 2023. Between January and May 2024, our partners provided education and cribs to 37 families.
In 2023, we trained or re-trained a total of 84 partners and, so far in 2024, we trained 27 partners. These individuals represent 12 active, Crib partner distribution agencies. Since 2018, WREMS grants within our program have provided cribs to approximately 168 families in need.

Mary Bridge Hospital – Safe Gun Storage: Distributed an average of 8 lockboxes per month / 100 per year. Mary Bridge Emergency Department works with families that report an unsecured firearm(s) in the home. They were also involved in the Children's Advocacy Center gun giveback event with Tacoma Police Department (October).

Pierce County Fall Prevention Coalition – Fall Prevention Education: Approximately 622 people reached via the distribution of our brochure through at least 25 events. Printed 10,000 copies of "Stepping Ahead For a Falls Free Community". Hosted 25 Fall Prevention Events.

Murdin Therapy – Otago in the home: WREMS funding allowed 22 adults to participate in fall reduction training and programs. 19 have completed 8 weeks. 11 have completed 24 weeks of exercise and fall risk assessment. Mobility has improved and falls were not seen in these 19 cases.

Ocean Shores FD – Fall Prevention: We began our fall prevention program by hosting four seminars in the community consisting of a slideshow presentation and screening materials for participants to take home. These took place on 1/16/24, 2/15/24, 3/22/24, 5/9/24. After we completed these first four seminars, we took all that information and packaged it into a fall prevention booklet.

Thurston County Public Health & Social Services – Naloxone distribution for priority populations: In Jan they participated in 2 Point-in-Time events to distribute Narcan and drug assistance information. During the contract period they also distributed 75 naloxone kits, 12 purchased with the WREMS funds.

FY25

St. Josephs Hospital – Penetrating Injuries: results to follow

Safe Kids Thurston county – safety calendars: results to follow

Pierce County Fall prevention coalition – Fall Prevention education: results to follow

Lewis County FD#2 – Drowning Prevention: results to follow

New Phoebe House – Family reunification: results to follow

NISSA – Unsafe Infant sleep prevention: results to follow

Murdin Therapy – Otago in the home: results to follow

- Prehospital training contracts were awarded in FY24 and FY25 to local EMS Councils for a total of $40,280 each year (total of $80,560.00) to fund Ongoing Training and Evaluation Programs in each West Region County. The current West Region providers number is 3,011 which is up 2 from our last Strategic Plan (3,009). These dollars are used to support County EMT classes, IV classes, MCI training, airway courses, the Ongoing Training and Education Program (OTEP) and more.
- Submitted Annual Reports to the WA State Auditor for FY23
- Completed FY 2023 WA State Auditor's Assessment Audit of Financial Accountability with no findings.

- Council members participated in EMS & Trauma Steering Committee Technical Advisory Committees, to include: Cardiac & Stroke TAC, Hospital TAC, Pediatric TAC, Prehospital TAC, and Regional Advisory TAC.
- Continued recruitment efforts of Council membership and we continue to maintain over 70% of positions filled.
- All Strategic Plan deliverables reports were delivered to DOH complete and on time.
- The Council continued to hold all meetings remotely and carry out the work of its strategic plan.
- In May of 2024 we brought back the annual EMS Conference. This 3-day event was held at the conference center in Ocean Shores. The event boasted over 25 classes with over 20 different speakers. We had over 130 attendees.
- In May of 2025 we again hosted the annual EMS Conference. This year we sold 245 tickets which represented 150 attendees. We had 47 speakers and included a full day course for PHTLS and Vehicle Extrication.
- We continue to update our website with new pictures, information, lessons learned, 988 suicide hotline link, various announcements and a new page providing links for Jobs and Volunteer Opportunities. We also update our site to reflect the EMS Conference and have links to the Sponsorship brochure and the Vendor brochure. All the artwork and design work for the conference is done in-house by the Executive Director, so that we do not need to incur unnecessary expenses.
- The Council reviewed 'After-Action' reports that support response improvement in a multidiscipline, multi-jurisdictional and multi-county disaster response.
- Older Falls prevention presentations were completed annually.
- Pediatric injury prevention presentations were complete annually.
- Continued our efforts to recruit trauma and first responders to attend Cardiac, Stroke, Trauma and Injury Prevention meetings.
- Scheduled Cardiac and Stroke committee's annual meetings.
- FY24 and FY25 budgets were developed and approved by the Executive Board and presented to the Council and to DOH. The FY25 budget was submitted with a deficit but the Council voted to have it resubmitted using funds 'in the bank' to ensure that it was a balanced proposal.
- Biennial contracts were distributed to and signed by local WREMS-TC.
- Suicide Prevention presentations were presented twice during the contract period to the IVP committee.
- Two-year meeting calendars were submitted and approved by all West Region Committees.

Challenges

The challenges remain complex:

- A rapidly changing healthcare environment (COVID, Mpox, flu),
- Limited and declining resources,
- Increasing demand, workforce shortages due to lack of interest in healthcare career pathways,
- Continuous 'divert' status (a Staffing Survey which ran monthly from Jan 2024 – Dec 2024 was presented to DOH in March 2025 with the results),
- Increased patient off-loading time for Ambulances at destinations

- Increased ‘wall times’ for patients at destinations,
- Increased hospital discharge time and access to rehab, skilled nursing, and long-term care facilities
- On-scene communication issues across counties and with military agencies at MCI events,
- Recent change in Thrombectomy availability at Thurston County Hospital continues adding extended transfer/care time for stroke patients,
- Barriers to quality assurance and improvement,
- Unequal access,
- Rapidly changing technology,
- Funding issues: There is a widening gap between Fire and EMS's primary source of revenue - levies based on property taxes, and operating costs.
- An informal presentation was presented to DOH management (in October 2024), outlining that all regions are operating on the same funds as in 2013. The presentation also presented that costs are up over 35% and that our major concern is for financial sustainability.
- Increase in population (up over 2.22% = additional 31,272) compounded by workforce shortages including hospital and EMS personnel resigning due to mandatory vaccination requirements. EMS personnel is up by 205 providers. This equates to each new provider being responsible for 153 persons.
- Sustainability of community collaboration.

Priorities

Our priorities reflect our vision and mission statement:

- Quality care and quality improvement,
- Cost efficiency,
- Access for as many as possible to appropriate care,
- Data-driven decision making,
- Education and outreach,
- Improving integration and collaboration with all stakeholders,
- Resource and workforce development, and regulatory adjustment to increase effectiveness and efficiency.
- Finding ways to create revenue to offset the 35% increase in COG and the 26% decrease in funding since 2013.
- Finding ways to increase the number of providers that is constantly decreasing.
- Finding ways to encourage providers to stay active.

Please see appendix 5 for the complete data report.

Goal 1 Introduction

Maintain, assess and increase emergency care resources.

Regional councils identify the need, establish the number and level of facilities, and recommend distribution and level of care of prehospital services, per RCW 70.168.100 (g)(h). Every two years, the West Region engages in the process of reviewing the minimum and maximum numbers, and the levels of trauma-designated hospitals and trauma-verified prehospital agencies in each county. The councils offer recommendations for changes to their min/max to the EMS and Trauma Steering Committee, and the DOH gives final approval.

Trauma-Designated Hospitals

In continuation of the findings from The American College of Surgeons Committee on Trauma (ACS) in April 2019, we continue with the *review and revision* of

- The criteria for trauma designation by level,
- Methodologies for calculation of min max numbers,
- And that the process for implementation be reviewed and revised.

Subsequently, DOH established a workgroup to assess methodologies for determining the distribution of Levels I and II across the state.

Meanwhile the EMS and Trauma Care Councils also conduct reviews of the regional hospital min/max numbers. The West Region solicits participation in this process from the West Region Trauma Quality Improvement Forum (QIF), which then makes recommendations to the Council. However, it has become difficult to conduct this review without clear methodologies and guidance. The 2014 DOH Criteria and Process for Establishing Number and Level of Designated Facilities is a reference for conducting the review but is insubstantial as guidance for a regional analysis of the needs and distribution of designated trauma centers. The regions need a standardized methodology to assist them in this task. (There is currently work on the Trauma Services Assessment)

There are 14 designated trauma care services currently operating within the West Region.[4] Overcrowding of emergency departments throughout Washington State has been partly attributed to the large number of mental health patients being held there due to a lack of resources and inpatient capacity for these patients elsewhere. To address this, the region has obtained new behavioral health resources in the last several years:

- In 2019 South Sound Behavioral Health opened a 108-bed mental health facility in Thurston County. Located in Lacey, the hospital provides 24/7 free assessments, inpatient and outpatient behavioral health

[4] (See Appendix 2B for a list of Approved Minimum & Maximum Numbers of Designated Trauma Care Services.)

and addiction treatment programs to all adults ages 18 and over and have committed to care for involuntary patients.

- Wellfound Behavioral Health Hospital in Tacoma opened an adult 120-bed psychiatric hospital in 2019, providing partial hospitalization and inpatient mental health care. In addition, Wellfound will take transfers from hospital emergency departments.

- Telecare Thurston Mason Evaluation and Treatment Center is a 15-bed mental health facility in Thurston County which accepts patients directly from the local hospital emergency department. It serves ages 18 and older who have a chronic or serious mental health disorder and are experiencing an acute crisis. Telecare will care for voluntary and involuntary patients.

The new legislation allowing voluntary participation of EMS ambulance and aid services to transport patients from the field to mental health or chemical dependency services (Washington SHB 1721), may also relieve some of the burden of mental health patients in the ED. For example, the Pierce County MPD incorporated SHB 1721 guidelines into the updated mental health transport protocol, and has reported some progress in deflecting admission of behavioral health patients in the ED.

Prehospital Trauma Verified Services

The WREMS-TC supports local EMS agencies in meeting the requirements of WAC to assure adequate availability of trauma-verified prehospital aid and ambulance services for each response area, based upon agency response time standards, geography, topography and population density. Identification of need with distribution of verified aid and ambulance services is determined by local county EMS councils in Grays Harbor/North Pacific, Lewis, Pierce and Thurston Counties. Each council has an operations committee responsible for recommending minimum/maximum numbers of prehospital services which is subsequently reviewed and endorsed by the county EMS council. Each county's recommendations are reviewed by the WREMS-TC and forwarded to WA DOH for approval.

Every two years, County evaluation of minimum/maximum numbers of prehospital services is conducted, considering the following objective criteria as outlined in the WA DOH's Guideline for Addressing Minimum/Maximum Levels of Trauma Verified Prehospital EMS Resources.

1. Demand for prehospital EMS resources.
2. Population.
3. Increased trauma responses.
4. Available prehospital EMS resources.
5. Response time. Does system quality improvement/evaluation suggest that response time for prehospital EMS resources has increased? Do current resources meet the response time requirements outlined in WAC 246-976-390?
6. Level of verified trauma service. Is there a demonstrated (data-driven) need for another level of service?

There are now 78 EMS trauma-verified aid and ambulance agencies within the West Region.[5] New applications for prehospital trauma verification are reviewed by the West Region Council in accordance with the following criteria from WAC 246-976-395(4) & (5):

(4) Regional EMS and trauma care councils may provide comments to the department regarding the verification application, including written statements on the following if applicable
(a) Compliance with the department-approved minimum and maximum number of verified trauma services for the level of verification being sought by the applicant.
(b) How the proposed service will impact care in the region to include discussion on.
(i) Clinical care.
(ii) Response time to prehospital incidents.
(iii) Resource availability; and
(iv) Unserved or underserved trauma response areas.
(c) How the applicant's proposed service will impact existing verified services in the region.
(5) Regional EMS/TC councils will solicit input from local EMS/TC councils where local councils exist.

[5] (See Appendix 5-A for a list of verified prehospital services in the West Region.)

Objective 1: Within the reporting cycle, the WREMS-TC will review the current minimum and maximum numbers and levels of Trauma Designated Services, and provide recommendations to the WA DOH.	**1**	**Strategy 1.** By September 2026, the WREMS Executive Board will solicit input from the Trauma QIF group. The Trauma QIF group will provide input based on a review and analysis of the WA State DOH Trauma Services Assessment DOH 530-101 = trauma registry data), from members and stakeholders regarding Regional Designated Adult, Pediatric and Rehabilitation Trauma Service's needs.
	2	**Strategy 2.** By December 2026, the WREMS Executive Board will review input from the Trauma QIF group for current designated Trauma Services designations and make recommendations for minimum and maximum numbers, levels and locations to the WREMS-TC.
	3	**Strategy 3.** By March 2027, the WREMS-TC will make recommendations regarding minimum and maximum numbers, levels and locations of designated Trauma Services to the Washington State Department of Health.
Objective 2: Within the reporting cycle, the WREMS-TC will review the current minimum and maximum numbers and levels of Prehospital EMS Licensed and Verified Services by county and provide recommendations to the WA DOH.	**1**	**Strategy 1.** By January 2026, the WREMS Executive Board will request that local EMS Councils and MPD Planning & Standards Committee review minimum and maximum numbers and levels of Prehospital EMS Licensed and Verified Services by county. They will make recommendations for any changes using the standardized methods provided by WA DOH to determine optimal prehospital system recommendations to the WREMS-TC for approval.
	2	**Strategy 2.** By April 2026, the WREMS Executive Board will review input and any changes suggested by EMS Councils and MPD Planning & Standards Committee to minimum and maximum numbers and levels of Prehospital EMS Licensed and Verified Services by county and make recommendations to the WREMS-TC.
	3	**Strategy 3.** By June 2026, the WREMS-TC will make recommendations for the minimum and maximum numbers of Prehospital EMS Licensed and Verified Services by county to the WA DOH.

Objective 3: Within the reporting cycle, the WREMS-TC will review the current minimum and maximum numbers and levels of Cardiac and Stroke facilities and provide recommendations to the WA DOH.	**1**	**Strategy 1.** By Feb 2027, the WREMS Executive Board will solicit input from the Cardiac and Stroke QIF groups. The Cardiac and Stroke QIF groups will provide input based on review and analysis of the WA State Emergency Cardiac and Stroke System (DOH 345-299 Participating Hospitals by Region), from members and stakeholders regarding changes to the minimum and maximum numbers, categorization levels and locations.
	2	**Strategy 2.** By May 2027, the WREMS Executive Board will review input from the Cardiac and Stroke QIF groups and make recommendations for minimum and maximum numbers, categorization levels and locations, to the WREMS-TC.
	3	**Strategy 3.** By June 2027, the WREMS-TC will make recommendations regarding minimum and maximum numbers, categorization levels and locations of designated Cardiac and Stroke facilities to the Washington State Department of Health.
Objective 4. Within the reporting cycle, the WREMS-TC will review the data provided by regional QIF committees in the region.	**1**	**Strategy 1.** By July 2026, the WREMS-TC will assess hospital divert hours and how that affects pre-hospital agencies.
	2	**Strategy 2.** By September 2026, the WREMS-TC will assess the healthcare system within the West Region to identify causes of 'back-ups' to support positive outcomes for our patients.
	3	**Strategy 3.** By November 2026, the WREMS-TC will research methods to entice individuals to enter the healthcare field.

Goal 2 Introduction

Support emergency preparedness activities.

The Council is committed to a "whole community" approach to preparing for, responding to, and recovering from an all-hazards, emergency incident.

As we move to the future, the region's priorities will be to focus on:

- Collaboration with local, regional and statewide partners to support all-hazards preparedness and response planning.
- Continue collaboration with pre-hospital emergency medical agency partners to support an all-hazards response effort.

The WREMS-TC is not an operational agent in the response function of this goal, but it is a critical partner that supports preparedness and response improvement planning.

Objective 1: Throughout the planning cycle, the WREMS-TC will collaborate with EMS, hospitals, public health, and emergency management to support cross-county all-hazards preparedness and response.		
	1	**Strategy 1.** By March 2026, the WREMS-TC will schedule a tabletop with a multi-discipline, multi-jurisdictional, and multi-county scenario to include state and tribal response partners.
	2	**Strategy 2.** By June 2026, the WREMS-TC will review After-Action Reports that support response improvement in a multi-discipline, multi-jurisdictional, and multi-county disaster response.
	3	**Strategy3.** By June 2026, the MPD Joint Standards and Planning Committee will continue their update of the West Region's Mass Casualty Incident (MCI) Patient Care Procedure (PCP) to include a new Prehospital MCI Algorithm based upon common elements of all West Region County MCI plans.

