East Region Emergency Medical Services and Trauma Care Council

Strategic Plan

July 1, 2021 – June 30, 2023

Submitted by East Region EMS and Trauma Care Council

Approved by EMS & Trauma Steering Committee ***May 2021***

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INTRODUCTION

The East Region consists of nine counties: Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens and Whitman. The region is 15,810 square miles with a population of approximately 764,270 residents. The region is rural in nature, with Spokane being considered urban with the largest population. There are 83 Licensed and Trauma Verified aid, ambulance, and Emergency Service Support Organization (ESSO) response agencies with 2,183 providers, of which 49% are volunteers. The region has 18 trauma designated facilities, which includes Lewiston, ID, and 17 cardiac and stroke categorized facilities in the region. The East Region is the largest geographic region in the state.

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

- **Adams County**: Adams County spans 1,930 sq. miles, with a population of 19,983. Wheat farming was a main focus of early residents. In 1909 Adams County proclaimed itself "bread basket of the world," with Ritzville reportedly being the world's largest inland wheat exporter. The county has two BLS Verified Ambulance agencies, one agency is currently seeking an upgrade in licensure to ALS, with 33 providers, of which 1% are volunteers. http://eastregion-ems.org/local-councils/adams-county/

- **Asotin County**: Asotin County spans 641 sq. miles with a population of 22,582. Asotin County is part of the Lewiston, ID-WA metropolitan statistical area, which includes Nez Perce County, Idaho, and Asotin County. The Region includes Lewiston in its trauma system. It is the fifth-smallest county in Washington by area. It is part of the Palouse, a wide and rolling prairie-like region of the middle Columbia basin. The county has one ILS verified Aid agency, two ALS Ambulances, one ALS Verified Ambulance, and one BLS Verified Ambulance agency with 124 EMS providers, of which 19% are volunteers.
  http://eastregion-ems.org/local-councils/asotin-county/

- **Ferry County**: Ferry County spans 2,257 sq. miles with a population of 7,649, making it the fourth-least populous county in Washington. It is located on the northern border of WA State. The county has two BLS Verified Ambulances with EMS 24 providers, of which 90% are volunteers.
  http://eastregion-ems.org/local-councils/ferry-county/

- **Garfield County**: Garfield County spans 718 sq. miles with a population of 2,247, making it the least populous county in Washington; with about 3.2 inhabitants per square mile, it is also the least densely populated county in Washington. The county has one BLS Verified Ambulance with 23 providers, of which 88% are volunteers.
  http://eastregion-ems.org/local-councils/garfield-county/

- **Lincoln County**: Lincoln County spans 2,339 sq. miles with a population of 10,740, making it the fifth-least populous county in Washington. Lincoln County lies on the channeled Scablands, known as the Big Bend Plateau. The county has two BLS Verified Aid Agencies, and seven BLS Verified Ambulance agencies with 90 providers, of which 98% are volunteers.
  http://eastregion-ems.org/local-councils/lincoln-county/

- **Pend Oreille County**: Pend Oreille County spans 1,425 sq. miles, located in the northeast corner of Washington, along the Canada–US border, with a population of 13,602. The county has four BLS Verified Aid agencies, three BLS Verified Ambulance Agencies, two ALS Verified Ambulance Agency, and one ESSO with 127 providers, of which 71% are volunteer.
  http://eastregion-ems.org/local-councils/pend-oreille-county/

- **Spokane County**: Spokane County spans 1,781 sq. miles with a population of 522,798, making it the fourth-most populous county in Washington state, the only county in the East region with an urban city. The county has four BLS Aid Agencies, four ALS Verified Aid Agencies, ten BLS Verified Aid agencies, one ALS Ambulance agency, one BLS Verified Ambulance, two ALS Verified Ambulance agencies, and two ESSO with 1,377 providers, of which 35% are volunteers.
  http://eastregion-ems.org/local-councils/spokane-county/

- **Stevens County**: Stevens County spans 2,541 sq. miles with a population of 45,723, ranks 23rd in population to the other counties of Washington State. Only 9.400% of the population lives within the six incorporated cities. The county has one BLS Aid agency, eight BLS Verified Aid agencies, three BLS Verified Ambulance agencies, and one ALS Verified Ambulance agency with 173 providers, of which 81% are volunteers.
  http://eastregion-ems.org/local-councils/stevens-county/

- **Whitman County**: Whitman County spans 2,178 sq. miles with a population of 50, 104. Whitman County is part of the Palouse, a wide and rolling prairie-like region of the middle Columbia basin. Whitman County has highly productive agriculture. Whitman County produces more barley, wheat, dry peas, and lentils than any other county in the United States. The county has nine BLS Verified Aid agencies, six BLS Verified Ambulance agencies, and one ALS Verified Ambulance agencies with 212 providers, of which 80% are volunteers.
  http://eastregion-ems.org/local-councils/whitman-county/

The East Region was established as part of the Emergency Medical Service (EMS) and Trauma Care System Legislation in 1990. Washington State regulations require Council membership to be comprised of Local Government, Prehospital, and Hospital agencies. Additional positions can be Medical Program Directors, Law Enforcement, Federally recognized Tribes, Dispatch, Emergency Management, Local Elected Official and Consumers. Regulation allows counties to have local EMS & Trauma Care Councils and provide EMS & Trauma System leadership.

The East and North Central Region EMS & Trauma Care Councils have successfully consolidated administrative services via contract since July 2013. This consolidation has reduced duplication of administrative services, significantly reducing expenses. It also allows both regions to accomplish the work of the DOH contract while maintaining the same level of system support.

A strong focus has been placed on EMS provider education and injury prevention for all Local Council areas to strengthen the emergency care system. For the volunteer Local Council members; meeting attendance and communication with the Region Council has been difficult. Utilizing new computer based meeting models has increased participation but due to limited human resources, many agencies cannot attend even the on-line meeting model.

Several Local Council Chairs have expressed challenges over the last two years regarding recruitment and retention of rural providers. It has been a consistent theme that is being echoed from our most rural areas that fewer people are in each agency impacting scheduling and response capability to 911 calls. East Region Council has attempted to be very efficient with the limited funding by providing new on-line training, in an effort to help our rural providers obtain current and contemporary education consistent with their OTEP plan.

Medical Program Directors (MPD) are physicians recognized to be knowledgeable in their county's administration and management of pre hospital emergency medical care and services. Medical Program Directors (MPD) are physicians certified by the Department of Health to provide oversight of EMS providers. MPD duties are described in WAC 246-976. MPDs must supervise and provide medical control and direction of certified EMS personnel. This is done verbally and by developing written protocols directing patient care. MPDs must participate with the local and regional EMSTC Councils to develop and revise regional plans.

The East Region's Strategic EMS & Trauma Care System Plan is comprised of goals adapted from the State Strategic EMS & Trauma Care System Plan. The Region Council utilizes input and recommendations from the local council representatives and stakeholders to meet the goals of the State and Region through development of applicable objectives and strategies.

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

- Executive Committee: Comprised of the Council President, Vice President, Treasurer, Secretary, and a County Council representative.

- Training and Education Committee: Comprised of members of the Regional and Local Council to review regional training needs, develop regional training programs based on the needs assessment, and quality improvement for training, and education to improve patient outcomes.

- Prehospital and Transportation Committee: Comprised of members of the Regional and Local Council to review, revise, and provide education on Minimum and Maximum numbers, Regional Patient Care Procedures, and County Operating Procedures.

- Injury and Violence Prevention Committee: Comprised of members of the Regional and Local Council, Regional QI Committee, and IVP Partners to review regional injury, illness and violence statistics; development of regional strategic plan goals and objectives to correlate with highest risk populations in our region for targeted interventions, injury prevention, and public education.

- Rehabilitation Committee: Comprised of members from local and regional rehabilitation centers to develop the regional strategic plan goals and objectives to correlate with highest risk populations in our region for targeted interventions, injury prevention, and public education.

- East Region QI Committee: Comprised of members of each designated facility's medical staff, the RN Coordinator of each service, EMS Providers, Medical Program Directors, Rehabilitation, Trauma Medical Director, and Regional Council members. The Mission of the North Central Region QI Committee is "to promote and support a comprehensive emergency care system in the East Region."

Mission Statement: To promote and support a comprehensive emergency care system.