	4	**Strategy 4:** During declared emergencies or after such events, the WREMS-TC will review and discuss EMS agency collaborations between local Department of Emergency Management and/or County Public Health Departments at scheduled meetings.
	5	**Strategy 5.** Throughout the planning cycle, the WREMS-TC will participate in and support the implementation of a WA State EMS Emergency Preparedness Toolkit.

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.

Washington State Dept. of Health (WA DOH) data tells us that in 2019 - 2023, 5,212 people died from preventable injuries in the West Region. Of these 952 were self-inflicted injuries. (Appendix 11)

The top-10 causes of injury and/or death in the West Region are listed here:

TOP 10 CAUSES OF INJURY DEATHS - WEST REGION		
1	Unintentional Poisonings	2,228
2	Unintentional Falls	1,245
3	Unintentional Motor Vehicle Accidents	766
4	Suicide - Firearm	675
5	Homicide - Firearm	227
6	Suicide - Suffocation	50
7	Unintentional Suffocation	21
8	Suicide - Poisoning	0
9	Adverse Medical Condition	0
10	Unintentional / Not Specified	0
	TOTAL	**5,212**
	SELF INFLICTED	952

The West Region includes many rural areas with limited resources. Building and strengthening partnerships is vital; it helps rural areas increase capacity and reduces duplication of efforts.

This data is used to set priorities, inform decisions regarding injury-prevention grant awards and evaluate the efficacy of prevention programs. By supporting evidence-based or even promising prevention strategies, and by providing education and resources to regional stakeholders the number of injuries and fatalities due to trauma can be reduced.

Regional Councils have strong support from WA DOH staff who share a wealth of expertise and resources. For example, IVP TAC and WA State Older Adult Falls Prevention Coalition meetings provide an opportunity to network with other regional prevention leads and address prevention issues at the state level.

The West Region is also currently collaborating with DOH staff, local and regional EMS responders along with the Training and Education committee in an effort to develop a pilot prevention program and/or an educational campaign directed at EMS Wellness and Resilience for first responders, and supports their goal of implementing a program or campaign statewide.
Injury prevention information on a wide variety of topics is shared with prevention partners across the regions and is also available on the WREMS website, www.wrems.com/prevention.

West Region IVP meetings are held five times per year. Meetings include an educational component and an updated report from WA DOH. The meetings provide an opportunity for building partnerships, sharing best practices, and learning about prevention programs that participants can adopt in their own communities. As of June 2020, WREMS Prevention meetings were held via Zoom; participation and engagement remain strong. WREMS IVP meetings bring together a wide array of stakeholders to include prehospital providers, hospitals, public health and for-profit and non-profit organizations. Every year by providing grant opportunities, new partnerships are forged.

Each year WREMS awards up to $20,000.00 in prevention grants. Such grants are used to develop or strengthen prevention programs in local communities. Grant applications must address a leading cause of injury and death in the region and use evidence-based or promising strategies. (See also, Appendix 13 for full details) A subcommittee reviews all prevention grant requests submitted. Grant recipients then submit bi-monthly updates which include interventions and outcomes, and a final project report at the end of the grant year. Grant recipients must attend at least one IVP meeting during the grant year. The grants are a valuable resource for rural, underserved areas; a relatively small grant can have a big impact there. Grants make it possible to develop successful prevention programs which can then be eligible for additional grant funds from other sources. Eleven prevention grants were awarded in FY24, and seven prevention grants were awarded in FY25. For the FY25, the Council voted to increase funding to $23,500.00 due to gains from Certificates of Deposit.

Historically, the annual West Region EMS Conference included a Prevention Workshop. Approximately 42 people attended the 2019 Prevention Workshop. That Workshop included interactive open water safety education, as well as a hands-on training in social media for prevention-focused public education. Since 2020, the West Region EMS Conferences were cancelled due to COVID-19 restrictions on gatherings.

With the COVID-19 pandemic, which began in 2020, we have seen an increase in the number of suicide deaths. WREMS-TC had amplified its commitment to providing education and resources in suicide prevention in the 2023-25 plan cycle. WREMS will work closely with the Thurston County TAC as they continue to develop Resilience Training Programs that can possibly be shared with other West Region Counties.

Current events have had a significant impact on the economy. Many families do not have the financial resources to purchase lifesaving safety equipment. Local prevention organizations, fire and EMS agencies, and local and state government are operating with reduced funding and staff for prevention work. WREMS continues to prioritize underserved communities when awarding prevention grants and other resources.

Since 2020, WREMS prevention grant recipients and partners adapted their programs to comply with COVID-19 social distancing requirements.

- NW Infant Survival & SIDS Alliance developed virtual safe sleep trainings, https://nwsids.org/

- Mary Bridge Children's Hospital provided virtual car seat checks, https://www.marybridge.org/services/childhood-safety/services/car-seat-inspections/

- The Crisis Clinic of Thurston & Mason Counties updated their website to provide suicide prevention education and resources online and continues to be available 24/7 through their Crisis Line, 360-586-2800 and youth line, 360-586-2777. https://crisis-clinic.org/

In FY24, we began to return to normal and COVID restrictions eased, the Prevention Grant recipients also return to a more normal work routine.

- Mary Bridge is working on a Safe Gun Storage project.
- Lewis County FD-2 is working on a Senior Fall Prevention Project
- NISSA (Northwest Infant Survival & SIDS Alliance) continues their important work on Unsafe Infant Sleep.
- New Phoebe House also continues to move forward with their program for parenting education for mothers in recovery.

Objective 1: Annually throughout the planning cycle, the WREMS-TC will research the most recent injury and mortality data available to identify the leading causes of traumatic injury and death in the West Region and support evidence-based, best available, or promising strategies and programs.	**1**	**Strategy 1a**. By August 2026, the WREMS-TC will review the most current injury and mortality data from WA DOH and other sources, as available, to determine the leading causes of traumatic injury and death in the West Region and use this information as criteria for funding local programs and activities.
		Strategy 1b. By April 2027, the WREMS-TC will review the most current injury and mortality data from WA DOH and other sources, as available, to determine the leading causes of traumatic injury and death in the West Region and use this information as criteria for funding local programs and activities.
	2	**Strategy 2a.** By September 2025, the IVP Grant Workgroup will identify evidence-based or promising injury prevention programs and activities and provide funding to regional injury prevention partners as funding is available.

		Strategy 2b. By September 2026, the IVP Grant Workgroup will identify evidence-based or promising injury prevention programs and activities and provide funding to regional injury prevention partners as funding is available.
Objective 2: Annually, throughout the planning cycle, the WREMS-TC will coordinate and offer training that addresses a leading cause of injury and mortality in the West Region.	**1**	**Strategy 1a.** By March 2026, the WREMS-TC will coordinate and offer at least one IVP training at one of the Council meetings.
		Strategy 1b. By March 2027, the WREMS-TC will coordinate and offer at least one IVP training at one of the Council meetings.
Objective 3: Throughout the planning cycle, the WREMS-TC will support suicide prevention, awareness & education programs and activities.	**1**	**Strategy 1.** Throughout the planning cycle, the WREMS-TC will share suicide prevention resources and information with regional stakeholders.
	2	**Strategy 2a.** Annually, by September 30, 2025, the WREMS Prevention grants will be offered for projects that address the leading causes of death and injury, including suicide.
		Strategy 2b. Annually, by September 30, 2026, the WREMS Prevention grants will be offered for projects that address the leading causes of death and injury, including suicide.
	3	**Strategy 3a.** Throughout the 2026 grant year, funding recipients will report on the progress of their programs, including interventions and outcomes, to the WREMS-TC.
		Strategy 3b. Throughout the 2027 grant year, funding recipients will report on the progress of their programs, including interventions and outcomes, to the WREMS-TC.
	4	**Strategy 4a.** Throughout the 2026 grant year, the WREMS-TC will provide quarterly progress reports to WA DOH.
		Strategy 4b. Throughout the 2027 grant year, the WREMS-TC will provide quarterly progress reports to WA DOH.
	5	**Strategy 5a.** By April 30, 2026, Suicide prevention education will be presented at a WREMS Prevention meeting.
		Strategy 5b. By April 30, 2027, Suicide prevention education will be presented at a WREMS Prevention meeting.
Objective 4: Annually, throughout the planning cycle,	**1**	**Strategy 1.** Throughout the planning cycle, the WREMS-TC will share older adult falls prevention resources and information with regional stakeholders.

the WREMS-TC will promote older adult falls prevention.	**2**	**Strategy 2a.** By September 30, 2025, the WREMS Prevention grants will be offered for projects that address the leading causes of death and injury, including older adult falls prevention.
		Strategy 2b. By September 30, 2026, the WREMS Prevention grants will be offered for projects that address the leading causes of death and injury, including older adult falls prevention.
	3	**Strategy 3a.** Throughout the 2026 grant year, funding recipients will report on the progress of their programs, including older adult falls prevention, interventions and outcomes, to the WREMS-TC.
		Strategy 3b. Throughout the 2027 grant year, funding recipients will report on the progress of their programs, including older adult falls prevention, interventions and outcomes, to the WREMS-TC.
	4	**Strategy 4a.** By June 30, 2026, older adult falls prevention education will be presented at a WREMS Prevention meeting.
		Strategy 4b. By June 30, 2027, older adult falls prevention education will be presented at a WREMS Prevention meeting.
	5	**Strategy 5.** Throughout each grant year, the WREMS-TC will provide quarterly progress reports to WA DOH on older adult falls programs.
Objective 5: Annually, Throughout the planning cycle, the WREMS-TC will solicit projects for pediatric injury prevention for the leading causes of death for children ages 1-14 yrs through the IVP grant project.	**1**	**Strategy 1.** Throughout each grant year, the WREMS-TC will provide quarterly progress reports to WA DOH on older adult falls programs.
	2	**Strategy 2a.** By September 30, 2025, WREMS Prevention grants will be offered for projects that address the leading causes of death and injury for children.
		Strategy 2b. By September 30, 2026, WREMS Prevention grants will be offered for projects that address the leading causes of death and injury for children. This will include data on pediatric falls from windows.
	3	**Strategy 3a.** Throughout the 2026 grant year, funding recipients will report on the progress of their programs, including interventions and outcomes, to the WREMS-TC.
		Strategy 3b. Throughout the 2027 grant year, funding recipients will report on the progress of their programs, including interventions and outcomes, to the WREMS-TC.

	4	**Strategy 4a.** By February 28, 2026, Pediatric injury prevention education will be presented at a WREMS Prevention meeting.
		Strategy 4b. By February 28, 2027, Pediatric injury prevention education will be presented at a WREMS Prevention meeting.
	5	**Strategy 5.** Throughout each grant year, the WREMS-TC will provide quarterly progress reports to WA DOH.
Objective 6: Throughout the planning cycle, the WREMS-TC will collaborate to educate the public, partners and policy makers on the Emergency Care System.	**1**	**Strategy 1.** Throughout the planning cycle, the WREMS-TC will make current Emergency Care system information available to stakeholders on the WREMS website and by email.

Goal 4 Introduction

Assess weakness and strengths of quality improvement programs in the region.

West Region Trauma Quality Improvement Forum

The WREMS-TC supports the independent, collaborative, regional quality improvement work of the Trauma Quality Improvement Forum (QIF).
The purpose of the Trauma QIF include:

- To improve patient outcomes,
- To identify areas for improvement,
- To educate providers
- And to build coordination between services.

The designated trauma facilities (Level II, III, IV and V), and trauma-verified ALS and BLS EMS agencies all participate at the Trauma QIF meetings,

- To review regional data,
- To provide case presentations,
- To share successful process-improvement projects
- And to receive trauma education presentations.

Hospital data for the Trauma QIF is regularly supplied through the WA State Trauma Registry. A Trauma QIF Plan calls for confidential meetings five times per year, a membership of both hospitals and prehospital agencies, and the sharing of case reviews and data. (See Appendix 10A for the West Region Trauma QIF plan.)

The Trauma QIF Plan Revision Workgroup convened once in January 2020 to begin an update of the West Region Trauma QIF Plan. The Workgroup discussed broadening the plan to address the issues of:

- How to prove the region is providing quality care,
- Identifying system issues and QI indicators
- And implementing systems QI.

The Plan Revision Workgroup needs to continue meeting to complete the updates. Goal 4 Objective 2, Strategy 3 is a strategy to continue those meetings.

West Region Cardiac & Stroke Quality Improvement Forum

The WREMS-TC also supports the Emergency Cardiac and Stroke System in the West Region. That System is similar to the WA Trauma System but is intended to save lives and reduce disability specifically for heart attack, cardiac arrest, and stroke patients. The WREMS-TC provides administrative support to the West Region Cardiac/Stroke QI Forum and brings together hospitals and prehospital agencies to review regional data, provide case presentations, and share successful process improvement projects. Cardiac and stroke

care differ, so the two groups meet separately to address their QI issues. The Cardiac/Stroke QI has a West Region Cardiac/Stroke QI Plan. (See Appendix 9 for the plan.)

During 2019-21, the West Region Stroke QI group identified one of the major barriers to reducing the time to treatment for acute stroke: inconsistent prehospital documentation of key stroke data elements. In 2020 the WREMS-TC was awarded a Coverdell Stroke grant from DOH to improve the prehospital provider's knowledge through education on the importance of documenting stroke indicators. An educational video was produced for prehospital providers through the collaborative efforts of the regional MPDs, Thurston County Medic One, and Chris Sharp Productions. The finished video, "Stroke Outcomes: Saving Lives Through Documentation" https://vimeo.com/389844612 was released in January 2020, and preliminary data has shown:

1) More EMS providers have consistently reported Last Known Well in clock hour time versus lapsed time, leading to improved, more accurate, and timely care and coordination of stroke patients.
2) A 10% improvement in EMS documentation of Last Known Well, FAST-BEFAST exam, pre-notification of arrival, stroke severity score.
3) A 5% improvement for patients with a LAMS 4 or 5 being transported to a comprehensive stroke center capable of endovascular treatment.
4) A 5% improvement of appropriately documented blood glucose levels in EMS documentation.

The West Region EMS responses captured, is about 20% lower than the rest of the state with Thurston County the weakest responses. This is due to liability issues that have now been resolved as of Nov 2024 with the implementation of mandatory reporting.

Grays Harbor	89%
Lewis County	99%
Pacific	94%
Pierce	88%
Thurston	100%

EMS transport times in minutes (mean and median) for stroke transports are as follows:

Incident County	Incident Year	Number of Stroke Transport (excluding interfacility)	Scene Time (average)	Scene Time (median)	Transport Time (average)	Transport Time (median)
Grays Harbor	2023	178	18.4	18.0	19.9	17.1
Lewis	2023	200	16.6	15.9	15.7	12.4
Pierce	2023	1765	15.4	14.5	15.5	14.2

Thurston	2023	358	10.7	10.0	12.6	10.2
Grays Harbor	2024	165	20.0	19.1	19.4	18.0
Lewis	2024	160	16.4	15.6	17.1	14.9
Pierce	2024	1574	15.1	14.1	15.0	14.0
Thurston	2024	298	12.5	11.0	15.8	12.2

Additionally, the door to needle time for the West Region is 46.5 minutes, which is just slightly higher than the 42.5-minute average for the state.

Regional Cardiac and Stroke QI Programs are challenged by the absence of regulation. The Cardiac and Stroke System is voluntary and receives no funding at the state level. It is a top concern for the WREMS-TC that the Emergency Cardiac & Stroke System receive funding.

West Region Prehospital QI

Each county in the West Region has a prehospital QI process. Some have case reviews with the local hospital and others have formal committees. There is a need for more prehospital participation at the regional level, for both Trauma and Cardiac/Stroke QI Forums. Goal 4, Objective 1, Strategy 4 is a strategy to enhance participation.

Submission of prehospital data into the WA Emergency Medical Service Information System (WEMSIS), has improved in the last two years but was not mandatory. This mandatory reporting requirement is now in place and reporting rates have improved as a result.