Vision: To have all EMS agencies verified and all hospital's trauma designated at the appropriate levels in order to provide every person in the region with access to medical service and trauma care in all communities

The East Region Council has had a number of successes during the 2019-2021 planning period:

- Accomplished the work outlined in the 2019-2021 strategic plan including the review of min/max numbers, trauma response area maps, and review of agency information provided by the Department of Health.
- Completed a min/max assessment for Adams County that increased the ability to provide ALS service.
- Completed Council roles and responsibilities education mandated by the State of Washington.
- Completed State Assessment Audits of financial accountability without findings.
- Provided technical guidance to County Councils with min/max review and agency licensure.
- Provided $95,200.00 in FY20/21 to organizations that provided ongoing education to participating EMS providers in the region so they could meet their OTEP requirements
- Continued Administrative Services contract with the North Central Region decreasing Administrative costs and allowing more funding towards Programs.
- Provided $27,015.00 in FY20/21 to support additional education opportunities to EMS Providers that include initial and renewal ESE courses, Initial EMS courses, initial EMS course materials.
- Provided $60,000.00 in FY20/21 to support Injury Prevention and Public Education with a strong focus on the leading cause of death and disability in the East Region; Senior Falls SAIL courses. , Stop the Bleed Campaigns, Car Seat Safety, and Bicycle Safety.
- Participated in Regional Advisory Committee, Prehospital TAC, Licensing and Verification Adhoc Workgroup, EMS Education Workgroup, Rule Making, and attended State Steering Committee meetings.
- Continued recruitment efforts of Council membership with increased participation from County Council members and County Commissioners.
- Regional Council members participated at the County and local level in planning and coordination of COVID-19 vaccination
- EMS Agencies collaborated with Public Health to provide COVID-19 contact tracing, home health checks, and COVID testing.
- Region Council members participated in the EMS & Trauma Care System Assessment and Public Forums.

The East Region Council has had a number of ongoing challengers during the 2019-2021 planning period:

- The East Region Council has encountered ongoing challenges of Council Board vacancies.
- The dissemination of Department of Health updates and information at the EMS Provider level is poor due to outdated contact lists.
- Agencies continue to express their frustrations with the rising cost of initial EMS courses. The Region had a significant decrease in funding within 2008-2013 due to the economy, with no increases to accommodate the rising cost of education in the years that followed.
- Increasing challenges in access to EMS services in rural areas related to a dramatic decrease in volunteers.
- EMS Participation, low attendance, at Regional QI remains a problem for facilities that provide Trauma, Cardiac, and Stroke Care.
- COVID-19 Pandemic placed a significant burden on EMS agencies in response, treatment, and transport. Response costs increased while transport revenues decreased.
- It was reported by EMST partners that many funding opportunities at the Federal, State, and County levels were only made available to publicly funded EMS & Fire services and not made available to private for profit EMS services.

GOAL 1

Maintain, Assess, and Increase Emergency Care Resources

In an effort to increase access to a quality, integrated emergency care system, we involve our local EMS councils and regional Trauma and Emergency Cardiac and Stroke CQI partners to provide input on designation, categorization, and min/max distribution. This approach has resulted in long-term partnerships between our regional system partners and an understanding of local and regional prehospital and hospital issues.

Utilizing the Region EMS TCC Min/Max guidance with standardized methodology to determine the need for minimum and maximum numbers has helped to understand need and duplication of resources. One challenge the East Region has been faced with is to identify agencies and their ability to respond.

The Department has categorized levels of Cardiac and Stroke services. The Region and County Councils have developed regional Patient Care Procedures and County Operating Procedures for patient transport to trauma, cardiac, and stroke services. The Region Council relies on input and recommendations from County Councils and County Medical Program Directors to identify and recommend minimum and maximum numbers for Prehospital levels of licensed and verified agencies, as well as trauma response area maps.

Objective 1: By May 2023, the Region Council will Determine min/max numbers for verified prehospital services.	Strategy 1: By June 2022, Region Council members will attend a meeting of each Local Council to review the process and provide guidance on determining min/max numbers for verified prehospital services.
	Strategy 2: By October 2022, the Region Council will request Local Councils perform a min/max assessment determine min/max needs for their county council area.
	Strategy 3: By January 2023, the Local Councils will provide the results and recommendations of the Local Council min/max assessment for verified prehospital services to the Region Council.
	Strategy 4: By March 2023, the Region Council will submit recommendations, with supporting documentation from Local Councils, to the Department for verified prehospital services as identified by the Local Councils min/max assessment.
Objective 2: By August 2022, the Region Council will Determine min/max numbers	Strategy 1: By March 2022, the Region Council will submit the current Department list of designated trauma and rehabilitation services to the Regional QI

for designated trauma and rehabilitation services.	Committee with request for recommendation of trauma service needs.
	Strategy 2: By June 2022, the Regional QI Committee will submit recommendations to the Region Council for designated trauma and rehabilitation services.
	Strategy 3: By August 2022, the Regional Council will submit recommendations to the Department for designated trauma and rehabilitation services identified by the Regional QI Committee.
Objective 3: By August 2022, the Region Council will review and document categorized cardiac and stroke facilities.	Strategy 1: By March 2022, the Region Council will submit the current Department list of categorized cardiac and stroke services to the Regional QI Committee with request for review and recommendations of cardiac and stroke service needs.
	Strategy 2: By June 2022, the Regional QI Committee will submit recommendations for categorized cardiac and stroke services to the Region Council.
	Strategy 3: By August 2022, the Region Council will submit recommendations for categorized cardiac and stroke services to the Department as identified by the Regional QI Committee.

WA State Department of Health Links:
Trauma Designated Services List
Cardiac and Stroke Categorized Facilities
Interactive Emergency Medical Care Map

GOAL 2

Support Emergency Preparedness Activities

Regional healthcare preparedness and response coordination in North Central Region EMS & Trauma Care Council, South Central Region EMS & Trauma Care Council and East Region EMS & Trauma Care Council is led by the Regional Emergency and Disaster Healthcare Coalition (REDi HCC). The REDi HCC supports healthcare emergency preparedness across the healthcare system to create resilient communities within the nineteen counties and four federally recognized tribes of eastern Washington. To fulfill the coalition mission to ensure quality patient care during medical surge events, the REDi HCC collaborates with all healthcare disciplines and provider types, emergency management, public health and emergency medical services (EMS) on capability-based projects and activities that advance regional planning, training, exercise, response and recovery.

With the consolidation of the Healthcare Coalitions from nine to two; the ability to access and participate in planning and exercises on a frequent basis at the local and regional level have diminished. The REDi Healthcare Coalition continues to host meetings to discuss regional response and include EMS in the Regional Response Plan.

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

Objective 1: During July 2021-June 2023, the Region Council will coordinate with, and participate in, emergency preparedness and response to all hazards incidents, patient transport, and planning initiatives to the extent possible with existing resources.	Strategy 1: On an ongoing basis, the Region Council, Executive Director will distribute emergency preparedness information and updates received from REDi HCC to regional system partners.
	Strategy 2: By July 2022, the Region Council, Executive Director will distribute the REDi HCC Response Plan to regional system partners.
	Strategy 3: By October 2022, the Region Council will develop and/or revise a PCP for Regional patient placement (Disaster Medical Coordinator Center, DMCC) plans.
	Strategy 4: By December 2022, the Region Council will approve a PCP for Regional patient placement (Disaster Medical Coordinator Center, DMCC) plans.
	Strategy 5: By January 2023, the Region Council will submit the PCP for Regional patient placement

	(Disaster Medical Coordinator Center, DMCC) plans to the Department for approval.
	Strategy 6: By March 2023, the Region Council will distribute the Department approved PCP for Regional patient placement (Disaster Medical Coordinator Center, DMCC) plans to regional system partners.
	Strategy 7: On and ongoing basis, The Region Council will report on EMS agency collaborations between local Department of Emergency Management and/or County Public Health Departments during a declared emergency.

Regional Emergency and Disaster Healthcare Coalition (REDi HCC)

GOAL 3

Plan, Implement, Monitor, and Report Outcomes of Programs to Reduce the Incidence and Impact of Injuries, Violence, and Illness in the Region

The East Region promotes programs and policies to reduce the incidence and impact of injuries, violence and illness. Programs supported by the East Region include; Senior Falls/Fall Risk, Safe Kids for bicycle safety and helmet fittings, Child Passenger Safety, and Stop the Bleed Campaigns.

The State and Region Council recognizes there is a significant change in availability of and funding for services within our communities. This will require a multidisciplinary collaborative approach to delivering healthcare in a more efficient and fiscally responsible way in getting "The right patient, to the right facility, with the right transportation, at the right cost, in the right amount of time."

The East Region members of the Region and Local Council, Medical Program Directors, Critical Access Hospital, Hospital Based EMS Agencies, Emergency Room Trauma Coordinators, and other system stakeholders participate in State and National Initiatives for a Community based Paramedicine and/or Mobile Integrated Healthcare System that promotes collaboration of healthcare partners within the East Region to address community challenges for care and/or transport of patients

Objective 1: Annually, by March, the Region Council will review relevant data from Department of Health and other data sources, and utilize regional injury and violence prevention partners to identify and recommend evidence-based and/or best-practice activities to support prevention efforts in the North Central Region.	Strategy 1: Annually, by July, the Region Council will review relevant regional/injury data from Department of Health, and identify regional partners that will provide best-practice prevention programs.
	Strategy 2: Annually, by October, the Region Council will choose regionally funded prevention activities to support recommended by the Injury and Violence Prevention workgroup.
	Strategy 3: Annually, by December, the Region Executive Director, will secure deliverable contracts with selected injury prevention partners to provide injury prevention programs.
	Strategy 4: Annually, by June, the contracted injury prevention partners will provide the Region Council with program activity reports and accomplishments as outlined in the contract agreement.
	Strategy 5: On an ongoing basis, as available, the Region Council will include program activity reports in the bi-monthly deliverable report to Department of Health.

Objective 2: During July 2021-June 2023, the Region Council will identify and explore emerging concepts for Mobile Integrated Healthcare (MIH) Community Paramedicine.	Strategy 1: On an ongoing basis, the Region Council will continue to collaborate with stakeholders to participate in State Initiatives or trainings regarding MIH Community Paramedicine concepts.
	Strategy 2: On an ongoing basis, the Region Council will provide stakeholders with information acquired from Initiatives and trainings pertaining to MIH Community Paramedicine.
	Strategy 3: On an ongoing basis, the Region Council will collaborate with stakeholders to implement Regional PCPs for MIH Community Paramedicine as they are developed.

WA State Department of Health Links:
Trauma Designated Services List
Cardiac and Stroke Categorized Facilities
Interactive Emergency Medical Care Map

GOAL 4

Assess Weaknesses and Strengths of Quality Improvement Programs in the Region

The East Region QI Committee is committed to optimal clinical care and system performance in the Region as it relates to trauma, cardiac, and stroke patients as evidenced by patient outcomes. A multidisciplinary team approach to concurrent and retrospective analysis of care delivery, patient care outcomes and compliance with the requirements of Washington State as per ***RCW 70.168.090*** is the fundamental goal. Region Council members attend the Regional QI Committee meetings and are actively involved in QI for the Region. The Region QI Committee has identified EMS participation as an area of weakness in the regions QI system.

The East Region has a Level I Adult and Pediatric Trauma Rehab Center offering comprehensive physical rehabilitation in a variety of care settings; with representation on the Region and Local Councils. The East Region Rehabilitation committee has members involved in EMS education and State initiatives.

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In July 2019, Substitute Senate Bill 5380 amended RCW 70.168.090, adding requirements for licensed ambulance and aid services to report patient data to the state emergency medical services (EMS) data system.

The Region is active in assisting the DOH Research, Analysis, and Data EMS partners in the transition of EMS partner reporting from hand written records to the use of electronic medical records.

Objective 1: During July 2021-June 2023, the Regional QI Committee will review regional emergency care system performance.	Strategy 1: On an ongoing basis, the Regional QI Committee will identify issues of emergency care system performance during quarterly meetings using key performance indicators.
	Strategy 2: On an ongoing basis, the Region Council representative will participate in Regional QI and report back to the Region Council quarterly.
	Strategy 3: On an ongoing basis, the Region Council will disseminate Regional QI system performance information to EMS partners.
Objective 2: During July 2021-June 2023, the Region Council will support EMS agency participation in WEMSIS.	Strategy 1: By June 2022, the Region Council will distribute legislative updates and reporting requirements for WEMSIS submission to EMS partners within the region.

	Strategy 2: By September 2022, the Region Council will conduct a survey of EMS partners to identify barriers in WEMSIS utilization and agency reporting.
	Strategy 3: By December 2022, the Region Council will provide EMS partner survey results identifying barriers to utilization to the DOH Research, Analysis, and Data section and Workgroup.
	Strategy 4: By March 2023, the Region Council will request DOH Research, Analysis, and Data section provide training in areas identified as barriers to utilization.
Objective 3: During July 2021-June 2023, the East Region Rehabilitation Committee will provide public education to the Region Council and community partners.	Strategy 1: Annually, in October, as resources are available, the Rehabilitation Committee will present a trauma case review to the Regional Council and/or community partners that include all components of the Emergency Care System.
	Strategy 2: On an ongoing basis, the Rehabilitation Committee will post educational opportunities related to trauma topics on the eastregion-ems.org website.

WA State Department of Health Links:
Trauma Designated Services List
Cardiac and Stroke Categorized Facilities
Interactive Emergency Medical Care Map
WA State Data Section and Key Performance Measures

GOAL 5

Promote Regional System Sustainability

Pursuant with RCW 70.168.100 and WAC 246-976-960; The East and North Central Region has demonstrated efficiency by sharing administrative resources since 2013. The two regions maintain independent business operations while serving the needs of the communities.

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

The Regional Training and Education Committee utilizes the EMS Agency Training Survey results to determine funding for educational programs for Prehospital providers.

With the increasing costs for EMS Education, agencies have difficulty with recruitment and retention of EMS Providers. The East Region

The Prehospital and Transportation workgroup reviews County Operating Procedures, Regional Patient Care Procedures, and Min/Max numbers in determining unserved or underserved areas. The workgroup will collaborate with the regional Training and Education Committee to distribute and educate providers on the Regional Patient Care Procedures and County Operating Procedures.

Objective 1: During July 2021-June 2023, the Region Council will manage the business of the Council, 501(c)(3) status, and Department contractual work, of the Regional Council. WAC	Strategy 1: Annually, by June, the Region Council will review and approve a fiscal year budget for Administration and Programs as outlined in the Department contract.
	Strategy 2: On an ongoing basis, the Region Council will review and approve financial reports and Department contract deliverables.
	Strategy 3: On an ongoing basis, the Region Council, Executive Director, will coordinate Council and Committee meetings and communications with regional partners.
	Strategy 4: On an ongoing basis, the North Central and East Region councils will continue to evaluate the collaboration of administrative resources and additional opportunities for sustainability.
Objective 2: During July 2021-June 2023, the Region Council will manage Regional Council	Strategy 1: Annually by January, the Region Council will review current membership to identify and recruit for open positions.

membership to ensure membership as outlined in RCW is represented.	Strategy 2: On an ongoing basis, the Region Council, Executive Director, will maintain a current roster with Regional Council membership positions, appointment expirations, and maintain records of all Council appointments and reappointments.
	Strategy 3: On an ongoing basis, the Region Council, Executive Director, will maintain a current roster with Regional Council member compliance with Open Pubic Meeting Act and other pertinent council member training.
Objective 3: Annually, by June, the Region Council will enhance workforce development, and support training and education for prehospital providers.	Strategy 1: By February 2022, the Regional Training and Education Committee will distribute a Needs Assessment Survey to EMS Agencies, providers, and MPDs.
	Strategy 2: Annually, by April, the Regional Training and Education Committee will review the compiled results of the Needs Assessment Survey.
	Strategy 3: Annually by June, the Regional Training and Education Committee will utilize the results of the Needs Assessment Survey to determine a fiscal year training plan and budget.
	Strategy 4: Annually, by June, the Regional Training and Education Committee will submit the proposed fiscal year training plan and program budget to the Region Council for approval.
	Strategy 5: Annually, by July, the Region Council will submit the compiled results of the Needs Assessment Survey to the Department with the Region Council approved program budget.
Objective 4: During July 2021-June 2023, the Region Council will review and update regional Patient Care Procedures (PCPs); and work toward statewide standardization of Regional PCPs.	Strategy 1: On an ongoing basis, the Regional Prehospital and Transportation Committee will utilize Department of Health guidance document and format to review Regional Patient Care Procedures (PCPs).
	Strategy 2: On and ongoing basis, the Regional Prehospital and Transportation Committee will include system partners, local councils, and county MPDs in review and development of Regional PCPs.
	Strategy 3: Annually by February, the Regional Prehospital and Transportation Committee will review, develop, and submit recommended drafts and revisions of the Regional PCPs to the Regional Council for approval.

	Strategy 4: Annually by April, the Region Council will submit approved Regional PCPs to the Department for approval.
	Strategy 5: Annually, by July, The Region Council will distribute Department approved Regional PCPs to system partners, local councils, and Medical Program Directors.