Objective 1: Throughout the planning cycle, the WREMS-TC will review regional emergency care system performance.	**1**	**Strategy 1.** On a quarterly basis throughout the contract year, the WREMS-TC will review meeting reports from the West Region Quality Improvement Forums for Trauma, Cardiac, and Stroke.
	2	**Strategy 2.** When appropriate, the WREMS-TC will share recommended opportunities for improvement from the QIF to the Training, Education and Development Committee (TED), IVP Committee, and the WREMS-TC. WREMS Committees will disseminate among West Region agencies/facilities.

	3	**Strategy 3a.** By November 15, 2025, the West Region local EMS councils will be requested to report quarterly 'lessons learned' from prehospital case reviews back to the Council as a Service Agreement Contract Deliverable for their prehospital training funds.
		Strategy 3b. By January 15, 2026, the West Region local EMS councils will be requested to report quarterly 'lessons learned' from prehospital case reviews back to the Council as a Service Agreement Contract Deliverable for their prehospital training funds.
		Strategy 3c. By April 15, 2026, the West Region local EMS councils will be requested to report quarterly 'lessons learned' from prehospital case reviews back to the Council as a Service Agreement Contract Deliverable for their prehospital training funds.
		Strategy 3d. By June 15, 2026, the West Region local EMS councils will be requested to report quarterly 'lessons learned' from prehospital case reviews back to the Council as a Service Agreement Contract Deliverable for their prehospital training funds.
		Strategy 3e. By November 15, 2026, the West Region local EMS councils will be requested to report quarterly 'lessons learned' from prehospital case reviews back to the Council as a Service Agreement Contract Deliverable for their prehospital training funds.
		Strategy 3f. By January 15, 2027, the West Region local EMS councils will be requested to report quarterly 'lessons learned' from prehospital case reviews back to the Council as a Service Agreement Contract Deliverable for their prehospital training funds.
		Strategy 3g. By April 15, 2026, the West Region local EMS councils will be requested to report quarterly 'lessons learned' from prehospital case reviews back to the Council as a Service Agreement Contract Deliverable for their prehospital training funds.
		Strategy 3h. By June 15, 2027, the West Region local EMS councils will be requested to report quarterly 'lessons learned' from prehospital case reviews back to the Council as a Service Agreement Contract Deliverable for their prehospital training funds.

	4	**Strategy 4.** When appropriate, 'lessons learned' will be posted on the West Region website. West Region staff will explore methods to inform constituents of the availability of the information.
	5	**Strategy 5a:** By November 15, 2025, the West Region local councils will be requested to submit a copy of an email verifying EMS attendance recruitment to regional trauma, cardiac and stroke quality improvement meetings as a Service Agreement Contract Deliverable for their prehospital training funds.
		Strategy 5b: By November 15, 2026, the West Region local councils will be requested to submit a copy of an email verifying EMS attendance recruitment to regional trauma, cardiac and stroke quality improvement meetings as a Service Agreement Contract Deliverable for their prehospital training funds.
Objective 2: Throughout the planning cycle, the West Region EMS Quality Improvement Forums will review Trauma, Cardiac and Stroke data.	**1**	**Strategy 1.** Throughout the planning cycle, the WREMS-TC will continue to assist the West Region Trauma, Cardiac and Stroke QIFs in meeting preparation.
	2	**Strategy 2a.** By June 30, 2026, participating members of the Trauma, Cardiac and Stroke QIFs will establish yearly schedules of meetings to review regional data to allow for comprehensive system evaluation. Early engagement with DOH for data and analytic support is encouraged to ensure time and staff capacity are available.
		Strategy 2b. By June 30, 2027, participating members of the Trauma, Cardiac and Stroke QIFs will establish yearly schedules of meetings to review regional data to allow for comprehensive system evaluation.
	3	**Strategy 3.** In January 2026, the West Region Trauma QIF will resume the update of the West Region QI – Trauma Plan to include strategic goals with at least three trauma system indicators to review and improve.
Objective 3: Throughout the planning cycle, the West Region Cardiac Quality Improvement Forum (QIF) will explore barriers to STEMI	**1**	**Strategy 1.** In December 2026 (and throughout the planning cycle), the West Region Cardiac QIF will work with the Region's MPDs to meet WEMSIS administrator training requirements for identified personnel to ensure data is/can be collected.

activation from all hospital admit sources, to include EMS transports and facility transfers.		
	2	**Strategy 2.** By December 31, 2026, the West Region Cardiac QIF will examine the WEMSIS data dictionary to develop appropriate STEMI reports to be analyzed on a routine basis. This strategy will also address identifying applicable prehospital training.
	3	**Strategy 3.** Once strategies 1 & 2 are completed, the West Region Cardiac QIF will identify, and address, barriers to direct-to-catheterization lab patients that come from a prehospital STEMI activation. This strategy will also address the Get with The Guidelines goals of 90 minutes from first medical contact to intervention and/or the 30 minute transport goal for lytic/non-catheterization sites.
Objective 4: Throughout the planning cycle, the West Region Stroke QIF will work to reduce the time to treatment for acute stroke by 5% from baseline.	**1**	**Strategy 1a.** In June 2026 (and throughout the planning cycle), the West Region Stroke QIF will work with the Region's MPDs to meet reporting requirements enacted by WEMSIS legislation requiring EMS agencies to train on appropriate data entry.
	2	**Strategy 2a.** In June 2026 (and throughout the planning cycle), the West Region Stroke QIF will examine the WEMSIS data dictionary to develop appropriate stroke reports to be analyzed on a routine basis. This strategy will also address identifying applicable prehospital training.

	3	**Strategy 3.** Throughout the planning cycle, the West Region Stroke QIF will identify barriers to reducing the time to treatment for acute stroke.
	4	**Strategy 4.** Throughout the planning cycle, the West Region Stroke QIF will share progress and results with the West Region Council and the Emergency Cardiac & Stroke Technical Advisory Committee.

Goal 5 Introduction

Promote regional system sustainability.

A quality Emergency Care System is maintained and broadened by the exchange of information and expertise among the West Region Council membership and the system stakeholders. The Council's inclusive membership and dedicated, engaged members, along with valued stakeholders, work together to build and expand the Care System.

The WREMS-TC adheres to a timeline for developing, reviewing, approving and implementing its annual fiscal budget. While the DOH contract with WREMS-TC has remained stable for almost a decade, other financial resources for the EMS and Trauma System have been declining (consider the lost funding in Grays Harbor in 2022 and the West Region supported their EMT class with $7,000.00 from our savings account. The West Region Council continues to be a responsible steward of public funds and continues to practice cost efficiencies and look for creative opportunities to cut costs.

Annual training grants are awarded to the West Region counties to supplement their training budgets. Contracts are initiated with local EMS councils to distribute funds for coordination and delivery of Ongoing Training and Evaluation Program (OTEP) and Continuing Medical Education (CME) EMS training. This supplemental funding covers a small portion of funds needed for training by the counties and the prehospital agencies they support.

The WREMS-TC sponsors an annual conference which provides high quality EMS education and training opportunities to West Region and Washington State providers. The WREMS-TC has produced the three-day conference for 36 years. Despite facing rising costs, diminishing funds, and a pandemic, the WREM-TC will annually provide either online training or an in-person conference. Although WREMS-TC has been unable to produce the EMS conference since 2019, due to necessary COVID-19 restrictions on gatherings, they were able to provide training opportunities remotely. In May of 2024 the annual EMS conference was once again held in Ocean Shores, WA. The attendance was approximately 130 first responders. The event covered three days of instruction and hands-on training. The event was very positive, and it is planned to continue in 2025. The conference also provided a profit of approximately four-thousand dollars, which will help with the financing for the 2025 conference. The support from our sponsors and vendors helped with this. We also created a new sponsorship tier which provides a free 'special conference t-shirt' that is given out to the first 150 registrants.

The WREMS-TC recognizes enhanced education for credentialed Senior EMS Instructors (SEIs) and EMS Evaluators (ESE) as critical for the sustainability of the EMS system. An example of enhancing workforce development is to improve EMT numbers by graduating more EMTs. The Council is committed to providing annual training and development for SEIs and ESEs. Workshops have historically been provided at the Council's annual EMS conference. During the May 2024 EMS Conference, we were able to provide a one-day SEI training event.

Along with funding EMS training, the WREMS-TC is dedicated to funding data-driven injury prevention projects which target the leading causes of trauma injury and death in the region. Additionally, we continue our concern for ongoing training for all healthcare providers and support RCW 43.70.613: Health care professionals—Health equity continuing education. (wa.gov) and RCW 43.70.615: Multicultural

health awareness and education program—Integration into health professions basic education preparation curriculum.

Objective 1: Throughout the planning cycle, the WREMS-TC will identify cost saving practices.	**1**	**Strategy 1a.** During March 2026, the WREMS-TC Executive Board will begin to develop a draft budget for the next fiscal year, which takes into consideration cost efficiencies.
		Strategy 1b. In June 2026, the WREMS Executive Board will present the next fiscal year's draft budget for Council member review and approval.
	2	**Strategy 2a.** During March 2027, the WREMS-TC Executive Board will begin to develop a draft budget for the next fiscal year, which takes into consideration cost efficiencies.
		Strategy 2b. In June 2027, the WREMS Executive Board will present the next fiscal year's draft budget for Council member review and approval.
Objective 2: Annually, the WREMS-TC will identify needs and allocate available funding to support prehospital training.	**1**	**Strategy 1a.** In February 2026, the WREMS Training and Education Committee will query stakeholders regarding how to best provide EMS education and training opportunities in the West Region.
		Strategy 1b. In February 2027, the WREMS Training and Education Committee will query stakeholders regarding how to best provide EMS education and training opportunities in the West Region.
	2	**Strategy 2.** In March 2026, the WREMS-TC will review needs and approve educational funding levels for each local EMS council.
	3	**Strategy 3.** During May 2026, the WREMS staff will initiate biennial contracts with local EMS councils to distribute funds for coordination and delivery of OTEP and CME EMS training.
	4	**Strategy 4:** Annually, by June, the WREMS-TC will facilitate SEI training and development by scheduling at least one SEI workshop.
	5	**Strategy 5.** Annually, by June, the WREMS-TC will conduct an EMS conference or regional training which provides EMS education and training opportunities within the West Region and is available to all Washington State and out of state providers.

Objective 3: Throughout the planning cycle, the WREMS-TC will work with the WA DOH and the State Auditor's Office to ensure the Regional Council business structure and practices remain compliant with RCW.	**1**	**Strategy 1.** Annually, at the beginning of the plan year, the WREMS-TC will provide WA DOH with a regional budget.
	2	**Strategy 2.** Annually, by November 15, the WREMS-TC will submit to the Washington State Auditor's Office an Annual Report of the previous year's financial information and required schedules.
Objective 4: Beginning in July 2025, the WREMS-TC will implement the 2026-2027 Regional EMS and Trauma System Strategic Plan.	**1**	**Strategy 1.** Beginning in July 2025, the WREMS staff will begin collaborating with stakeholders to accomplish the WA DOH reporting process on implementing the 2026-27 Strategic Plan.
	2	**Strategy 2.** By August 2025, the WREMS Office will distribute the 2026-2027 Plan to the local councils and county MPDs and post it on the Council website.
	3	**Strategy 3.** Beginning August 2025, and throughout the plan cycle, the WREMS Office will provide quarterly progress reports to the WA DOH and to the Executive Board.
Objective 5: Throughout the planning cycle, the WREMS-TC will facilitate the exchange of information throughout the emergency care system.	**1**	**Strategy 1.** Beginning in July 2025, and throughout the plan cycle, WREMS Executive Board and staff will manage Council membership to ensure adequate representation.
	2	**Strategy 2.** Beginning in July 2025, and throughout the plan cycle, meeting facilities, agendas and minutes will be provided to WREMS-TC members and regional stakeholders in advance of each meeting through email.
	3	**Strategy 3.** Beginning in July 2025, and throughout the plan cycle, WREMS-TC members will participate in stakeholder meetings including EMS & Trauma Steering Committee and various Technical Advisory Committees and then share information with the WREMS-TC at regularly scheduled meetings.

	4	**Strategy 4.** Throughout the planning cycle, WREMS-TC will bring EMS system and patient care issues forward to the WA DOH, as necessary.
Objective 6: By March 2027, the WREMS-TC will complete a review and update of the Regional EMS & Trauma Care System Strategic Plan to define the system direction and work in the West Region for FY 2028-29.	**1**	**Strategy 1.** By September 2025, the WREMS-TC will obtain and begin a review of directives from the WA DOH for the 2026-27 system plan components.
	2	**Strategy 2.** From November 2026-March 2027, the regional designated planners will develop objectives and strategies identifying work under each plan goal to maintain, further develop or refine the regional system and will report progress to the WREMS-TC.
	3	**Strategy 3.** By March 2027, the designated planners will present a completed draft of the 2028-2029 West Region Strategic Plan to the WREMS-TC, and subsequently to the WA DOH.

Goal 6 Introduction

Sustain a region-wide system of designated trauma rehabilitation services to provide adequate capacity and distribution of resources to support high quality trauma rehabilitation.

Washington Trauma Registry data presented at the January 2015 DOH EMS & Trauma Steering Committee (EMSTC) showed the percentage of trauma patients discharged to acute rehabilitation centers was declining in our state. Data showed only a small percentage of the trauma patients who needed rehabilitation care received it. Data further showed that patients who received rehabilitation care were almost 9 times more likely to be discharged home or to an Adult Family Home. Those that do not receive proper rehabilitation care experience a higher mortality rate. More recent data from the WA Trauma Registry shows the number of trauma patients discharged to acute care rehabilitation has stopped declining and has become steady.

There is currently only one trauma-designated rehabilitation center within the West Region; MultiCare Good Samaritan Hospital in Puyallup is a Level I. Their Trauma Rehabilitation Service is recognized as one of the best rehabilitation centers in the nation. Good Samaritan Hospital's expansion of its rehabilitation unit to 48 beds was completed in 2019.

CHI Franciscan St. Joseph Medical Center closed their inpatient trauma rehabilitation unit to open the free-standing CHI Franciscan Rehabilitation Hospital in Tacoma in May 2018. The 60-bed inpatient acute rehabilitation hospital offers care tailored to individuals recovering from stroke, brain injury, neurological conditions, spinal cord injury, amputation, and orthopedic injury. It is not a trauma-designated facility.

The shortage of trauma designated rehabilitation facilities may be partly due to the CMS limitations imposed which govern reimbursement of trauma rehabilitation, and the difficulty of finding placement of TBI patients. Limited acute care hospital bed capacity has also impacted rehabilitation units and beds. In some cases, rehab beds will be removed to make space for acute care beds. This was the case at several facilities in 2020 due to COVID-19.

Another issue rehabilitation facilities are struggling with is being able to discharge patients to Adult Family Homes and Skilled Nursing Facilities. It has been difficult to find bed space which results in longer lengths of stay in the rehabilitation unit than is needed or required. This trend continues through FY22 and FY 23.

The WREMS-TC is concerned about the lack of access to local rehabilitation facility resources in the more rural areas of Lewis, North Pacific and Grays Harbor counties. The work outlined for the 2024-25 cycle continues to focus on outpatient rehabilitation care availability in the West Region. It is vital that trauma rehabilitation patients be referred to outpatient rehabilitation care in their own communities; however, many rural areas do not have access to these services.

Objective 1: Throughout the planning cycle, the WREMS-TC will continue to integrate trauma rehabilitation information/issues into Regional Council meetings.	**1**	**Strategy 1.** Quarterly during the plan cycle, the Trauma Rehabilitation Representative of the West Region Council will prepare regular reports and updates for the WREMS-TC meetings from the DOH EMS and Trauma Steering Committee's Trauma Rehabilitation TAC.
	2	**Strategy 2.** By October 2026, an ad hoc workgroup of the WREMS-TC will work with the Rehab Without Walls agency to identify pathways for rural communities to access therapy.
	3	**Strategy 3**. By June 2026, the WREMS-TC will research the reasons why rehabilitation facilities within our region closed, and research barriers to opening new facilities.
	4	**Strategy 4.** By June 2026 the WREMS-TC will collaborate with and identify pathways to support local healthcare systems' / entities' in establishing rehabilitation facilities in non-traditional areas such as Joint Base Lewis-McChord and Lewis or Grays Harbor counties.
Objective 2: During the Plan cycle, the trauma rehabilitation committee will continue to meet.	**1**	**Strategy 1.** By March 2026, the West Region Trauma Rehabilitation Committee will meet to explore strategies to address the need for rehabilitation outpatient clinic services in underserved communities within the West Region.
	2	**Strategy 2.** By September 2026, the West Region Trauma Rehabilitation Committee will report their strategies to the WREMS-TC.

West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 1

ADULT AND PEDIATRIC TRAUMA DESIGNATED HOSPITALS AND REHAB FACILITIES

WA Department of Health Trauma Designated Services					
REGION	Trauma Designation			Facility	City
	Adult	Pediatric	Rehab		
WEST	II			Madigan Army Medical Center	JB Lewis McChord
		II P		Mary Bridge Children's Hospital & Health Center	Tacoma
	II			St. Joseph Medical Center	Tacoma
	II			Tacoma General Hospital	Tacoma
	III			Harbor Regional Health	Aberdeen
	III		I R	MultiCare Good Samaritan Hospital	Puyallup
	III			Providence St. Peter Hospital	Olympia
	IV			MultiCare Allenmore Hospital	Tacoma
	IV			Providence Centralia Hospital	Centralia
	IV			St. Anthony Hospital	Gig Harbor
	IV			St. Clare Hospital	Lakewood
	IV			Summit Pacific Medical Center	Elma
	V			Arbor Health	Morton
	V			Willapa Harbor Hospital	South Bend

West Region Emergency Medical Services
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Appendix 2

West Region Approved Minimum/Maximum Numbers of Designated Trauma Care Services

REGION	Level	State Approved		Current Status (#)
		MIN	MAX	
WEST	I	0	0	0
	II	2	3	3
	III	1	6	3
	IV	2	8	5
	V	1	3	2
	* I P	0	0	0
	* II P	1	1	1
	* III P	0	0	0

West Region Emergency Medical Services
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Appendix 3

Approved Minimum/Maximum Numbers of Designated Rehabilitation Trauma Care Services

REGION	Level	State Approved		Current Status (#)
		MIN	MAX	
WEST	I R	0	1	1
	II R	1	4	0

West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 4

Washington State Emergency Care Categorized Cardiac and Stroke System Hospitals

Washington State **Emergency Cardiac and Stroke System** Participating Hospitals by Region					
REGION	**Categorization Level**		**Facility**	**City**	**County**
	Cardiac	**Stroke**			
WEST	II	III	Allenmore Hospital	Tacoma	Pierce
	I	NP	Capital Medical Center	Olympia	Thurston
	II	II	Grays Harbor Community Hospital	Aberdeen	Grays Harbor
	I	II	Madigan Army Medical Center *	Tacoma	Pierce
	II	III	Summit Pacific Medical Center	McCleary	Grays Harbor
	II	III	Morton General Hospital	Morton	Lewis
	I	II	MultiCare Good Samaritan Hospital	Puyallup	Pierce
	II	III	Providence Centralia Hospital	Centralia	Lewis
	I	II	Providence St. Peter Hospital	Olympia	Thurston
	II	II	St. Anthony Hospital	Gig Harbor	Pierce
	II	III	St. Clare Hospital	Lakewood	Pierce
	I	I	St. Joseph Medical Center	Tacoma	Pierce
	I	I	Tacoma General Hospital	Tacoma	Pierce
	II	III	Willapa Harbor Hospital	South Bend	Pierce

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.

West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 5

EMS Resources, Prehospital Verified Services

WEST REGION: EMS AGENCY REPORT						VEHICLES		PERSONNEL		
COUNTY	CREDENTIAL #	SERVICE NAME	CITY	SERVICE TYPE	CARE LEVEL	# AMB	# AID	# BLS	# ILS	# ALS
Grays Harbor	AIDV.ES.00000165	Grays Harbor Fire District #6	Hoquiam	AIDV	BLS	0	5	3	0	0
Grays Harbor	AMBV.ES.61583587	Grays Harbor FD # 10	Aberdeen	AIDV	BLS	0	3	7	0	0
Grays Harbor	AIDV.ES.00000171	Grays Harbor/Pacific County Fire District 15	Cosmopolis	AIDV	BLS	0	3	4	0	0
Grays Harbor	AIDV.ES.00000173	Grays Harbor Fire Dist #17	Humptulips	AIDV	BLS	0	1	1	0	0
Grays Harbor	AIDV.ES.00000181	Cosmopolis Fire Department	Cosmopolis	AIDV	BLS	0	3	4	0	0
Grays Harbor	AIDV.ES.60316683	City of McCleary	McCleary	AIDV	BLS	0	1	3	0	0
Grays Harbor	AMB.ES.61503416	Ride To Wellness LLC.	Elma	AMB	BLS	2	0	0	0	0
Grays Harbor	AMBV.ES.00000162	Grays Harbor Fire District No. 2	Aberdeen	AMBV	ALS	3	6	22	0	5
Grays Harbor	AMBV.ES.00000163	Lake Quinault Volunteer Fire Department	Quinault	AMBV	BLS	2	0	3	0	0

Grays Harbor	AMBV.ES.00000164	East Grays Harbor Fire And Rescue	Elma	AMBV	ALS	5	0	8	0	6
Grays Harbor	AMBV.ES.00000167	Grays Harbor Fire District #8	Pacific Beach	AMBV	BLS	2	0	7	0	0
Grays Harbor	AMBV.ES.00000180	Aberdeen Fire Department	Aberdeen	AMBV	ALS	4	0	23	0	16
Grays Harbor	AMBV.ES.00000183	Hoquiam Fire Department	Hoquiam	AMBV	ALS	4	0	7	0	14
Grays Harbor	AMBV.ES.00000184	Montesano Fire Department	Montesano	AMBV	ALS	3	4	16	0	6
Grays Harbor	AMBV.ES.00000185	Ocean Shores Fire Department	Ocean Shores	AMBV	ALS	4	0	18	0	12
Grays Harbor	AMBV.ES.00000190	Quinault Nation Ambulance	Taholah	AMBV	ALS	2	0	6	0	4
Grays Harbor	AMBV.ES.60459224	Grays Harbor Fire Dist #7	Copalis Beach	AMBV	BLS	3	2	6	0	0
Grays Harbor	AMBV.ES.60898389	South Beach Regional Fire Authority	Westport	AMBV	ALS	4	0	19	0	7
Grays Harbor	AMBV.ES.60954556	Grays Harbor Fire Protection District #1	Oakville	AMBV	BLS	3	0	11	0	0
Grays Harbor	AMBV.ES.61453421	Olympic Ambulance Service Inc	Sequim	AMBV	ALS	0	0	0	0	1
Lewis	AIDV.ES.00000394	Lewis County Fire District #13	Curtis	AIDV	BLS	0	7	3	0	0
Lewis	AMBV.ES.00000383	Onalaska Ambulance	Onalaska	AMBV	ALS	3	2	7	0	4
Lewis	AMBV.ES.00000384	Lewis County Fire District 2	Toledo	AMBV	ALS	2	0	8	0	0

Lewis	AMBV.ES.00000385	Lewis County Fire District #3	Mossyrock	AMBV	ILS	1	0	9	3	1
Lewis	AMBV.ES.00000387	Lewis County Fire Protection Dist #5	Napavine	AMBV	ALS	3	0	9	0	3
Lewis	AMBV.ES.00000388	Lewis County Fire District #6	Chehalis	AMBV	ALS	2	2	12	1	5
Lewis	AMBV.ES.00000391	Mineral Fire & Rescue	Mineral	AMBV	ILS	1	0	1	2	0
Lewis	AMBV.ES.00000392	Lewis County Fire District 10	Packwood	AMBV	ILS	2	1	4	3	0
Lewis	AMBV.ES.00000395	Randle Fire and EMS	Randle	AMBV	ILS	3	0	6	3	0
Lewis	AMBV.ES.00000396	Lewis County Fire District #15	Winlock	AMBV	ALS	3	0	8	0	6
Lewis	AMBV.ES.00000398	Glenoma Fire and EMS	Glenoma	AMBV	ILS	1	0	1	2	0
Lewis	AMBV.ES.00000404	Riverside Fire Authority	Centralia	AMBV	ALS	5	0	46	0	17
Lewis	AMBV.ES.00000409	American Medical Response	Centralia	AMBV	ALS	8	0	9	0	20
Lewis	AMBV.ES.60271398	Cowlitz County - Lewis County Fire Dist.20	Vader	AMBV	BLS	2	0	4	0	0
Lewis	AMBV.ES.60434896	Lewis County Fire District #8	Salkum	AMBV	ALS	3	1	12	0	3
Lewis	AMBV.ES.60512846	Lewis County Fire District #4	Morton	AMBV	BLS	1	0	6	0	0
Lewis	AMBV.ES.60678519	Lewis County Fire District 17	Ashford	AMBV	BLS	1	0	0	0	0

Lewis	AMBV.ES.60921023	City of Chehalis	Chehalis	AMBV	ALS	1	6	11	0	2
Lewis	AMBV.ES.60946891	Adventure Medics LLC	Onalaska	AMBV	ALS	3	1	2	2	8
Lewis	AMBV.ES.61095039	Lewis County Fire Protection District 11	Pe Ell	AMBV	BLS	1	0	4	0	0
Pacific	AMBV.ES.00000464	Raymond Fire Department	Raymond	AMBV	ALS	4	3	14	0	6
Pierce	AID.ES.60446008	Boeing Fire Department	Seattle	AID	BLS	0	1	0	0	0
Pierce	AID.ES.60479785	Crystal MT.	Enumclaw	AID	ALS	0	0	15	0	0
Pierce	AID.ES.60916624	Tacoma Mountain Rescue	Tacoma	AID	ALS	0	1	0	0	0
Pierce	AIDV.ES.00000506	Pierce County Fire District 26	Enumclaw	AIDV	BLS	0	2	13	0	0
Pierce	AIDV.ES.00000515	Town of Carbonado Fire Department	Carbonado	AIDV	BLS	0	3	7	0	0
Pierce	AIDV.ES.00000538	Joint Base Lewis-McChord Fire and Emergency Services	Tacoma	AIDV	ALS	0	10	87	1	13
Pierce	AMBV.ES.00000485 AMB.ES.61635632	West Pierce Fire and Rescue. Stellar EMS	University Place	AMBV	ALS	12	16	129	0	54
Pierce	AMBV.ES.00000487	Gig Harbor Fire and Medic One	Gig Harbor	AMBV	ALS	6	16	86	0	35
Pierce	AMBV.ES.00000488	Central Pierce Fire and Rescue	Spanaway	AMBV	ALS	14	24	227	0	87

Pierce	AMBV.ES.00000496	Riverside Fire and Rescue	Puyallup	AMBV	BLS	2	2	23	0	0
Pierce	AMBV.ES.00000498	Key Peninsula Fire Department	Lakebay	AMBV	ALS	3	8	18	0	18
Pierce	AMBV.ES.00000502	Graham Fire and Rescue	Graham	AMBV	ALS	7	13	76	0	37
Pierce	AMBV.ES.00000503	East Pierce Fire and Rescue	Bonney Lake	AMBV	ALS	16	18	105	0	58
Pierce	AMBV.ES.00000504	Pierce County Fire District #23	Elbe	AMBV	BLS	4	0	18	0	1
Pierce	AMBV.ES.00000507	Anderson Island Fire and Rescue	Anderson Island	AMBV	BLS	2	0	16	0	0
Pierce	AMBV.ES.00000514	City of Buckley Fire Department	Buckley	AMBV	ALS	3	0	37	0	3
Pierce	AMBV.ES.00000516	Dupont Fire Department	Dupont	AMBV	ALS	2	3	11	0	4
Pierce	AMBV.ES.00000525	Tacoma Fire Department	Tacoma	AMBV	ALS	19	34	321	0	88
Pierce	AMBV.ES.00000542	Madigan Ambulance Service	Tacoma	AMBV	ALS	4	0	5	0	8
Pierce	AMBV.ES.00000545	American Medical Response Ambulance Service INC	Tukwila	AMBV	ALS	3	0	6	0	9
Pierce	AMBV.ES.60028645	Orting Valley Fire and Rescue	Orting	AMBV	ALS	3	10	18	0	10
Pierce	AMBV.ES.60078104	South Pierce Fire & Rescue	Eatonville	AMBV	ALS	6	0	16	0	17
Pierce	AMBV.ES.60176668	Pierce County Fire Dist #13	Tacoma	AMBV	BLS	1	2	37	0	1

Pierce	AMBV.ES.60227208	McNeil Island Fire Department	Steilacoom	AMBV	BLS	4	0	12	0	0
Pierce	AMBV.ES.60919416	Platinum Nine Holdings LLC	Everett	AMBV	ALS	10	0	3	0	8
Pierce	AMBV.ES.61381217	Olympic Ambulance Service Inc	Sequim	AMBV	ALS	3	0	82	0	5
Pierce	AMBV.ES.61398404	Ruston Fire Department	Ruston	AMBV	BLS	1	1	13	0	0
Pierce	ESSO.ES.60349830	Explorer Search and Rescue	Tacoma	ESSO		0	0	2	0	0
Pierce	ESSO.ES.60414875	Pierce County Emergency Management /EMS	Tacoma	ESSO		0	0	7	0	7
Thurston	AID.ES.00000753	Bucoda Fire Department	Bucoda	AID	BLS	0	3	2	0	0
Thurston	BLS AMBV.ES.61537722	SE FIRE Authority			BLS	3	0	2	0	0
Thurston	AMBV.ES.00000737	West Thurston Fire	Olympia	AMBV	BLS	5	12	44	0	0
Thurston	AMBV.ES.00000739	Lacey Fire District #3	Lacey	AMBV	ALS	8	14	98	0	34
Thurston	AMBV.ES.00000745	McLane Black Lake Fire Department	Olympia	AMBV	BLS	4	12	34	0	0
Thurston	AMBV.ES.00000751	Thurston County Fire Protection District #17 and Bald Hills Fire Department	Yelm	AMBV	BLS	2	9	12	0	0

Thurston	AMBV.ES.00000754	City of Olympia Fire Department	Olympia	AMBV	ALS	6	11	75	0	21
Thurston	AMBV.ES.00000756	Tumwater Fire Department	Tumwater	AMBV	ALS	4	7	27	0	24
Thurston	AMBV.ES.00000759	American Medical Response	Olympia	AMBV	BLS	5	0	18	0	0
Thurston	AMBV.ES.00000760	Olympic Ambulance Service Inc	Sequim	AMBV	BLS	20	0	83	1	0
Thurston	AMBV.ES.60626687	Thurston County Fire Protection District 8	Olympia	AMBV	BLS	2	8	33	0	0
Thurston	AMBV.ES.60695928	South Thurston Fire & EMS	Tenino	AMBV	BLS	4	7	24	0	0
Thurston	AMBV.ES.60937451	Thurston County Fire District #6	East Olympia	AMBV	BLS	2	6	21	0	0
Thurston	AMBV.ES.61311962	Griffin Fire Department	Olympia	AMBV	BLS	2	3	22	0	0
Thurston	AMBV.ES.61500307	Platinum Nine Holdings LLC	Arlington	AMBV	BLS	3	0	0	0	0
Thurston	ESSO.ES.61476967	Thurston County Medic One	Olympia	ESSO		0	0	2	0	4

Total Prehospital Verified Services by County						
COUNTY	AMBV - ALS	AMBV - ILS	AMBV - BLS	AIDV - ALS	AIDV -ILS	AIDV - BLS
Grays Harbor	9		5	0		5
Lewis	10	5	4	0	0	1
Pacific	4			0		
Pierce	15		6	2		1
Thurston	3		11		1	

Total Prehospital Non-Verified Services by County							
COUNTY	AMB - ALS	AMB - ILS	AMB - BLS	AID - ALS	AID -ILS	AID - BLS	ESSO
Grays Harbor			1				
Lewis							
Pacific							
Pierce			1	2		2	
Thurston						1	