WA State Department of Health Links:
Trauma Designated Services List
Cardiac and Stroke Categorized Facilities
Interactive Emergency Medical Care Map

APPENDICIES

NOTE: The appendices within this plan contain detailed charts with specific information for use in system planning. These are living documents and as such change during the plan period. The use of links (as available) to the WA DOH website will provide the most current information.

Appendix 1. Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Services (General Acute Trauma Services).

Level	State Approved		Current Status
	Min	Max	
I	0	0	0
II	1	3	1
III	3	4	4
IV	4	7	5
V	3	9	7
II P	1	2	1
III P	1	2	1

WA State Department of Health Resource links:
Trauma Designated Services Facility List
Trauma Designated Services Minimum/Maximum List

Appendix 2. Washington State Emergency Care Categorized Cardiac and Stroke System Hospitals.

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

WA State Department of Health Resource links:
Cardiac and Stroke Categorized Facilities

Appendix 3. Approved Minimum/Maximum (Min/Max) numbers of Designated Rehabilitation Trauma Care Services

Level	State Approved		Current Status
	Min	Max	
I-R			1
I-PR			1
II-R	1	2	0
II-PR			0

WA State Department of Health Resource links:
Trauma Designated Services Minimum/Maximum List

Appendix 4. EMS Resources, Prehospital Verified Services, Prehospital Non-Verified Services.

County	Credential #	Agency Name	City	Agency Type	Care Level	Ground Vehicles		Personnel		
						# AMB	# AID	# BLS	# ILS	# ALS
Adams	**2**					**7**	**0**	**27**	**5**	**1**
	AMBV.ES.00000001	East Adams Rural Hospital	Ritzville	AMBV	ALS	4	0	21	0	1
	AMBV.ES.00000002	Othello Ambulance Service	Othello	AMBV	BLS	3	0	6	5	0
Asotin	**5**					**21**	**6**	**65**	**7**	**52**
	AIDV.ES.00000004	Clarkston Fire Department	Clarkston	AIDV	ILS	0	3	3	3	10
	AMB.ES.60115262	Clarkston Fire Department	Clarkston	AMB	ALS	4	0	5	0	4
	AMB.ES.60534793	PACT EMS	Moscow	AMB	ALS	7	0	7	0	5
	AMBV.ES.00000904	Lewiston Fire Department	Lewiston	AMBV	ALS	7	0	24	4	33
	AMBV.ES.60444690	Asotin Co. Fire District #1	Clarkston	AMBV	BLS	3	3	26	3	0
Ferry	**2**					**7**	**0**	**22**	**2**	**0**
	AMBV.ES.00000123	North Ferry County Ambulance	Curlew	AMBV	BLS	3	0	9	2	0
	AMBV.ES.00000126	Ferry CO EMS District No 1	Republic	AMBV	BLS	4	0	13	0	0
Garfield	**1**					**2**	**0**	**22**	**1**	**0**
	AMBV.ES.00000137	Garfield County Fire District #1	Pomeroy	AMBV	BLS	2	0	22	1	0
Lincoln	**9**					**10**	**9**	**76**	**12**	**2**
	AIDV.ES.00000412	Lincoln County Fire Protection District #4	Reardan	AIDV	BLS	0	3	17	0	0

	AIDV.ES.60094304	Lincoln County Fire District #7	Creston	AIDV	BLS	0	1	1	2	0
	AMBV.ES.00000410	Lincoln County Fire District #1	Sprague	AMBV	BLS	2	1	7	1	0
	AMBV.ES.00000413	Lincoln County Fire Protection District No. 6	Harrington	AMBV	BLS	1	0	6	0	0
	AMBV.ES.00000416	Creston Ambulance Service	Creston	AMBV	BLS	1	0	9	4	0
	AMBV.ES.00000417	Wilbur Fire Department	Wilbur	AMBV	BLS	1	2	7	1	0
	AMBV.ES.00000420	Odessa Ambulance	Odessa	AMBV	BLS	2	0	11	1	0
	AMBV.ES.60456753	Davenport Ambulance	Davenport	AMBV	BLS	2	0	13	1	2
	AMBV.ES.60744082	Lincoln County Fire District 8	Almira	AMBV	BLS	1	2	5	2	0
Pend Oreille	**10**					**13**	**23**	**106**	**5**	**16**
	AIDV.ES.00000471	Pend Oreille County Fire District #5	Cusick	AIDV	BLS	0	3	3	0	0
	AIDV.ES.00000472	Pend Oreille Fire District #6	Newport	AIDV	BLS	0	2	3	0	0
	AIDV.ES.60104745	Pend Oreille County Fire District #8	Newport	AIDV	BLS	0	1	2	0	0
	AMBV.ES.00000468	Pend Oreille County Fire District #2	Ione	AMBV	BLS	3	3	21	0	6
	AMBV.ES.00000481	Ponderay Newsprint Ambulance	Usk	AMBV	BLS	1	0	3	0	0
	AMBV.ES.60620522	Kalispel Tribal Fire Department	Usk	AMBV	BLS	2	5	6	1	0
	AMBV.ES.60683795	Pend Oreille Co Fire Protection District #4	Newport	AMBV	BLS	3	1	19	2	1
	AMBV.ES.60720550	South Pend Oreille Fire and Rescue	Newport	AMBV	BLS	3	7	34	2	1
	AMBV.ES.60834025	Pend Oreille Paramedics	Newport	AMBV	ALS	3	1	10	0	8
	ESSO.ES.60281196	Pend Oreille Operations	Mataline Falls	ESSO		0	0	5	0	0
Spokane	**25**					**56**	**201**	**979**	**46**	**352**
	AID.ES.60352468	Northern Quest Resort and Casino	Airway Heights	AID	BLS	0	1	3	1	3
	AID.ES.60419544	Fairchild AFB Fire Department	Fairchild Air Force Base	AID	BLS	0	5	12	0	0
	AID.ES.60551074	Mount Spokane Ski Patrol	Spokane	AID	BLS	0	1	4	0	0
	AID.ES.60777437	Spokane County Raceway	Airway Heights	AID	BLS	0	3	0	0	0

	AIDV.ES.00000663	Spokane Valley Fire Department	Spokane Valley	AIDV	ALS	0	13	124	1	41
	AIDV.ES.00000665	Spokane County Fire District # 3	Cheney	AIDV	BLS	0	12	79	1	0
	AIDV.ES.00000666	Spokane County Fire District 4	Chattaroy	AIDV	BLS	0	34	128	2	10
	AIDV.ES.00000667	Spokane County Fire District #5	Nine Mile Falls	AIDV	BLS	0	5	5	1	0
	AIDV.ES.00000669	Spokane County Fire Protection District #8	Valleyford	AIDV	ALS	0	13	47	1	16
	AIDV.ES.00000670	Spokane County Fire District #9	Mead	AIDV	ALS	0	25	88	3	26
	AIDV.ES.00000671	Spokane County Fire District #10	Airway Heights	AIDV	BLS	0	12	48	2	0
	AIDV.ES.00000672	Spokane County FPD #11	Rockford	AIDV	BLS	0	3	15	1	0
	AIDV.ES.00000673	Spokane County Fire District #12	Waverly	AIDV	BLS	0	3	5	0	0
	AIDV.ES.00000674	Newman Lake Fire and Rescue	Newman Lake	AIDV	BLS	0	2	9	5	0
	AIDV.ES.00000691	Airway Heights Fire Department	Airway Heights	AIDV	BLS	0	4	34	1	0
	AIDV.ES.00000692	City of Cheney Fire Department	Cheney	AIDV	BLS	0	4	4	5	3
	AIDV.ES.00000697	Spokane Fire Department	Spokane	AIDV	ALS	0	43	255	3	97
	AIDV.ES.60424330	Spokane International Airport Fire Department	Spokane	AIDV	BLS	0	1	12	0	0
	AIRV.ES.60019210	Life Flight Network	Aurora	AIDV	BLS	0	1	10	0	0
	AMB.ES.60661477	Life Flight Network	Aurora	AMB	ALS	5	0	12	0	28
	AMBV.ES.00000664	Fairfield Ambulance Service	Fairfield	AMBV	BLS	1	0	4	0	0
	AMBV.ES.00000709	American Medical Response	Spokane	AMBV	ALS	42	11	57	7	83
	AMBV.ES.00000712	Deer Park Volunteer Ambulance	Deer Park	AMBV	ALS	5	2	49	10	5
	ESSO.ES.60285027	Goodrich Landing Systems (UTC) Aerospace Systems	Spokane	ESSO		0	0	4	0	0
	ESSO.ES.60451720	Spokane County Sheriff's Office	Spokane	ESSO		0	0	4	0	0
Stevens	**13**					**12**	**45**	**134**	**39**	**0**
	AID.ES.60330867	49 Degrees North Ski Patrol	Chewelah	AID	BLS	0	0	7	0	0
	AIDV.ES.00000722	Stevens County Fire Protection District #1	Clayton	AIDV	BLS	0	8	34	15	0

	AIDV.ES.00000723	Stevens County Fire District #4	Valley	AIDV	BLS	0	13	14	0	0
	AIDV.ES.00000724	Stevens County Fire District 7/Arden Fire Department	Colville	AIDV	BLS	0	11	13	1	0
	AIDV.ES.00000725	Joint Fire Protection District #3 and #8	Kettle Falls	AIDV	BLS	0	4	9	3	0
	AIDV.ES.00000726	Stevens County Fire Protection District #12	Rice	AIDV	BLS	0	2	5	0	0
	AIDV.ES.00000730	Northport Fire Department 1st Response	Northport	AIDV	BLS	0	2	6	0	0
	AIDV.ES.60019790	Stevens County Fire District #5	Addy	AIDV	BLS	0	3	8	0	0
	AIDV.ES.60839524	Stevens County Fire District #13	Evans	AIDV	BLS	0	2	3	0	0
	AMBV.ES.00000733	Stevens County Sheriffs Ambulance	Colville	AMBV	BLS	5	0	12	8	0
	AMBV.ES.00000734	Chewelah Rural Ambulance Association	Chewelah	AMBV	BLS	3	0	12	7	0
	AMBV.ES.60448538	Spokane Tribal Emergency Response	Wellpinit	AMBV	BLS	3	0	11	6	0
	AMBV.ES.60800657	Deer Park Volunteer Ambulance	Deer Park	AMBV	ALS	1	0	3	0	0
Whitman	**16**					**18**	**34**	**174**	**15**	**23**
	AIDV.ES.00000835	Palouse EMS	Palouse	AIDV	BLS	0	1	12	0	0
	AIDV.ES.00000836	Whitman County FPD #5	Lamont	AIDV	BLS	0	2	2	0	0
	AIDV.ES.00000838	Steptoe Fire Department	Steptoe	AIDV	BLS	0	2	4	1	0
	AIDV.ES.00000840	Whitman County Fire Protection District #14	Colton	AIDV	BLS	0	2	14	0	0
	AIDV.ES.00000845	Whitman County Fire District #10	Oakesdale	AIDV	BLS	0	2	2	0	0
	AIDV.ES.00000848	St. John Volunteer Fire Department	Saint John	AIDV	BLS	0	3	9	0	0
	AIDV.ES.00000850	Colfax Fire Department	Colfax	AIDV	BLS	0	3	5	0	0
	AIDV.ES.60340004	Whitman County Fire District No. 6	Endicott	AIDV	BLS	0	1	5	0	0
	AIDV.ES.60506154	Pullman-Moscow Regional Airport Fire Department	Pullman	AIDV	BLS	0	1	6	0	0

	AMBV.ES.00000846	Pullman Fire Department	Pullman	AMBV	ALS	5	10	35	3	22
	AMBV.ES.00000852	Garfield-Farmington EMS	Garfield	AMBV	BLS	2	1	7	0	1
	AMBV.ES.00000853	Tekoa Community Ambulance Association	Tekoa	AMBV	BLS	2	0	10	0	0
	AMBV.ES.00000854	Volunteer Firemen Inc	Colfax	AMBV	BLS	3	0	28	4	0
	AMBV.ES.60044365	Whitman County Fire District No 8	Lacrosse	AMBV	BLS	1	0	8	0	0
	AMBV.ES.60679634	Whitman County Fire District #7	Rosalia	AMBV	BLS	2	3	11	6	0
	AMBV.ES.60858728	Whitman County Rural Fire Protection District #12	Pullman	AMBV	BLS	3	3	16	1	0

Numbers are current as of March 2021 EMS Resource List

Total Prehospital Verified Services by County*						
County	**AMBV-ALS**	**AMBV-ILS**	**AMBV-BLS**	**AIDV-ALS**	**AIDV-ILS**	**AIDV-BLS**
Adams	1	0	1	0	0	0
Asotin	1	0	1	0	1	0
Ferry	0	0	2	0	0	0
Garfield	0	0	1	0	0	0
Lincoln	0	0	7	0	0	2
Pend Oreille	1	0	4	0	0	3
Spokane	2	0	1	4	0	10
Stevens	1	0	3	0	0	8
Whitman	1	0	6	0	0	9

***Numbers are current as of March 2021 EMS Resource List**

Total Prehospital Non-Verified Services by County*							
County	**AMB-ALS**	**AMB-ILS**	**AMB-BLS**	**AID-ALS**	**AID-ILS**	**AID-BLS**	**ESSO**
Adams	0	0	0	0	0	0	0
Asotin	2	0	0	0	0	0	0
Ferry	0	0	0	0	0	0	0
Garfield	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0
Pend Oreille	0	0	0	0	0	0	01
Spokane	1	0	0	1	0	3	2
Stevens	0	0	0	0	0	1	0
Whitman	0	0	0	0	0	0	0

***Numbers are current as of February 2021 EMS Resource List**

Appendix 5. Approved Minimum/Maximum (Min/Max) numbers of Verified Trauma Services by Level and Type by County.

Approved Min/Max numbers of Verified Trauma Services by Level and Type by County

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Adams	AIDV	BLS	0	0	0
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	2	2	1
		ILS	0	0	0
		ALS	1	2	1
Asotin	AIDV	BLS	1	1	0
		ILS	1	1	1
		ALS	0	0	0
	AMBV	BLS	1	1	1
		ILS	0	0	0
		ALS	1	1	1 (Idaho)

*Adams County: In order to avoid inefficient and unnecessary duplication of ALS services; the intent of the AMBV ALS max of two is intended to equitably distribute ALS resources within the county.

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Ferry	AIDV	BLS	0	0	0
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	2	2	2
		ILS	0	0	0
		ALS	0	0	0

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Garfield	AIDV	BLS	0	0	0
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	1	1	1
		ILS	0	0	0
		ALS	0	0	0

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Lincoln	AIDV	BLS	2	3	2
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	6	8	7
		ILS	0	0	0
		ALS	0	0	0

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Pend Oreille	AIDV	BLS	6	7	3
		ILS	0	0	0
		ALS	0	0	0
	AMBV	BLS	2	7	4
		ILS	0	0	0
		ALS	0	2	1

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Spokane	AIDV	BLS	12	12	10
		ILS	0	0	0
		ALS	4	4	4
	AMBV	BLS	1	1	1
		ILS	0	0	0

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
		ALS	2	2	2

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Stevens	**AIDV**	**BLS**	4	9*	8
		ILS	0	2	0
		ALS	0	0	0
	AMBV	**BLS**	3	5	3
		ILS	0	2	0
		ALS	1	2*	1

*Denotes Min/Max adjustment approved by Steering Committee 5/18/2022

County	Verified Service Type	Care Level	State Approved Minimum #	State Approved Maximum #	Current Status (total # verified for each service type)
Whitman	**AIDV**	**BLS**	10	13	9
		ILS	0	0	0
		ALS	0	0	0
	AMBV	**BLS**	8	13	6
		ILS	1	5	0
		ALS	1	1	1

WA State Department of Health Resource links:
Interactive Emergency Medical Care Map

Appendix 6. Trauma Response Areas (TRAs) by County.