	# of EMR			# of EMT			# of AEMT			# of Paramedic		
COUNTY	Paid	Volunteer	None	Paid	Volunteer	None	Paid	Volunteer	None	Paid	Volunteer	None
Grays Harbor	0	18		66	94		1	0		76	2	
Lewis	0	17		64	83		6	10		73	2	
Pacific	0	1		59	43		2	0		38	1	
Pierce	0	0		1315	206		1	0		472	8	
Thurston	0	0		476	141		1	0		81	0	

West Region Emergency Medical Services & Trauma Care System Strategic Plan

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)**
GRAYS HARBOR	AIDV	BLS	7	9	6
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	2	6	4
		ILS	0	1	0
		ALS	6	9	9
LEWIS	AIDV	BLS	1	21	1
		ILS	0	2	0
		ALS	0	2	0
	AMBV	BLS	5	21	4
		ILS	1	6	5
		ALS	1	11	10
PACIFIC	AIDV	BLS	1	2	0
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	0	0	0
		ILS	0	0	0
		ALS	1	1	1

PIERCE	AIDV	BLS	1	14	2
		ILS	0	0	0
		ALS	0	10	1
	AMBV	BLS	1	11	6
		ILS	0	0	0
		ALS	1	16	15
THURSTON	AIDV	BLS	1	3	0
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	1	11	11
		ILS	0	0	0
		ALS	1	3	3

West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 7

Trauma Response Areas (TRAs) by County

Grays Harbor County

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Grays Harbor	#1	GHFD #1 EGHFR McCleary FD	Encompasses the geographic boundaries of GHFD #1, City of Elma FD and City of McCleary FD. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	Personnel: 27 BLS 0 ILS 9 ALS Vehicles: 6 AMB 1 AID
Grays Harbor	#2	GHFD #2 Montesano FD	Encompasses the geographic boundaries of GHFD #2 and Montesano FD. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	Personnel: 30 BLS 0 ILS 12 ALS Vehicles: 6 AMB 8 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Grays Harbor	#3	Aberdeen FD Hoquiam FD Cosmopolis FD GHFD #6 GHFD #10 GHFD #15 GHFD #17	Encompasses the geographic boundaries of Aberdeen FD, Cosmopolis FD, Hoquiam FD, GHFD #6, GHFD #10, GHFD #15, GHFD #17. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	Personnel: 53 BLS 0 ILS 31ALS Vehicles: 11AMB 9 AID
Grays Harbor	#4	South Beach Regional Fire Authority	Encompasses the geographic boundaries of Westport, Ocosta, Grayland, North Cove, and Tokeland in Pacific County to milepost 17 on Highway 105. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	Personnel: 17 BLS 0 ILS 8 ALS Vehicles: 4 AMB 0 AID
Grays Harbor	#5	Ocean Shores FD GHFD #4 GHFD #7 GHFD #8 Hoquiam FD Quinault Nation Amb	Encompasses the geographic boundaries of Ocean Shores FD, Taholah FD, GHFD #7, GHFD #8,. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	Personnel: 39 BLS 2 ILS 32 ALS Vehicles: 15 AMB 5 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Grays Harbor	#6	Quinault Nation Amb GHFD #2 GHFD #4 GHFD #8 GHFD #10 GHFD #17 Hoquiam FD	Encompasses the geographic boundaries of GHFD #4 and Quinault Nation Ambulance. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	Personnel: 47 BLS 2 ILS 24 ALS Vehicles: 14 AMB 9 AID

Lewis County

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Lewis	#1	Riverside FA AMR	Within the current boundaries of the City of Chehalis and urban growth area	Personnel: 55 BLS 0 ILS 39 ALS Vehicles: 11 AMB 0 AID
Lewis	#2	Lewis Co FD #6 AMR Chehalis FD	Within the current boundaries of the City of Chehalis and urban growth area	Personnel: 39 BLS 2 ILS

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
				38 ALS Vehicles: 11 AMB 6 AID
Lewis	#3	Riverside FA AMR Lewis Co FD #5 Lewis Co FD #6 Lewis Co FD #11 Lewis Co FD #13	Area 3 is located in the NW corner of Lewis County bordering Thurston County to the North, Grays Harbor County and Pacific County to the West, and on the South by an imaginary line proceeding due West from the intersection of US Highway 12 and I-5 and on the east by Interstate 5.	Personnel: 60 BLS 1 ILS 36 ALS Vehicles: 19 AMB 10 AID
Lewis	#4	Riverside FA AMR Lewis Co FD #1 Lewis Co FD #2 Lewis Co FD #6 Lewis Co FD #8	Area 4 is bordered on the east side of Interstate 5, bordering Thurston County to the North and US Highway 12 to the south, the eastern border is the community of Mossyrock.	Personnel: 118 BLS 2 ILS 52 ALS Vehicles: 26 AMB 5 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Lewis	#5	Lewis Co FD #2 AMR Lewis Co FD #13 Lewis Co FD #15 Cowlitz-Lewis Co FD #20	Area 5 is located West of Interstate 5 and South of an imaginary line running west from US Highway 12 and Interstate 5 to Pacific Co, then South to Cowlitz County.	Personnel: 40 BLS 0 ILS 27 ALS Vehicles: 14 AMB 7 AID
Lewis	#6	Lewis Co FD #2 Lewis Co FD #3 Lewis Co FD #8 Adventure Medics	Area 6 is located East of Interstate 5 and North of the Cowlitz Co line bordering US Highway 12 to the North and Mossyrock to the East.	Personnel: 36 BLAS 1 ILS 11 ALS Vehicles: 7 AMB 1 AID
Lewis	#7	Lewis Co FD #3 Lewis Co FD #4 Lewis Co # 9 Lewis Co #14 Lewis CO #18 Adventure Medics	Area 7 is east from Mossyrock to Kiona Creek 5 miles west of Randle on Us Highway 12, then North to the Pierce Co line and South to the Cowlitz Co and Skamania Co line.	Personnel: 30 BLS 6 ILS 9 ALS Vehicles: 9 AMB 1 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Lewis	#8	Lewis Co FD #10 Randle Fire & EMS Lewis Co FD #17	East on US Highway 12 from Kiona Creek to the Summit of White Pass at milepost 151 at the Yakima Co line, south to the Skamania Co and Yakima Co lines and North to the Pierce Co line/Nisqually River including the Mt Rainier wilderness area.	Personnel: 10 BLS 7 ILS 0 ALS Vehicles: 6 AMB 1 AID

Pacific County (North)

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
North Pacific	#1	Raymond FD South Beach RFA	City of Raymond, City of South Bend, Pacific Co FD #3, #6, #7 & #8 and all adjoining forest lands, both public and private. Encompasses FD #5 to milepost 17 on Highway 105 and any adjoining forest lands, both public and private. Encompasses area of Pacific Co in and around the community of	Personnel: 13 BLS 0 ILS 7 ALS Vehicles: 4 AMB 4 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
			Brooklyn in the northeast corner of Pacific Co.	

Pierce County

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Pierce	#1	Ruston FD Steilacoom PS PCFD #13 PCFD #14 PCFD #27 McNeil Isl FD PCFD #3 PCFD #5 PCFD #16 PCFD #22 Central Pierce F&R Tacoma FD AMR Falck NW Rural Metro	**Area #1 (North)** Area 1 is bordered by Kitsap County in NE by an imaginary line running along 160th St east to Colvos Passage at water, then west along 160th St KPN to NW corner at Kitsap/Mason/Pierce counties border where the imaginary line goes south along 198th Ave KPN to water at Rocky Bay in Case Inlet to Thurston county border at Nisqually River at Nisqually Beach, then	Personnel: 154 BLS 0 ILS 17 ALS Vehicles: 21 AMB 17 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
			follows water line north to Chambers Creek Rd W, then east to Waller Rd, then north to River Rd, then east to Freeman Rd E, then north to Yuma St, then east to Meridian-Hwy 161 then north to an imaginary line bordering King County running west along 384th St through city of Milton to Pacific Hwy, then north to a point at 7th St Ct NE where it runs NNW to a point at Water St in Dash Point. There it enters the water and crosses the Puget Sound to meet the point at Colvos Passage.	
Pierce	#2	Steilacoom PS JBLM FD Dupont FD PCFD #3 PCFD #17 PCFD #21 Central Pierce F&R AMR Falck NW MAMC Rural Metro Tacoma FD	**Area #2 (South)** Area 2 is bordered by Thurston County in SW at the Nisqually River at Nisqually Beach, then follows water line north to Chambers Creek Rd W, then along an imaginary line east to Waller Rd, then south along an imaginary line along Mountain Hwy to 260th, then west to 8th Ave E, then south along an imaginary line to Thurston county border at Nisqually River, then west along	Personnel: 592 BLS 1 ILS 174 ALS Vehicles: 39 AMB 56 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
			Nisqually River to Nisqually Beach.	
Pierce	#3	PCFD #26 Greenwater Rescue Carbonado FD PCFD #14 PCFD #23 PCFD #17 PCFD #18 PCFD #21 PCFD #22 Buckley FD Central Pierce F&R AMR Falck NW Rural Metro	**Area #3 (East)** Area #3 is bordered by Thurston County in SW at a point where an imaginary line running south along 8th Ave E would then intersect the Nisqually River, it then follows the Nisqually River east to a Thurston, Pierce, and Lewis Counties junction at Hwy 7 in Elbe, then continues east along Nisqually River to Mt. Rainier Nat'l Park at end of Hwy 706 along imaginary line east to Yakima County border, then NE along imaginary line bordering Yakima, Kittitas, King, Pierce Counties junction at Green River, then west along Green Water River to junction with White River continuing NW along White River to a point in Muckleshoot Indian Reservation where the imaginary line goes along imaginary line along 1st Ave E west through Auburn, then along County Line west to 384th St west to Meridian-Hwy 161, then	Personnel: 592 BLS 0 ILS 245 ALS Vehicles: 103 AMB 76 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
			south to Yuma St, then west to Freeman, then south River Rd, then west to Waller Rd, then south along an imaginary line along Mountain Hwy to 260th, then west to 8th Ave E, then south along an imaginary line to Thurston county border at Nisqually River.	

Thurston County

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Thurston	#1	City of Olympia FD Lacey FD #3 Tumwater FD AMR	City of Olympia jurisdictional boundaries	Personnel: 107 BLS 0 ILS 25 ALS Vehicles: 13 AMB 11 AID
Thurston	#2	City of Olympia FD Lacey FD #3	City of Tumwater jurisdictional boundaries &	Personnel: 26 BLS 0 ILS

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
		Tumwater FD Olympic Ambulance	FD# 15 jurisdictional boundaries	33 ALS Vehicles: 4 AMB 4 AID
Thurston	#3	City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance	City of Lacey jurisdictional boundaries & FD# 3 jurisdictional boundaries	Personnel: 206 BLS 0 ILS 32 ALS Vehicles: 23 AMB 15 AID
Thurston	#4	SE Thurston FA City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance	SETRFA City of Yelm jurisdictional boundaries & FD# 2 jurisdictional boundaries & City of Rainer jurisdictional boundaries & FD# 4 jurisdictional boundaries	Personnel: 46 BLS 0 ILS 0 ALS Vehicles: 3 AMB 7 AID
Thurston	#5	SE Thurston FA City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance	SETRFA City of Yelm jurisdictional boundaries & FD# 2 jurisdictional boundaries & City of Rainer jurisdictional boundaries & FD# 4 jurisdictional boundaries	Personnel: 46 BLS 0 ILS 0 ALS Vehicles: 3 AMB

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
				7 AID
Thurston	#6	Thurston Co FD #17 City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance	FD# 17 jurisdictional boundaries	Personnel: 13 BLS 0 ILS 0 ALS Vehicles: 2 AMB 9 AID
Thurston	#7	South Thurston Fire & EMS City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance	City of Tenino jurisdictional boundaries & FD# 12 jurisdictional boundaries	Personnel: 26 BLS 0 ILS 0 ALS Vehicles: 4 AMB 8 AID
Thurston	#8	South Thurston Fire & EMS City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance	Town of Bucoda jurisdictional boundaries	Personnel: 2 BLS 0 ILS 0 ALS Vehicles: 1 AMB 4 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Thurston	#9	South Thurston Fire & EMS City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance	FD# 16 jurisdictional boundaries	Personnel: 26 BLS 0 ILS 0 ALS Vehicles: 4 AMB 8 AID
Thurston	#10	West Thurston Fire City of Olympia FD Lacey FD #3 Tumwater FD	WTRA FD# 11 jurisdictional boundaries & FD# 1 jurisdictional boundaries	Personnel: 52 BLS 0 ILS 0 ALS Vehicles: 5 AMB 16 AID
Thurston	#11	McLane Black Lake FD City of Olympia FD Lacey FD #3 Tumwater FD	FD# 5 jurisdictional boundaries	Personnel: 35 BLS 0 ILS 0 ALS Vehicles: 4 AMB 12 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Thurston	#12	Thurston Co FD #6 City of Olympia FD Lacey FD #3 Tumwater FD	FD# 6 jurisdictional boundaries	Personnel: 21 BLS 0 ILS 0 ALS Vehicles: 2 AMB 6 AID
Thurston	#13	Thurston Co FD #8 City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance	FD #8 jurisdictional boundaries	Personnel: 37 BLS 0 ILS 0 ALS Vehicles: 2 AMB 10 AID
Thurston	#14	McLane Black Lake FD City of Olympia FD Lacey FD #3 Tumwater FD	FD# 9 jurisdictional boundaries	Personnel: 35 BLS 0 ILS 0 ALS Vehicles: 4 AMB 12 AID

Trauma Response Area by County				
County	**Trauma Response Area Number**	**Name of Agency Responding in Trauma Response Area**	**Description of Trauma Response Area's Geographic Boundaries**	**Number of Verified Services in the response area**
Thurston	#15	TCFD #13 City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance	FD# 13 jurisdictional boundaries	Personnel: 26 BLS 0 ILS 0 ALS Vehicles: 2 AMB 3 AID
Thurston	16	South Thurston Fire Olympic Ambulance	FD# 16 jurisdictional boundaries	Personnel: 26 BLS 0 ILS 0 ALS Vehicles: 4 AMB 8 AID
Thurston	17	Fire Protection dist #13 Olympic Ambulance	FD# 17 jurisdictional boundaries	Personnel: 13 BLS 0 ILS 0 ALS Vehicles: 2 AMB 9 AID

West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 8

Approved EMS Education and Training Programs and Testing Sites

redential #	Status	Expiration Date	Facility Name	Site County
TRNG.ES.60117935-PRO	APPROVED	04/30/2027	Grays Harbor EMS And Trauma Care Council	Grays Harbor
TRNG.ES.60124990-PRO	APPROVED	04/30/2027	Centralia College	Lewis
TRNG.ES.60795337-PRO	APPROVED	04/30/2028	Glenoma Fire and EMS	Lewis
TRNG.ES.60128932-PRO	APPROVED	07/31/2027	Pacific County Fire District #1	Pacific
TRNG.ES.60128987-PRO	APPROVED	04/30/2027	Bates Technical College	Pierce
TRNG.ES.60128993-PRO	APPROVED	04/30/2027	City of Buckley Fire Department	Pierce
TRNG.ES.60122307-PRO	APPROVED	04/30/2028	Pierce College Fort Steilacoom EMS	Pierce
TRNG.ES.60128980-PRO	APPROVED	04/30/2027	Pierce County Emergency Management/EMS	Pierce
TRNG.ES.60116437-PRO	APPROVED	04/30/2028	Tacoma Community College	Pierce
TRNG.ES.60128972-PRO	APPROVED	04/30/2027	Tacoma Fire Department	Pierce
TRNG.ES.60129031-PRO	APPROVED	04/30/2028	Thurston County Medic One	Thurston

8B = ESE/SEIC/SEI

ESE			
County	2023	2024	Change
Grays Harbor	59	80	21
Lewis	56	74	18
Pacific	21	18	-3
Pierce	354	401	47
Thurston	105	140	35
TOTALS:	595	713	118

SEIC			
County	2023	2024	Change
Grays Harbor	0	1	1
Lewis	1	1	0
Pacific	1		-1
Pierce	4	5	1
Thurston	1	5	4
TOTALS:	7	12	5

SEI			
County	2023	2024	Change
Grays Harbor	5	3	-2
Lewis	5	5	0
Pacific	1	1	0
Pierce	18	22	4
Thurston	6	9	3
TOTALS:	35	40	5

Total EMS educators in the West Region = 765

West Region Emergency Medical Services
& Trauma Care System Strategic Plan

Appendix 9

NREMT Testing Sites

(Identify) NATIONAL REGISTRY EMERGENCY MEDICAL TECHNICIAN TESTING SITES		
Facility Name	**Site City**	**Site County**
Pearson Vue	Olympia	Thurston

Appendix 10

Patient Care Procedures

Who To Contact

Grays Harbor and N. Pacific Counties

Medical Program Director	Julie Buck, MD
Grays Harbor County EMS Council	Louisa Schreier

Lewis County

Medical Program Director	Peter McCahill, MD
Lewis County EMS Council	Adam Fullbright

Pierce County

Medical Program Director	Clark Waffle, MD
Pierce County EMS Coordinator	Norma Pancake

Thurston County

Medical Program Director	Larry Fontanilla, MD
Thurston County Medic One	Chris Clem

WA Department of Health

Office of Community Health Systems, EMS Health Systems Quality Assurance	Scott Williams

To Request Additional Copies

West Region EMS & Trauma Care Council	Greg Perry

Patient Care Procedures = Table of Contents

Patient Care Procedure #1

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

Regulatory Framework

RCW 18.73.030 RCW 70.168.015 WAC 246-976-960 WAC 246-976-260
WAC 246-976-390

QI Suggestions

The response times and all agencies that do not meet the state standard will be reviewed by the local MPD and referred to West Region Quality Improvement Forum as necessary. Response times will be tracked over a two-year period and the standards reevaluated based on input from the MPDs and responder agencies.

Intent

To define the minimum level of medical care personnel dispatch to an emergency scene and provide minimum response times.

Guidance

The regional standard for response times and responders shall be in accordance with current WAC 246-976-390 and WAC 246-976-260 as follows:

Verified aid services must meet the following minimum agency response times for response areas as defined by the department and identified in the approved regional plan:

(a) To urban response areas: Eight minutes or less, eighty percent of the time;
(b) To suburban response areas: Fifteen minutes or less, eighty percent of the time;
(c) To rural response areas: Forty-five minutes or less, eighty percent of the time;
(d) To wilderness response areas: As soon as possible.

Verified aid services must provide the following personnel on each trauma response including:

(a) An aid service providing BLS level of care must staff an aid vehicle with at least one emergency medical responder (EMR).
(b) An aid service providing ILS level of care must staff an aid vehicle with at least one advanced emergency medical technician (AEMT).
(c) An aid service providing ALS level of care must staff an aid vehicle with at least one paramedic.

Verified ground ambulance services must meet the following minimum agency response times for all EMS and trauma responses to response areas identified in their department-approved application on file, as defined by the department and identified in the regional plan:

(a) To urban response areas: Ten minutes or less, eighty percent of the time;
(b) To suburban response areas: Twenty minutes or less, eighty percent of the time;
(c) To rural response areas: Forty-five minutes or less, eighty percent of the time;
(d) To wilderness response areas: As soon as possible.

Verified ambulance services must provide the following personnel on each trauma response including:

(a) An ambulance service providing BLS level of care must staff an ambulance with a minimum of at least one emergency medical technician (EMT) and one person certified as an emergency medical responder (EMR) or a driver with a certificate of advanced first aid qualification or department-approved equivalent.
(b) An ambulance service providing ILS level of care must staff an ambulance with a minimum of at least one advanced emergency medical technician (AEMT) and one EMT.
(c) An ambulance service providing ALS level of care must staff an ambulance with a minimum of at least one paramedic and one EMT.

Examples

Per WAC 246-976-430(2) verified prehospital services that transports trauma patients must:

(a) Provide an initial report of patient care to the receiving facility at the time the trauma patient is delivered as described in WAC 246-976-455.

(b) Within twenty-four hours after the trauma patient is delivered, send a complete patient care report to the receiving facility to include the data in WAC 246-976-430, see WREMS PCP #6.

Patient Care Procedure #2

Guidelines for Rendezvous with Agencies that offer Higher Level of Care

REGULATORY FRAMEWORK

WAC 246-976-960

QI Suggestions

This needs to be developed
Non transport to transport
BLS to ALS
BLS and ALS to a Facility

(refer to COPS/Protocols)

Intent

Guidance

Examples

Patient Care Procedure #3

Air Medical Services – Activation and Utilization

Regulatory Framework

See also Air ambulance Service Plan =
https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/530129.pdf

QI Suggestions

The West Region Quality Improvement Forum will review reports by air transport agencies of launches, cancels, and transports. The QI forum may be able to obtain this information:

a. directly from the air medical company or,

b. the destinations or,

c. the State Trauma Registry.

Intent

1. To define who may initiate the request for on-scene emergency medical air transport services.
2. To define under what circumstances nonmedical personnel may request air transport on scene service.
3. To define medical control/receiving center communication and transport destination determination.
4. To reduce prehospital time for transport of trauma patients to receiving facility.

Guidance

Any public safety personnel, medical or non-medical, may call to request on scene air transport when it appears necessary and when prehospital response is not readily available. **This call should be initiated through dispatch services**. In areas where communications with local dispatch is not possible/available, direct contact with the air transport service is appropriate.

Air ambulance activation requires appropriate landing zones are available at or near the scene and at the receiving facility. Consider air transport when:

1) Hoisting might be needed;

2) Helicopter transport will reduce the prehospital time to the greatest extent regarding the trauma triage procedures requirements.

a. (see trauma triage destination procedure) Activation of the helicopter does not predetermine the destination.

Medical control will consider the following in confirming patient destination: location, Estimated Time of Arrival (ETA) of helicopter, availability of ground transportation, proximity of other designated trauma receiving centers, their current capabilities and availability.

The air transport service is responsible for communicating to the initiating dispatch center the estimated time of arrival and significant updates as necessary. Air transport services are subject to their own protocols for appropriate activation. Air transport must contact the initiating dispatch center if unable to respond.

Examples

Patient Care Procedure #4

On Scene Command

Regulatory Framework

QI Suggestions

Significant communication problems affecting patient care will be investigated by the provider agency and if indicated will be reported to the Local EMS Council or, if appropriate, to a higher level of jurisdiction. EMS personnel will maintain the communication equipment and training needed to communicate in accordance with WAC.

The West Region Council will address the issues of communication as needed.

Intent

To define methods of expedient on-scene communication between prehospital personnel and medical control and receiving centers (Medical, Cardiac, Stroke and Trauma facilities).

Guidance

Communications between prehospital personnel, medical control and receiving medical centers, will utilize the most effective communication means to expedite patient information exchange.

The State of Washington, the West Region EMS & Trauma Care Council, and regional designated trauma facilities will coordinate with prehospital and hospital EMS providers to create the most effective communication system based on the EMS provider's geographic location and resource capabilities.

Examples

Communication between the EMS prehospital provider and the receiving center can be direct (provider to center) or indirect (provider to medical control to designated trauma facility). Local medical control will be responsible for establishing communication procedures between the prehospital provider(s) and receiving hospital(s).

Patient Care Procedure #5.1

Pre-Hospital Trauma Triage and Destination Procedure

Regulatory Framework

RCW 18.73.030 RCW 70.168.015 WAC 246-976-960

QI Suggestions

Quality Measures are monitored by the Trauma Quality Improvement Forum. Quarterly data will be reviewed to determine the following system components.

- Adherence to the Washington State Prehospital Trauma Triage Destination Procedure
- 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

Per WAC 246-976-430, each prehospital agency is required to participate in the state data system by submitting a completed patient care report to the facility to which the patient was transported. The West Region Trauma Quality Improvement Forum will review trauma team activation and surgeon activation, as reported by the State Trauma Registry. This will include procedures and guidelines.

Intent

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.

This Procedure also provides the foundation for COP and Protocol development where more specific guidance is necessary at the local level to achieve the above purpose.

Guidance

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 Washington State Prehospital Trauma Triage Destination Procedure.

Examples

Each county should consult their local Protocols and COP's.

Triage is performed by the first arriving EMS unit using the Washington State Prehospital Trauma Triage Destination Procedure.

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. County Operating Procedures (COPs) further define the 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.

Destination for Patients:

Any patient meeting any RED criteria should be transported to the closest level I or II trauma service within 30-minute transport time (air or ground *). Transport times greater than 30 minutes will be taken to the closest, most appropriate trauma service.
*This would include a Level 1 Trauma center outside the West Region (Harborview as an example)

Any patient meeting any YELLOW criteria: Should be transported to a designated trauma service. It need not be the highest level.

Refer to Designated Trauma Centers in the West Region.

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

Specialty Care Services may not be available in every area of the West 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 Washington State Prehospital Trauma Triage Destination Procedure**,** where secondary triage and stabilizing care can take place, and then the patient will be transferred to the most appropriate trauma center capable of definitive care.

Figure 1. Washington State Prehospital Trauma Triage Destination Procedure
(figure 1 is intended to be read from top to bottom, left to right)

RED CRITERIA: High Risk for Serious Injury

INJURY PATTERNS

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

MENTAL STATUS AND VITAL SIGNS

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

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

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

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

Patients meeting any RED criteria should be transported to the 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

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

EMS JUDGEMENT

Consider risk factors, including:

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

If concerned, take to a trauma service.

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

State of Washington
Prehospital Cardiac Triage Destination Procedure

Why triage cardiac patients?

The faster a patient having a heart attack or who's been resuscitated gets treatment, the less likely he or she will die or be permanently disabled. Patients with unstable angina and non-ST elevation acute coronary syndromes (UA/NSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure?

A. **Assess applicability for triage** – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the "Assess Immediate Criteria" box. **NOTE**: Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.

B. **Assess immediate criteria** – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to "Assess Transport Time and Determine Destination" box. If the patient does not meet immediate criteria, or you can't do an ECG, go to the "Assess High Risk Criteria" box.

C. **Assess high risk criteria** – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:

- ☐ 3 or more CAD (coronary artery disease) risk factors:
  - Age ≥ 55: epidemiological data for WA show that incidence of heart attack increases at this age
  - Family history: father or brother with heart disease before 55, or mother or sister before 65
  - High blood pressure: ≥140/90, or patient/family report, or patient on blood pressure medication
  - High cholesterol: patient/family report or patient on cholesterol medication
  - Diabetes: patient/family report
  - Current smoker: patient/family report.
- ☐ Aspirin use in last 7 days: any aspirin use in last 7 days.
- ☐ ≥2 anginal events in last 24 hours: 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
- ☐ Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery.
- ☐ ST deviation ≥ 0.5 mm (if available): ST depression ≥ 0.5 mm is significant; transient ST elevation ≥ 0.5 mm for < 20 minutes is treated as ST-segment depression and is high risk; ST elevation >1 mm for more than 20 minutes places these patients in the STEMI treatment category.
- ☐ Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.

D. **Determine destination** – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For BLS, this is generally within 30 minutes transport time, and for ALS, generally 60 minutes transport time. See below for further guidance. Regional patient care procedures and county operating procedures may provide additional guidance.

E. **Inform the hospital en route so staff can activate the cath lab and call in staff if necessary.**

What if a Level I Cardiac Hospital is just a little farther down the road than a Level II?

You can make slight changes to the 30/60 minute timeframe. The benefits of opening an artery faster at a Level I can outweigh the extra transport time. To determine whether to transport beyond the 30 or 60 minutes, figure the difference in transport time between the Level I Cardiac Hospital and the Level II Cardiac Hospital. For BLS, if the difference is more than 30 minutes, go to the Level II Cardiac Hospital. For ALS, if the difference is more than 60 minutes, go to the level II Cardiac Hospital.

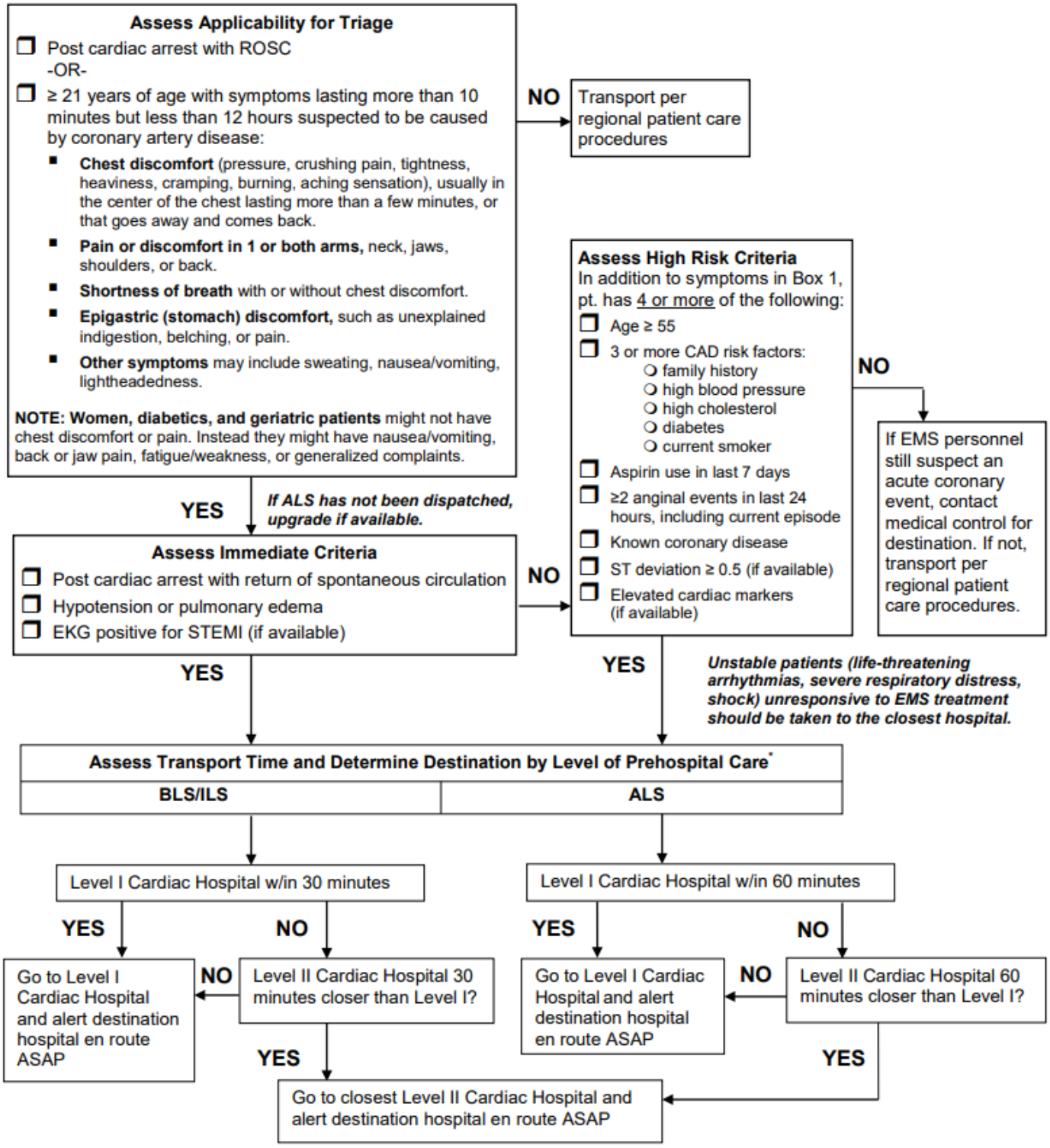
BLS examples: A) minutes to Level I minus minutes to Level II = 29: go to Level I
B) Minutes to Level I minus minutes to Level II = 35: go to Level II

ALS examples: A) minutes to Level I minus minutes to Level II = 45: go to Level I
B) Minutes to Level I minus minutes to Level II = 68: go to Level II

NOTE: We recommend ALS use a fibrinolytic checklist to determine if a patient is ineligible for fibrinolysis. If ineligible, transport to closest Level I hospital even if it's greater than 60 minutes or rendezvous with air transport.

What if there are two or more Level I or II facilities to choose from?