*Key: For each level the type and number should be indicated	
Aid-BLS = A	Ambulance-BLS = D
Aid-ILS = B	Ambulance-ILS = E
Aid-ALS = C	Ambulance-ALS = F

Adams County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries** (Description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS to describe as available	**Type and # of Verified Services available in each Response Areas** (*Use key below – **See explanation)
Adams	101	GIS description is on file with the Department Of Health	D-1
Adams	102	GIS description is on file with the Department Of Health	D-1
Adams	103	GIS description is on file with the Department Of Health	D-1
Adams	104	GIS description is on file with the Department Of Health	D-1
Adams	105	GIS description is on file with the Department Of Health	D-1
Adams	106	GIS description is on file with the Department Of Health	D-1

Asotin County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries** (Description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS to describe as available	**Type of Verified Services in each area**
Asotin	201	GIS description is on file with the Department Of Health	B-1 F-1
Asotin	202	GIS description is on file with the Department Of Health	B-1 F-1
Asotin	203	GIS description is on file with the Department Of Health	B-1 F-1

*Key: For each level the type and number should be indicated	
Aid-BLS = A	Ambulance-BLS = D
Aid-ILS = B	Ambulance-ILS = E
Aid-ALS = C	Ambulance-ALS = F

Ferry County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries** (Description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS to describe as available	**Type of Verified Services in each area**
Ferry	1001	GIS description is on file with the Department Of Health	D-2
Ferry	1002	GIS description is on file with the Department Of Health	D-4,
Ferry	1003	GIS description is on file with the Department Of Health	
Ferry	0CCT	GIS description is on file with the Department Of Health	

Garfield County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries** (Description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS to describe as available	**Type and # of Verified Services in each Response Area**
Garfield	1	GIS description is on file with the Department Of Health	A1 D1
Garfield	0	GIS description is on file with the Department Of Health (Covered by Oregon)	NA

*Key: For each level the type and number should be indicated	
Aid-BLS = A	Ambulance-BLS = D
Aid-ILS = B	Ambulance-ILS = E
Aid-ALS = C	Ambulance-ALS = F

Lincoln County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries** (Description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS to describe as available	**Type and # of Verified Services in each Area**
Lincoln	2201	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2202	GIS description is on file with the Department Of Health	A-3 D-2
Lincoln	2203	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2204	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2205	GIS description is on file with the Department Of Health	D-1
Lincoln	2206	GIS description is on file with the Department Of Health	D-1
Lincoln	2207	GIS description is on file with the Department Of Health	A-2 D-2
Lincoln	2208	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2209	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2210	GIS description is on file with the Department Of Health	D-1
Lincoln	2211	GIS description is on file with the Department Of Health	D-1
Lincoln	2212	GIS description is on file with the Department Of Health	A-2 D-1
Lincoln	2213	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2214	GIS description is on file with the Department Of Health	D-1
Lincoln	2215	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2216	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2217	GIS description is on file with the Department Of Health	D-1
Lincoln	2218	GIS description is on file with the Department Of Health	A-1 D-1

Lincoln	2219	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2220	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2221	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2222	GIS description is on file with the Department Of Health	D-1
Lincoln	2223	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2224	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2225	GIS description is on file with the Department Of Health	A-1 D-1
Lincoln	2226	GIS description is on file with the Department Of Health	

Pend Oreille County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services in each Response Areas * Use key**
Pend Oreille	2604	GIS description is on file with the Department Of Health	A-1 D-1
Pend Oreille	2602	GIS description is on file with the Department Of Health	A-1 D-1
Pend Oreille	2604	GIS description is on file with the Department Of Health	A-1 D-1
Pend Oreille	2604	GIS description is on file with the Department Of Health	A-1 D-1
Pend Oreille	2605	GIS description is on file with the Department Of Health	A-1 D-1
Pend Oreille	2606	GIS description is on file with the Department Of Health	A-1 D-1
Pend Oreille	2604	GIS description is on file with the Department Of Health	A-1 D-1
Pend Oreille	2608	GIS description is on file with the Department Of Health	A-1 D-1
Pend Oreille	2609	GIS description is on file with the Department Of Health	D-1
Pend Oreille	3201	GIS description is on file with the Department Of Health	D-1
Pend Oreille (2)	60164514	The geographical location and all areas inclusive of the area owned by the Kalispell Tribe.	Licensed but not verified.

***Key: For each level the type and number should be indicated**

Aid-BLS = A	Ambulance-BLS = D
Aid-ILS = B	Ambulance-ILS = E
Aid-ALS = C	Ambulance-ALS = F

Spokane County	Trauma Response Area	Description	Type and # of Verified Services in each area
Spokane	3201	GIS description is on file with the Department Of Health	C-1 F-1
Spokane	3202	GIS description is on file with the Department Of Health	A-1 D-1 F-1
Spokane	3203	GIS description is on file with the Department Of Health	C-1 F-1
Spokane	3204	GIS description is on file with the Department Of Health	A-1 F-2
Spokane	3205	GIS description is on file with the Department Of Health	C-1 F-1
Spokane	3206	GIS description is on file with the Department Of Health	C-1 F-1
Spokane	3207	GIS description is on file with the Department Of Health	A-1 F-1
Spokane	3208	GIS description is on file with the Department Of Health	C-1 F-1
Spokane	3209	GIS description is on file with the Department Of Health	A-1 F-1
Spokane	3210	GIS description is on file with the Department Of Health	A-1 F-1
Spokane	3211	GIS description is on file with the Department Of Health	A-1 F-1
Spokane	3212	GIS description is on file with the Department Of Health	A-1 F-1
Spokane	3213	GIS description is on file with the Department Of Health	A-1 F-1
Spokane	3214	GIS description is on file with the Department Of Health	A-1 F-1
Spokane	3215	GIS description is on file with the Department Of Health	A-1 F-1
Spokane	3216	GIS description is on file with the Department Of Health	A-2 F-1
Spokane	3217	GIS description is on file with the Department Of Health	
Spokane	ONB	GIS description is on file with the Department Of Health	

***Key: For each level the type and number should be indicated**

Aid-BLS = A	Ambulance-BLS = D
Aid-ILS = B	Ambulance-ILS = E
Aid-ALS = C	Ambulance-ALS = F

Stevens County	Trauma Response Area	Description	Type and # of Verified Services in each area
Stevens	#3301	GIS description is on file with the Department Of Health	A-1 D-1
Stevens	#3302	GIS description is on file with the Department Of Health	A-1 D-1
Stevens	#3303	GIS description is on file with the Department Of Health.	D-1
Stevens	#3304	GIS description is on file with the Department Of Health	D-1
Stevens	#3305	GIS description is on file with the Department Of Health	A-1 D-1
Stevens	#3306	GIS description is on file with the Department Of Health	D-1
Stevens	#3307	GIS description is on file with the Department Of Health	D-1
Stevens	#3308	GIS description is on file with the Department Of Health	A-1 D-1 F-1
Stevens	#3309	GIS description is on file with the Department Of Health	A-1 D-1
Stevens	3310	GIS description is on file with the Department Of Health	D-1
Stevens	#3311	GIS description is on file with the Department Of Health	A-1 D-1
Stevens	#3312	GIS description is on file with the Department Of Health	
Stevens	#3313	GIS description is on file with the Department Of Health	
Stevens	#3314	GIS description is on file with the Department Of Health	
Stevens	#3315	GIS description is on file with the Department Of Health	
Stevens	#3316	GIS description is on file with the Department Of Health	
Stevens	#3317	GIS description is on file with the Department Of Health	
Stevens	#3318	GIS description is on file with the Department Of Health	
Stevens	#3319	GIS description is on file with the Department Of Health	
Stevens	#3320	GIS description is on file with the Department Of Health	
Stevens	#3321	GIS description is on file with the Department Of Health	
Stevens	#3322	GIS description is on file with the Department Of Health	
Stevens	#3323	GIS description is on file with the Department Of Health	
Stevens	#3324	GIS description is on file with the Department Of Health	
Stevens	#3325	GIS description is on file with the Department Of Health	
Stevens	#3326	GIS description is on file with the Department Of Health	

Stevens	#3327	GIS description is on file with the Department Of Health	
Stevens	#3328	GIS description is on file with the Department Of Health	

***Key: For each level the type and number should be indicated**

Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

Whitman County	Trauma Response Area Number	DESCRIPTION OF TRAUMA RESPONSE AREA	Type And Number Of Verified Services
Whitman	3801	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3802	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3803	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3804	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3805	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3806	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3807	GIS description is on file with the Department Of Health	A-1 F-1
Whitman	3808	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3809	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3810	GIS description is on file with the Department Of Health	D-1
Whitman	3811	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3812	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3813	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3814	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3815	GIS description is on file with the Department Of Health	D-1

Whitman	3816	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3817	GIS description is on file with the Department Of Health	D-1
Whitman	3818	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3819	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3820	GIS description is on file with the Department Of Health	D-1 F-1
Whitman	3821	GIS description is on file with the Department Of Health	A-2 D-1
Whitman	3822	GIS description is on file with the Department Of Health	D-1
Whitman	3823	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3824	GIS description is on file with the Department Of Health	A-1 D-1
Whitman	3825	GIS description is on file with the Department Of Health	A-1 F-1
Whitman	3826	GIS description is on file with the Department Of Health	F-1
Whitman	3827	GIS description is on file with the Department Of Health	A-1 F-1
Whitman	3828	GIS description is on file with the Department Of Health	D-1 F-1
Whitman	3829	GIS description is on file with the Department Of Health	D-1 F-1
Whitman	3830	GIS description is on file with the Department Of Health	A-1 D-1

The East Region developed GIS Trauma Response Area (TRA) Maps in 2007 and 2008 before the Department Of Health began GIS mapping for other EMS regions in the state. East Region TRA Maps were provided to the Department Of Health by disk initially and updates have been provided via email as they have happened. In many cases these maps were the first GIS maps in many counties of the region.