If there are two or more of the same level facilities to choose from within the transport times, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in destination decision.



* **Slight modifications to the transport times may be made in county operating procedures. See page 2.**
Consider ALS and air transport for all transports greater than 30 minutes.
If there are two or more Level I facilities to choose from within the transport timeframe, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in determining destination. This also applies if there are two or more Level II facilities to choose from.

DOH 346-050 April 2011

5.3 Stroke Triage and Destination Procedure

REGULATORY FRAMEWORK

RCW 18.73.030 RCW 70.168.015 WAC 246-976-960

QI Suggestions

West Region prehospital agencies participate in local and regional stroke quality improvement. The West Region Stroke Quality Improvement Forum, as established in October 2012, conducts quality improvement reviews to include all aspects of patient care from prevention, dispatch, pre-hospital, hospital and through rehabilitation.

Intent

In the West Region, patients presenting with stroke signs/symptoms shall be identified and transported according to the State of Washington Prehospital Stroke Triage (Destination) Procedures and County Medical Protocols/County Operating Procedures.

Guidance

See the attached State of Washington Prehospital Stroke Triage Destination Procedure.

As of January 1, 2011, the region will utilize the resources of categorized stroke facilities as they are designated within the region.

Examples

For the most current State of Washington Prehospital Stroke Triage Destination Procedure go to: https://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf

Prehospital Stroke Triage Destination Procedure

STEP 1: Assess Likelihood of Stroke

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

If any of above, proceed to STEP 2, if none, transport per regional PCP/county operating procedures

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

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

If FAST negative, transport per regional/county operating procedures

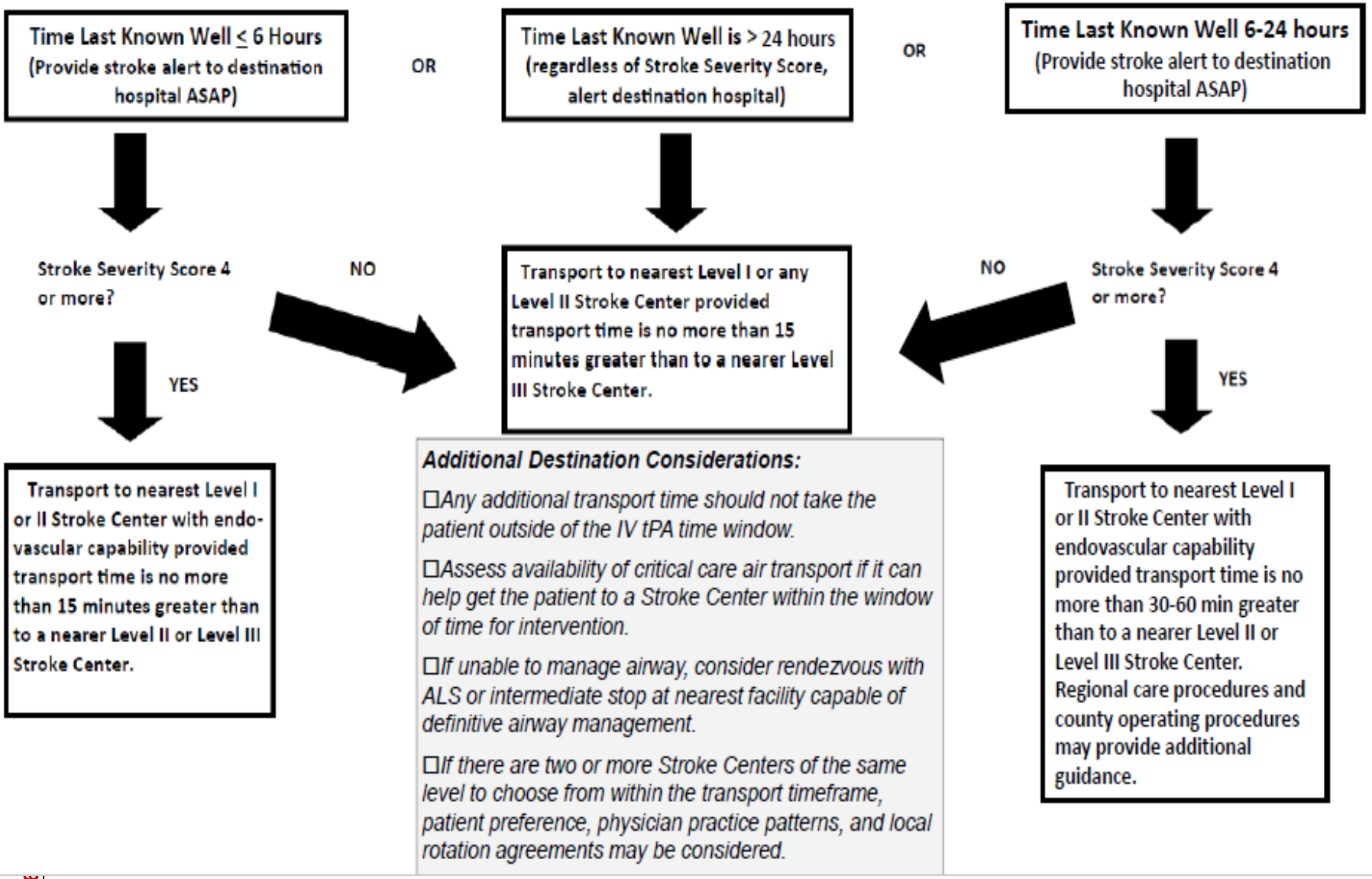
STEP 3: If F.A.S.T. Positive - Calculate Stroke Severity Score (LAMS)

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

Total Stroke Severity Score = (max. 5 points)

DOH 530-182 February 2019

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



The purpose of the Prehospital Stroke Triage and Destination Procedure is to identify stroke patients in the field and take them to the most appropriate hospital, which might not be the nearest hospital. Stroke treatment is time-critical – the sooner patients are treated, the better their chances of survival and recovering function.

For strokes caused by a blocked blood vessel in the brain (ischemic, the majority of strokes), clot-busting medication (tPA) must be administered within 4.5 hours from the time the patient was last known well, a treatment that can be given at WA DOH Level 1, 2 or 3 stroke centers.

If a patient "presents" to EMS with a severe stroke, they are more likely to have blockage of a large vessel and can benefit from mechanical clot retrieval (thrombectomy). Thrombectomy must begin within 24 hours since last known well, and is a more complex intervention, only available in Level I and a small number of Level II stroke centers.

There are 3 key elements to determine the appropriate destination hospital:

- **FAST stroke screen** to identify a patient with a high probability of stroke.
- **Stroke Severity Score** to determine if a patient meets criteria for "severe" stroke.
- **Time since Last Known Well (LKW)** which helps determine eligibility for tPA and thrombectomy.

STEPS to determine destination:

Do a FAST Stroke Screen Assessment: (**F**acial droop, **A**rm drift, **S**peech changes, **T**ime since LKW) is a simple way to tell if someone might be having a stroke. If FAST is negative, stroke is less likely, and standard destination procedures apply. If FAST is positive (face or arms or speech is abnormal), it's likely the patient is having a stroke and the EMS provider moves on to assessing stroke severity.

Assess Stroke Severity Score: The stroke severity assessment scores the FAST stroke screen. Patients get points for deficits:

- **Facial droop** gets 1 point if present, 0 points if absent;
- **Arm drift** (have patient hold arms up in air) gets 2 points if an arm falls rapidly, 1 point if slowly drifts down and 0 points if the arms stay steady;
- **Grip strength** gets 2 points if no real effort can be made, 1 point if grip is clearly there but weak, and 0 points if grips seem of full strength.
- **Add up the points:** A score $\geq$ 4 is interpreted as "severe."

Determine time since LKW: It is important to use the LKW time as opposed to when symptoms were first noticed. If a patient woke up in the morning with symptoms and was well when they went to bed, time LKW is the time they went to bed. If stroke symptoms occur when the patient is awake, LKW could be the same time the symptoms started if the patient or a bystander noticed the onset. LKW time could also be prior to symptoms starting if a patient delays reporting symptoms or, for example, someone discovers a patient with symptoms but saw them well 2 hours prior.

Determine Destination:

- **Time since LKW $\leq$ 6 hours and "Severe" (score $\geq$ 4):** This group benefits from preferential transport to a thrombectomy stroke center. The patient should be taken directly to the nearest thrombectomy stroke center provided it is no more than 15 extra minutes travel compared to the nearest stroke center.

- **Time since LKW is > 24 hours (regardless of severity score):** These patients should be taken to nearest Level I or II stroke center provided it is no more than 15 minutes greater than to a nearer Level III stroke center.
- **Time since LKW 6-24 hours but NOT "Severe":** These patients should be taken directly to the nearest Level I or Level II stroke center provided it is no more than 15 extra minutes travel compared to a nearer Level 3 stroke center.
- **Time since LKW 6-24 hours AND "Severe":** Transport to nearest Level I or II Stroke Center with endovascular capability provided transport time is no more than 30-60 min greater than to a nearer Level II or Level III Stroke Center. Regional care procedures and county operating procedures may provide additional guidance.

Notification: Immediately notify the destination hospital of incoming stroke. If the patient is within 6 hours LKW, call a stroke alert according to county operating procedures or locally determined protocol.

Document: key medical history, medication list and next of kin phone contacts; time on scene; FAST assessment and results (or reason why not); blood glucose level; LKW time (including unknown); and whether the hospital was notified from the field and if it was a stroke alert.

Note: In December 2022, Providence St. Peter Hospital in Thurston County announced that they can no longer accept Stroke patients requiring mechanical thrombectomy for large vessel occlusion. This will leave Thurston County with no comprehensive stroke (Level 1) facility due to a change in their staff. From this time forward, until a change has been announced, the MPD for Thurston County is requesting to immediately start performing a LAMS score and documenting it in your patient record. Starting December 16, 2022, for patients that have a LAMS score of 4 or 5, these patients should be transported to either Tacoma General or St. Joseph's.
This information was also sent to all counties in the West Region.

Note: Stroke procedures are currently under review by the West Region Stroke QIF committee. Changes and suggestions will be available for the new strategic plan.

Note: Refer to Pierce, Gray's Harbor and Lewis Counties COP's regarding BEFAST.

5.4 Transfer to Behavioral Health Facilities

REGULATORY FRAMEWORK

RCW 18.73.030 RCW 70.168.015 WAC 246-976-960

QI Suggestions

The local EMS Council and MPD must establish a quality assurance process to monitor programs.

Intent

In the West Region, licensed EMS ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170, if approved by their county Medical Program Director (MPD).

Guidance

In the state of Washington, Emergency Medical Services (EMS) licensed ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170.

As of December 6, 2017 the MPD and the local EMS and Trauma Care Council must develop a county operating procedure (COP)s. The COP must be consistent with the WA State Department of Health Guideline for Implementation of SHB 1721 and this PCP.

Examples

1. Participation

a. Prehospital EMS agency participation is voluntary unless directed by the county MPD.
b. Receiving mental health and/or chemical dependency facility participation is voluntary.

2. Participating agencies and facilities will adhere to the WA State Department of Health Guideline for Implementation of SHB 1721.

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

4. Prior to implementing and during ongoing operation of transport to alternate receiving facilities the following must be in place with DOH approval:
a. County operating procedure;
b. MPD patient care protocol
c. MPD specialized training for EMS providers participating in transport programs in accordance with RCW 70.168.170.

Washington State Department of Health
Guideline for Implementing SHB 1721
July 2016

Background

In 2015 the Washington State Legislature passed legislation (SHB 1721) allowing emergency medical services ambulance and aid services to transport patients from the field to mental health or chemical dependency services. Participation is voluntary.

The Legislation

SHB 1721 section one calls for the Department of Health (department) in consultation, with the Department of Social and Health Services, to convene a workgroup comprising members of the steering committee and representatives of ambulance services, firefighters, mental health providers, and chemical dependency treatment programs. The workgroup was to establish alternative facility guidelines for developing protocols, procedures, and applicable training appropriate to the level of emergency medical service provider.

The guidelines shall consider when to transport to a mental health facility or chemical dependency treatment program to include:

- The presence of a medical emergency that requires immediate medical care;
- The severity of the mental health or substance use disorder needs of the patient;
- The training of emergency medical service personnel to respond to a patient experiencing emergency mental health or substance abuse disorders; and
- The risk the patient presents to the patient's self, the public, and the emergency medical service personnel.

By July 1, 2016, the department shall make the guidelines available to all regional emergency medical services and trauma care councils for incorporation into the patient care procedures of regional emergency medical services and trauma care plans.

Please forward questions about this document to:

Department of Health
Office of Community Health Systems
EMS and Trauma Section
P.O. Box 47853
Olympia, WA 98504
360-236-2841
HSQA.EMS@doh.wa.gov

What this means for regional EMS and trauma care councils
Regional EMS and trauma care councils shall develop a patient care procedure (PCP) that provides guidance to medical program directors and EMS agencies to operationalize transport of patients to a mental health or chemical dependency treatment facility. The PCP must:

- Direct participating facilities and agencies to adhere to the Washington State Department of Health Guideline for the Implementing SHB 1721 (guideline);
- Identify health care representatives and interested parties to be included in collaborative workgroups for designing and monitoring programs;
- Direct facilities that participate in the program to work with the medical program director (MPD) and EMS entities to reach consensus on criteria that all facilities and EMS entities participating in the program will follow for accepting patients.
- Include a statement that the facility participation is voluntary;
- Direct the local EMS council and MPD to establish a quality assurance process to monitor programs;
- Direct the local EMS council and MPD to develop and establish a county operating procedure (COP) inclusive of the standards recommended by the guideline and PCP, to include dispatch criteria, response parameters and other local nuances to operationalize the program;
- Direct the EMS MPD to establish a patient care protocol (protocol) inclusive of the standards and screening criteria recommended by the guideline and PCP;
- Direct the MPD to develop and implement department-approved education for emergency medical service personnel in accordance with the training requirements of the guideline. Educational programs must be approved by the department.

What this means for Local EMS and Trauma Care Councils
Local EMS and trauma care councils must collaborate with the MPD to develop a COP inclusive of the standards in the guideline. The COP must be consistent with state standards and the PCP.

The COP must include:

- A list of approved mental health and chemical dependency facilities participating in the program;
- Destination determination criteria including considerations for transports that may take the EMS service out of its county of origin;
- A list of options for methods of transport and any pertinent timelines for transport to occur;
- Guidance to EMS providers on when to contact law enforcement, and any procedures that must be considered during EMS and law enforcement interactions;
- Guidance to EMS providers on when to contact the designated mental health professional (DMHP) and any procedures to be considered during an involuntary hold.

What this means for medical program directors
MPDs must develop a patient care protocol inclusive of the standards and screening criteria in the guideline and PCP. The protocol must be consistent with state standards, PCP, and COP. The protocol should assist EMS providers in:

- Determining medical emergency that requires immediate care;
- Assessing the risk the patient presents to the patient's self, the public, and the emergency medical service personnel;
- Determining the severity of mental health or substance use disorder.

MPDs must develop and implement department-approved education for emergency medical service personnel who will respond and transport patients to mental health and chemical dependency facilities. Training must include content that meets the outlined criteria in **Appendix C** of this document.

Washington State Department of Health

Appendix A

EMS Screening Criteria for Transport to Mental Health Services

Inclusion criteria:

Facility:

Reference:

RCW 71.05.020 - Definitions
RCW 71.05.153 - Emergent detention of persons with mental disorders – Procedure

Mental health services authorized to receive patients include; crisis stabilization units, evaluation and treatment facilities and triage facilities.

Mental health services who have elected to operate as an involuntary facility may receive patients referred by a peace officer or a patient in involuntary status by a DMHP.

Patient:

- Voluntary with a mental health chief complaint willing to go to an alternative destination.
- Patients with a mental health chief complaint referred by a peace officer.
- Patients with a mental health chief complaint detained under the Involuntary Treatment Act (ITA) by a DMHP. The proper documents must be completed and signed by a DMHP for reimbursement.
- Patients with mental health complaints must have a clear history of mental health problems. No new onset mental health problems.
- The patient's current condition cannot be explained by another medical issue and traumatic injury is not suspected.
- The EMS agency was dispatched via 911.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- Suicidal patients may accept voluntary care, or may be detained by a peace officer or DMHP.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

Exclusion criteria:

Facility:

- Lack of bed availability
- Intake staff identifies concerns that exceed the ability of the facility to provide adequate care to the patient that requires local hospital emergency department -physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over last 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being utilized that the patient cannot manage.
- New onset of mental health problems. Mental health problem is not clearly indicated in patient history.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.
- Any evidence for acute medical or traumatic problem.

Procedure:

- Scene safety and crisis de-escalation.
- Consider contacting law enforcement to assist EMS with on-scene mitigation of suicidal patients who are not voluntary, and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and illicit drug use.
- Assess for inclusion and exclusion criteria.
- For patients who meet screening criteria, contact receiving center to determine resource availability. MPDs should consider identifying and including a list of available secondary resources other than the emergency room that can be used if a primary resource is unavailable.
- Contact medical control for approval.
- Secure a safe method of transportation identified and approved by the MPD in COPs or protocols.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- At time of patient care transfer, the completed inclusion/exclusion checklist should be provided to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

Washington State Department of Health

Appendix B

EMS Screening Guideline for Transport to Chemical Dependency Services

Inclusion criteria:

Facility:

RCW 70.96A chemical dependency centers, and treatment centers, include sobering centers, and acute and subacute detox centers.

- Facility is identified as a crisis stabilization unit, evaluation and treatment facility, or triage facility that provides chemical dependency treatment services and mental health services.

Patient:

- Voluntary patients with a chemical dependency chief complaint willing to go to an alternative destination.
- Patients with a chemical dependency chief complaint referred by a peace officer.
- Patients with a mental health and/or chemical dependency chief complaint detained under the Involuntary Treatment Act (ITA) by a designated chemical dependency specialist (DCDS). The proper documents must be completed and signed by a DCDS for reimbursement.
- The patient's current condition cannot be not explained by another medical issue.
- The EMS agency was dispatched via 911 or police request.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

Exclusion criteria:

Facility:

- Lack of bed availability.
- Intake staff identifies concerns that require local hospital emergency department - physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose.
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy.
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over past 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being used.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.
- Any evidence for acute medical or traumatic problem.

Procedure:

- Scene safety and crisis de-escalation.
- Contact law enforcement for suicidal patients who are not voluntary, and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and drug use.
- Assess for inclusion and exclusion criteria.

- For patients who meet screening criteria, contact receiving center for resource availability.
- Contact medical control for approval.
- Secure safe method of transportation.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- At time of patient care transfer, provide the completed inclusion-exclusion checklist to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

Washington State Department of Health

Appendix C

Education: The following is the minimum suggested content for department-approved MPD specialized training that shall be provided to EMS providers participating in transport programs authorized by SHB 1721 legislation and operating within the parameters of the guideline. Education programs must be approved by the department. Education must be provided on initial implementation and in an ongoing manner. MPDs may add content to the minimum recommended standards.

I. Review of the Regulatory Framework
- A. SHB 1721 Legislation and Department of Health Guideline
- B. Regional Patient Care Procedure
- C. County Operating Procedure
- D. Patient Care Protocol

II. Define Terms
- A. Receiving centers
  1. Mental Health Centers
  2. Chemical Dependency Centers
- B. Mental Health Professionals
  1. Emergency Social Worker
  2. Designated Mental Health Professional (DMHP)
- C. Involuntary referral
  1. Peace Officer
  2. DMHP
  3. Detainment Laws
  4. Mandatory reporting

III. Behavioral Health Emergencies and Crisis Response
- A. Crisis Intervention
  1. Crisis recognition and assessment
  2. Securing physical safety
     a. Withdraw from contact until scene safe
     b. Contain situation
     c. Call for adequate help
     d. Call for Law Enforcement
  3. Mitigation
  4. Destination decision making/Implementing an action plan
- B. Principles of crisis intervention
  1. Simplicity
  2. Brevity
  3. Innovation
  4. Practicality
  5. Proximity

6. Immediacy
7. Expectancy

C. SAFER-R
1. Stabilize the Situation
2. Acknowledge that something distressing has occurred
3. Facilitate the person's understanding of the situation
4. Encourage the person to make an acceptable plan of action
5. Recovery is evident

D. History/Assessment Tools
1. SAMPLE
2. OPQRST
3. SEA-3
4. MSE

F. Recognition of Increasing Rage/Risk of Violence
1. Bulging neck veins
2. Reddened face
3. Gritted Teeth
4. Muscle tension around jaw
5. Threatening Gestures
6. Threatening Posture
7. Display of a weapon
8. Clenched Fists
9. Wild or staring eyes

G. Suicide
1. Risk factors
2. Overt and covert clues
3. SADPERSONS Suicide assessment scale
4. Steps to bring a suicidal person to safety
   a. Secure the environment
   b. Develop trust and rapport
   c. Engage in a thorough risk assessment
   d. Develop a greater understanding of the person and issues that led up to the current situation
   e. Explore alternatives to suicide
   f. Select the best option for available alternatives
   g. Develop an action plan
   h. Implement the action plan
   i. Refer to appropriate facility

H. Dementia and Delirium
1. Definitions
2. Distinctions
3. Effect and association with emergent medical disorders
   a. Trauma
   b. Infection

c. Alcohol and drugs
d. Toxicology
e. Seizure
f. Stroke
g. Hypoglycemia
h. Metabolic derangements
i. Environmental stressors
j. Endocrine disorders
k. Respiratory failure

I. Alcohol
1. Intoxication
2. Abuse
3. Dependence
4. Withdrawal
a. Seizures
b. Delirium Tremens
c. Wernicke's Encephalopathy and Korsakoff's psychosis

J. Drugs (intoxication and withdrawal)
1. Amphetamines
2. Cocaine
3. Cannabis
4. Hallucinogens
5. Inhalants
6. Opioids
7. PCP
8. Sedatives, hypnotics, anxiolytics
9. Toxidromes
10. Common psychiatric medication side effects

K. Psychosis (schizophrenia and similar disorders)
1. Definitions
2. Association with and mimics of substance abuse and intoxication

L. Mood disorders (depression, mania, Bipolar)
1. Definitions
2. Association with and mimics of medical disorders

M. Anxiety Disorders
1. Definitions
2. Mimics of medical disorders

IV. Review Checklists
A. Inclusion Criteria
1. Patient
2. Facility
B. Exclusion Criteria

1. Patient
2. Facility

C. Procedure
1. Scene management
2. Documentation standards

Washington State Department of Health

Appendix D

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5.5 Pre-Hospital Triage and Destination Procedure – Other

QI Suggestions

Intent

Guidance

Examples

Patient Care Procedure #6

EMS/Medical Control Communications

Regulatory Framework

QI Suggestions

Significant communication problems affecting patient care will be investigated by the provider agency and if indicated it will be reported to the Local EMS Council and if appropriate, to a higher level of jurisdiction. EMS personnel will maintain the communication equipment and training needed to communicate in accordance with WAC.

The West Region Council will address the issues of communication as needed.

Intent

To define methods of expedient communication between prehospital personnel and medical control and receiving centers.

To define methods of communication between medical controls and regional designated trauma facilities and other facilities.

Guidance

Communications between prehospital personnel and medical controls and receiving medical centers will utilize the most effective means of communication to expedite patient information exchange.

Communication between the EMS prehospital provider and the receiving center can be direct (provider to center) or indirect (provider to medical control to designated trauma facility). Local medical control will be responsible for establishing communication procedures between the prehospital provider(s) and receiving hospital(s).

Examples

Patient Care Procedure #7

Divert Guidance for EMS

Regulatory Framework

n/a

QI Suggestions

Significant Divert problems affecting patient care will be investigated by the provider agency and if indicated will be reported to the Local EMS Council and if appropriate to a higher level of jurisdiction. The West Region Council will address the issues of communication as needed.

Intent

The goal is to guide EMS agencies when a hospital reports they are on divert for accepting certain patients.

Guidance

EMS personnel are expected to take under advisement when a hospital reports they are on a certain type of patient divert. If they feel that they cannot safely transport the patient to the next appropriate facility, then the EMS personnel may notify the hospital that they are enroute and provide a report as indicated.
If the patient is being diverted to different facility due to a local COP which specifies why they are being diverted, then EMS must follow that direction. If the patient is unstable and the EMS personnel does not feel the patient can make it to the preferred hospital, then they may choose to come to the initial hospital for further stabilization.
EMS personal must provide clear communication to the receiving hospital if they are making the decision not to follow the request to divert.
EMS may utilize available medical control / Base Station direction for complex cases where they are not clear how to proceed. They will then follow the direction provided from those entities on final destination.

Examples

If a stroke patient is being requested to divert from a non-comprehensive stroke facility to a comprehensive stroke facility due to a criteria in a local COP then EMS must follow that direction if the patient is stable to transport to that destination.
If your trauma patient is unstable and you don't feel you can make it to an appropriate level II facility, then it is acceptable to notify a closer facility you are in route and not able to divert to another facility.

Patient Care Procedure #8

Cross Border Transport

Regulatory Framework

QI Suggestions

N/A

Intent

Guidance

Examples

Patient Care Procedure #9

Inter-Facility Transport Procedure

Regulatory Framework

QI Suggestions

The numbers of and reasons for interfacility transfers will be reviewed by the West Region SAME AS ABOVE

Intent

To establish recommendations for transport of patients from one facility to another facility for continuity / higher level of specialty care.

Guidance

All interfacility transfers will be in compliance with state and local regulations.

Major trauma patients that were transported to undesignated trauma facilities for the purposes of stabilization and resuscitation must be transferred to a designated trauma facility.

The transferring facility must make arrangements for an appropriate level of care during transport.

The receiving center and the receiving medical provider (physician) must both accept the transfer prior to the patient's leaving the sending facility.

All appropriate documentation must accompany the patient to the receiving center.

The transferring physician's orders will be followed during transport as scope of provider care allows. Should the patient's condition change during transport, the sending physician, if readily available, or nearest medical control should be contacted for further orders.

Prehospital protocols from county of origin will be followed during the transport.

To the extent possible, a patient whose condition requires treatment at a higher-level facility should be transferred to an appropriate facility within the region.

The destination medical center will be given the following information:

- Brief history
- Pertinent physical findings
- Summary of treatment
- Response to therapy and current condition

Further orders may be given by the receiving physician.

Examples

Hospital personnel will be oriented to regional transfer requirements and familiarized with state and local regulations.

Patient Care Procedure #10.1 MCI

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

Regulatory Framework

QI Suggestions

Significant problems affecting patient care will be investigated by the provider agency(ies) and reported to same as above for review. A Regional After-Action Review will be conducted as indicated, post a Mass Casualty Incident, to identify issues to resolve prior to any subsequent event.

Intent

To provide direction for the use of appropriate emergency medical care procedures, while in an MCI environment, that is consistent with the Washington State DOH "Mass Casualty-All Hazards Field Protocols" as well as those protocols established by the County Medical Program Director (MPD).

To provide for the standardization/integration of Mass Casualty Incident (MCI) Plans between counties throughout the West Region. To enhance the response capability of EMS agencies between counties throughout the West Region during an MCI incident

Guidance

Pre-hospital EMS responders will follow, their local protocols and:

a. include applicable parts of the Washington State DOH 'Mass Casualty All Hazards Field Protocols', and

b. include county MCI plans using SALT during an All Hazards-MCI incident. Prehospital EMS responders will additionally follow any other All Hazards-MCI protocols/procedures set forth by the County Medical Program Director.

The West Region EMS & Trauma Care Council, Regional Disaster Medical Control Center Hospitals in Region 3 (Providence St. Peter Hospital) and in Region 5 (Good Samaritan Hospital) and EMS agencies throughout the West Region will coordinate to plan the most effective response to an All Hazards-Mass Casualty Incident based on the EMS provider's geographic and resource capabilities. Local medical control and/or emergency management and dispatch agencies will be responsible for communicating and coordinating needs between the prehospital provider agencies and the Incident site(s) during an actual event.

TRAINING

In coordination with the county MPDs and EMS directors, the following will be distributed to the regional EMS agencies:

1. Mass Casualty-All Hazards Field Protocols website address: https://www.doh.wa.gov/Portals/1/Documents/Pubs/530142.pdf
2. West Region Patient Care Procedure # 8, All Hazards-Mass Casualty Incident Response
3. Weapons of Mass Destruction Awareness Level web-based or face-to-face training on signs and symptoms AWR160 www.hsi.wa.gov or www.training.fema.gov
4. Advanced Burn Life Support: http://www.ameriburn.org/ABLS/ABLSNow.htm
5. WMD Emergency Medical Services Training (EMS) face-to-face at http://cdp.dhs.gov/coursesems.html
6. FEMA's NIMS training link: http://www.training.fema.gov/NIMS/

Prehospital Mass Casualty Incident (MCI) General Algorithm

Receive dispatch
Respond as directed
Arrive at scene & Establish Incident Command (IC)
Scene Assessment and size-up
Determine if mass casualty conditions exist
Implement county MCI plan
Request additional resources as needed
The dispatch center shall coordinate notification and dispatch of appropriate agencies and resources to the scene Notification of the Disaster Medical Control Center (DMCC) will be according to county protocol.
The appropriate local Public Health Department shall be notified in events where a public health threat exists.
Identify hazards and determine needs to control or eliminate them. Take immediate action to isolate and deny access (Site Access Control) or mitigate the hazards as necessary to prevent additional injuries. Consider possibility of terrorist attack (WMD, secondary device)
Initiate **SALT**
Reaffirm additional resources
Initiate ICS 201 and/or other similar NIMS compliant worksheets
Upon arrival at medical facilities, transfer care of patients to medical facility staff (medical facility should activate their respective MCI Plan as necessary).
Prepare transport vehicle to return to service

Examples

Patient Care Procedure #10.2 All Hazards

Regulatory Framework

QI Suggestions

Intent

Guidance

See PCP 10.1

Examples

Patient Care Procedure #10.3 Other

Regulatory Framework

QI Suggestions

Intent

Guidance

Examples

Appendix 12

West Region Population

POPULATION - WEST REGION				
SOURCE: https://ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm_april1_population_final.pdf				
	CENSUS 2024	CENSUS 2022	% change	# change
Grays Harbor	**77,400**	**76,400**	**101.3%**	**1,000**
Unincorporated	29,420	29,125	**101.0%**	**295**
percentage of total	38%	38%		
Incorporated	47,980	47,275	**101.5%**	**705**
percentage of total	62%	62%		

	CENSUS 2024	CENSUS 2022	% change	# change
LEWIS	**84,950**	**83,400**	**101.9%**	**1,550**
Unincorporated	50,550	50,185	**100.7%**	**365**
percentage of total	60%	60%		
Incorporated	34,400	33,215	**103.6%**	**1,185**
percentage of total	40%	40%		

	CENSUS 2024	CENSUS 2022	% change	# change
Pierce	**952,600**	**930,553**	**102.4%**	**22,047**
Unincorporated	447,645	440,800	**101.6%**	**6,845**
percentage of total	47%	47%		
Incorporated	504,955	496,600	**101.7%**	**8,355**
percentage of total	53%	53%		

	CENSUS	CENSUS	% change	# change
	2024	2022		
Pacific (represents 50% for WREMS)	11,975	11,800	101.5%	175
Unincorporated	8,093	7,980	101.4%	113
percentage of total	68%	68%		
Incorporated	3,883	3,820	101.6%	63
percentage of total	32%	32%		

	CENSUS	CENSUS	% change	# change
	2024	2022		
Thurston	307,000	300,500	102.2%	6,500
Unincorporated	145,735	143,760	101.4%	1,975
percentage of total	47%	48%		
Incorporated	161,265	156,740	102.9%	4,525
percentage of total	53%	52%		

	CENSUS	CENSUS	% change	# change
	2024	2022		
TOTALS	1,433,925	1,402,653	102.2%	31,272
Unincorporated	681,443	671,850	101.4%	9,593
percentage of total	48%	48%		
Incorporated	752,483	737,650	102.0%	14,833
percentage of total	52%	53%		


WEST REGION
TRAUMA
CARDIAC
MEDICAL
PEDS
EMERGENCY MEDICAL SERVICES