Layers have been added to the mapping project that include trauma designated levels of facilities, HEAR systems for both EMS agencies and hospitals, and the numbers and locations of vehicles each agency has. Because we have only one volunteer who is trained on GIS mapping, we have been unable to really work the project to its fullest potential.

The tables below show that the Department Of Health has access to the GIS description of each TRA. Upon request from their map maker and/or ours a very detailed printout and/or description of the area can be provided by email in a very short time if the map maker is available. It only requires the flip of a switch.

Trauma Response Area Maps:
Interactive Emergency Medical Care Map

Appendix 7. Approved EMS Education and Training Programs

Credential #	Status	Expiration Date	Facility Name	Site City	Site County
TRNG.ES.60136631-PRO	APPROVED	08/31/2022	Clarkston Fire Department	Clarkston	Asotin
TRNG.ES.60114491-PRO	APPROVED	08/31/2022	Lincoln County Fire District 4	Reardan	Lincoln
TRNG.ES.60128950-PRO	APPROVED	08/31/2024	Pend Oreille County Fire District 12	Cusick	Pend Oreille
TRNG.ES.60128965-PRO	APPROVED	08/31/2022	South Pend Oreille Fire and Rescue	Newport	Pend Oreille
TRNG.ES.60136352-PRO	APPROVED	08/31/2022	Deer Park Volunteer Ambulance	Deer Park	Spokane
TRNG.ES.60114613-PRO	APPROVED	08/31/2022	Inland Northwest Health Services	Spokane	Spokane
TRNG.ES.60136378-PRO	APPROVED	08/31/2022	Spokane Community College	Spokane	Spokane
TRNG.ES.60122894-PRO	APPROVED	08/31/2022	Spokane County Fire District 4	Chattaroy	Spokane
TRNG.ES.60136371-PRO	APPROVED	08/31/2023	Spokane County Fire District 3 Station 31	Cheney	Spokane
TRNG.ES.60122524-PRO	APPROVED	08/31/2023	Spokane County Fire District 9	Mead	Spokane
TRNG.ES.60136464-PRO	APPROVED	08/31/2024	Chewelah Rural Ambulance Asso.	Chewelah	Stevens
TRNG.ES.60115682-PRO	APPROVED	08/31/2022	Stevens County Sheriffs Ambulance	Colville	Stevens
TRNG.ES.60122828-PRO	APPROVED	08/31/2022	Pullman Fire Department	Pullman	Whitman
TRNG.ES.60136612-PRO	APPROVED	08/31/2023	Whitman County Emergency Medical Services Council	Colfax	Whitman

Approved EMS Educators by County

County	SEI	SEI-C	ESE
Adams	2	0	4
Asotin	1	0	7
Ferry	1	0	12
Garfield	0	0	3
Lincoln	4	0	35
Pend Oreille	2	0	23
Spokane	14	3	255
Stevens	3	2	54
Whitman	2	2	40

Numbers are current as of February 2021

Appendix 8. Patient Care Procedures

EAST REGION EMS & TRAUMA CARE COUNCIL
REGION PATIENT CARE PROCEDURES

TABLE OF CONTENTS

REGULATIONS

The following regulations provide guidance on subject matter contained in this document. Please note, that this is not an inclusive list. For more information, please contact a Department of Health Emergency Care System representative.

1.1 Revised Code of Washington (RCW):

- **RCW 18.73** – Emergency medical care and transportation services
  - RCW 18.73.030 - Definitions
- **RCW Chapter 70.168** – Statewide Trauma Care System
  - RCW 70.168.015 – Definitions
  - RCW 70.168.100 – Regional Emergency medical Services and Trauma Care Councils
  - RCW 70.168.170 – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

1.2 Washington Administrative Code (WAC):

- **WAC Chapter 246-976** – Emergency Medical Services and Trauma Care Systems
  - WAC 246-976-920 – Medical Program Director
  - WAC 246-976-960 – Regional emergency medical services and trauma care councils
  - WAC 246-976-970 – Local emergency medical services and trauma care councils

1.1 DISPATCH OF MEDICAL PERSONNEL

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

1. PURPOSE:

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

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

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

4. DEFINITIONS:

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

- Discovery Time": The interval from injury to discovery of the injury;
- "System Access Time": The interval from discovery to call received;
- "911 Time": The interval from call received to dispatch notified, including the

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

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

*Reformatted 11/6/2020 with no changes

1.2 RESPONSE TIMES

Effective Date: 9/2010

1. PURPOSE:

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

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

3. **GENERAL PROCEDURES:**

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

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

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

4. DEFINITIONS:

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

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

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

*Reformatted 11/6/2020 with no changes

3. AIR AMBULANCE SERVICES – ACTIVATION AND UTILIZATION

Effective Date: September 1, 2020

1. PURPOSE:

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

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

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

H. Air ambulance services must be appropriately utilized during an MCI. If such request is made, the requesting prehospital agency should clearly communicate the need for either on scene or rendezvous location to respond to. Air ambulance services will determine most appropriate aircraft for transport based on patient status, weather, and location of incident.

4. TRANSPORT CONSIDERATIONS:

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

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

5. CONSIDERATIONS FOR AIR AMBULANCE TRANSPORT:

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

a. Hazardous materials exposure
b. Highly infectious disease (such as Ebola)
c. Inclement weather
d. Patient weight and size

If any of the conditions above are present:

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

6. SAFETY OF GROUND CREWS AROUND AIRCRAFT

To promote safety of all personnel, ground crews must:

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

7. LANDING ZONE CONSIDERATIONS:

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

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

A. Select a location for the landing zone that is at least:
    a. Night; 100 ft. x 100 ft.
    b. Daytime: 75 ft. x 75 ft.
B. Assure the landing zone location is free of loose debris.
C. Assure the approach and departure paths are free of obstructions, and identify to the pilot hazards such as wires, poles, antennae, trees, wind speed and direction, etc.
D. Provide air ambulance services with the latitude and longitude of the landing zone. Avoid using nomenclature such as "Zone 1."
E. Mark night landing zones with lights. Cones may be used if secured or held down. Do not use flares.

F. Establish security for the landing zone for safety and privacy.
G. Avoid pointing spotlights and high beams towards the aircraft. Bright lights should be dimmed as the aircraft approaches.
H. Do not approach an aircraft unless escorted by an aircrew member.
I. Consult with aircrew members before loading and unloading. Loading and unloading procedures will be conducted under the direction of the flight crew.

8. DEFINITIONS:

- ***"Standby"*** Upon receiving the request, dispatch will notify the pilot and crew of the possible flight. The crew will respond to the aircraft and ensure they are in a flight ready status. The crew will then remain at or near the aircraft until such time as they are launched or released from standby.
- ***"Launch time"*** launch time is the time the skids lift the helipad en route to the scene location.
- ***"Early activation"*** Departing for a requested scene prior to arrival of the first responders, based on a high index of suspicion that specialty services will be necessary.

9. APPENDICES

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

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

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

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	New	6/10/2020	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.1 TRAUMA TRIAGE AND TRANSPORT

Effective Date: 9/2010

1. PURPOSE:

A. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedure.
B. To ensure that all emergency medical and/or trauma patients are transported to the most appropriate designated facility in accordance with the current WAC.
C. To allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

A. The provider must determine primary resuscitation is needed for the patient and apply per level of training.
B. The first certified EMS/TC provider determines that a patient:
    a. Needs definitive trauma care
    b. Meets the trauma triage criteria
    c. Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure)
    d. Determine if patients meet all hazards criteria
C. The provider then determines what step in the Prehospital Triage Procedure that the patient's condition/injuries meet; determination of destination is made based upon the step identified and the following:
    a. For patient meets Step 1 or Step 2 Criteria:
        - Take the patient to the highest-level trauma center within 30 minutes transport time via ground or air transport according to Department Of

Health approved Regional Patient Care Procedures.

b. Patient meets Step 3 Criteria:
    - Take the patient to the nearest designated facility.
    - Consult county procedure, IF:
        - The patient requests to bypass the nearest facility*
        - EMS personnel judgment suggests that the patient be taken to a higher-level facility*

c. On-line medical control for all counties shall be accessed per County Operating Procedures (COPs).

D. Communication will be initiated with the receiving facility as soon as possible to allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.

E. The receiving facility will notify the verified ambulance service about diversion according to COPs.

F. Medical control and/or the receiving facility will be provided with the following information, as outlined in the Prehospital Destination Tool:
    a. Identification of EMS agency
    b. Vital signs. (Include First and/or Worst)
    c. Level of consciousness
    d. Anatomy of injury
    e. Biomechanics of injury
    f. Any co-morbid factors
    g. Timely updates on patient status

G. All information shall be documented on an appropriate medical incident report (MIR) form accepted by the County MPD, which meets trauma registry data collection requirements as outlined in WAC.

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

*Reformatted 11/6/2020 with no changes

5.2 CARDIAC TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/01/2018

1. PURPOSE:

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

2. SCOPE:

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

3. GENERAL PROCEDURES:

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

4. APPENDICES:

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

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	10/11/2017	☐ Major ☒ Minor
			☐ Major ☐ Minor

5.3 STROKE TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/01/2018

1. PURPOSE:

A. To implement regional policies and procedures for all stroke patients who meet criteria for stroke triage activation as described in the State of Washington Prehospital Stroke Triage Destination Procedure.

B. To ensure that all stroke patients are transported to the most appropriate categorized facility as described in RCW 70.168.150

C. To allow the receiving facilities adequate time to activate their stroke response team.

2. **SCOPE**:

A. All ambulance and aid services shall comply with the State of Washington Prehospital Stroke Triage Destination Procedure.

B. All ambulance services shall transport patients to the most appropriate categorized stroke facility as identified in the County Operating Procedures (COPs).

C. All categorized receiving facilities will determine when it is appropriate to divert ambulances to another categorized facility.

D. All ambulance and aid services shall consider ALS rendezvous or Air Medical services if beyond the designated time requirements in the Triage Destination Procedure.

3. **GENERAL PROCEDURES:**

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

4. **APPENDICES:**

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

Appendix 2. State of Washington Emergency Cardiac and Stroke Categorized Facilities
https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EmergencyCardiacandStrokeSystem/ForMPDsandEMS

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	10/11/2017	☐ Major ☒ Minor
			☐ Major ☐ Minor

5.4 MENTAL HEALTH AND CHEMICAL DEPENDENCY DESTINATION PROCEDURE

Effective Date: 11/01/2018

1. PURPOSE:

To operational licensed EMS aid and/or ambulance services who may transport patients from the field to mental health or chemical dependency services in accordance with WA State legislation HB 1721.

2. **SCOPE**:

In 2015, the WA State Legislature passed HB 1721 allowing Emergency Medical Services (EMS) licensed ambulance and aid services to transport patients from the field to mental health or chemical dependency services. In the East 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).

3. **GENERAL PROCEDURES:**

1. Prehospital EMS agency and 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 HB 1721 (see attached appendices)
3. Facilities that participate will work with county Medical Program Director (MPD) and EMS agencies to establish criteria that all participating facilities and EMS agencies will follow for accepting patients.
4. MPD and the Local EMS and Trauma Care Council must develop a county operating procedure (COP). The COP must be consistent with the WA State Department of Health Guideline for Implementation of HB 1721 and this PCP.
5. 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) Ensure EMS providers receive training in accordance with WA State Department of Health Guideline for Implementation of HB 1721
    d) Facilities that accept referrals directly from prehospital providers

4. **APPENDICES:**

Appendix 1. WA State Department of Health Guideline for Implementation of HB 1721

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

5.5 TRIAGE TRANSPORT OF MEDICAL AND NON-TRAUMA

Effective Date: 10/2002

1. PURPOSE:

A. To implement regional policies and procedures for all ***medical and non-major trauma patients who do not meet the criteria for trauma system activation*** as described in the Washington Prehospital Trauma Triage Tool.

B. To ensure that all medical and/or non-major trauma patients are transported to the most appropriate facility.

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

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

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

*Reformatted 11/6/2020 with no changes

5.6 PEDIATRIC TRAUMA TRIAGE TRANSPORT

Effective Date: 10/2002

1. PURPOSE:

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

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

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

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

*Reformatted 11/6/2020 with no changes

6 EMS MEDICAL CONTROL

Effective Date: 10/2002

1. PURPOSE:

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

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

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

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council			☐ Major ☐ Minor
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9 INTERFACILTY TRANSFER OF PATIENTS

Effective Date: 10/2002

1. PURPOSE:

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

2. **SCOPE**:

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

3. **GENERAL PROCEDURES:**

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

DEFINITIONS:

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

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10.1 ALL HAZARDS MCI

Effective Date: 9/2002
Revised: 4/2012

1. PURPOSE:

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

2. **SCOPE**:

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

A. All verified ambulance and verified aid services shall respond to an MCI per the county MCI plans.
B. Licensed ambulance and licensed aid services shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and/or in support of verified EMS services.
C. EMS certified first response personnel shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and /or in support of verified EMS services.
D. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
E. All EMS agencies working during an MCI event shall operate within the National Incident Management System or the Incident Command System (ICS) as identified in the jurisdiction that has authority, protocol and MCI plan.

3. **GENERAL PROCEDURES:**

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

C. EMS personnel may use the ***Prehospital Mass Casualty Incident (MCI) general Algorithm*** during the MCI incident (attached).

DEFINITIONS:

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

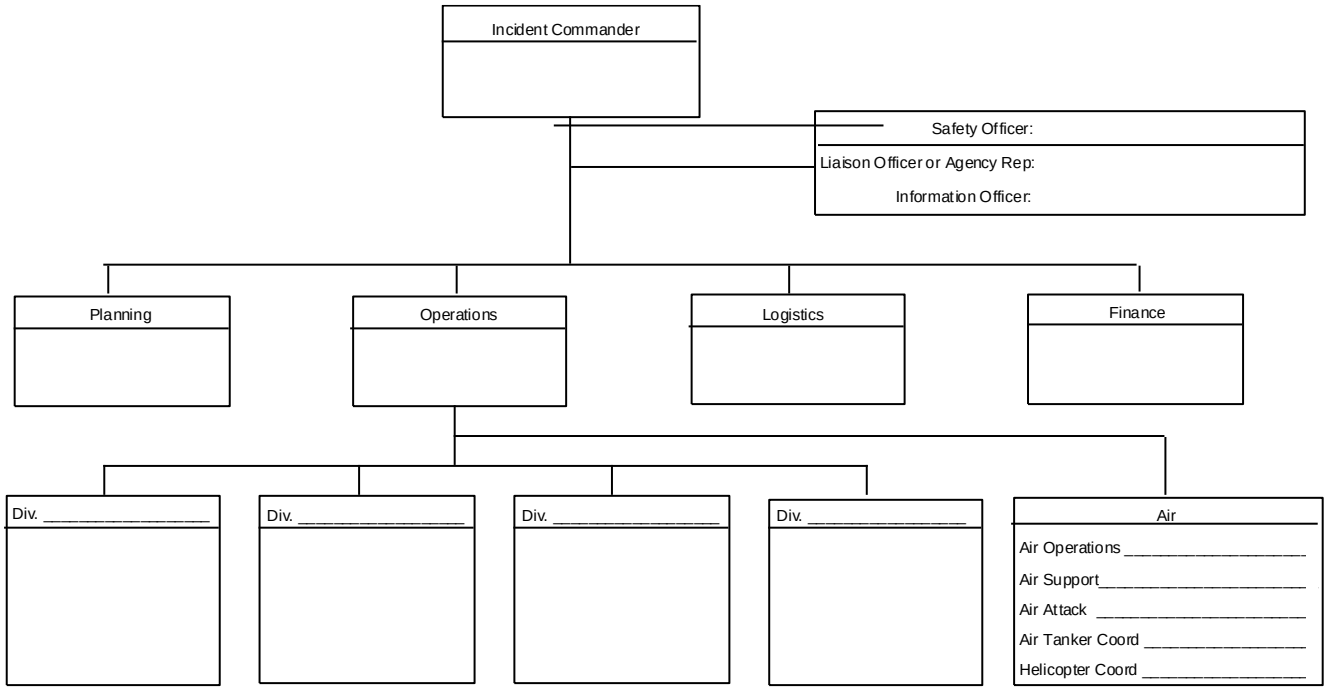
4. APPENDICES

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

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

4. Map Sketch

5. Current Organization



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

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

		M F	G		BUS/OTR _____ TIME _____	OTR_____

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10.2 ALL HAZARDS MCI DMCC

Effective Date: 4/2011
Revised: 4/2012

1. PURPOSE:

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

2. **SCOPE**:

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

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

3. **GENERAL PROCEDURES:**

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

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

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Appendix 9. Other Appendices

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

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

State of Washington Prehospital Trauma Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf