



Regional EMS and Trauma Care Council Resource Handbook



The Resource Handbook is available on the Department website at:
<http://www.doh.wa.gov/Portals/1/Documents/Pubs/346058.pdf>

Nathan Weed, Director
Office of Community Health Systems

Table of Contents

Purpose	2
Historical Snapshot of EMS and Trauma Systems.....	3
Brief History on EMS and Trauma Systems in the United States.....	3
The Evolution of the Washington State EMS and Trauma System	3
Regional EMS & Trauma Care Systems	6
Regional EMS and Trauma Care Councils	6
Regional Council Business Model	7
Department of Health Contracts with Regional Councils	7
Regional Plans	8
Regional EMS and Trauma Care Council Membership	10
Regional Council Member Appointment Process	10
Regional Council Member Responsibilities.....	11
Regional Council Executive Board.....	12
Local EMS and Trauma Care Councils	13
Local Council Member Responsibilities	13
Council Training Resources	14
Ethics, Confidentiality and the Open Public Meetings Act (OPMA) Training.....	14
Trauma Service Verification and Facility Designation.....	14
Prehospital: Trauma Service Verification.....	15
Trauma Service Designation: Hospital/Health Care Facility	15
Trauma Rehabilitation Service Designation.....	16
Appendices.....	16
Appendix A: Hyperlinks to Washington State EMS-Trauma System Legislation	16
Appendix B: Regional Advisory Committee Technical Advisory Committee Information	16
Appendix C: Resources.....	18
Regional Council Planning and Procedure Resources.....	18
Appendix D: Definitions	18
Appendix E: Coverdell Program	18
Paul Coverdell National Acute Stroke Program	19

Purpose

The purpose of this handbook is to provide information on the history and operations of the emergency medical services and trauma care system (EMS and TCS) in Washington State.

The main audience is members of regional and local EMS and trauma care councils in the state. It is also a tool for orienting new regional or local council members and others interested in the system.

The Washington State Department of Health (department), Office of Community Health Systems (OCHS) is responsible for updating the handbook, which is available for download as a PDF document from the Department of Health website. www.doh.wa.gov

Historical Snapshot of EMS and Trauma Systems

Brief History on EMS and Trauma Systems in the United States

Before 1969

Until the late 1960s, few areas in the nation had adequate prehospital emergency medical care. The thought was care began in the hospital emergency department. Rescue techniques were crude, ambulance attendants poorly trained, and equipment minimal. There was no radio communication and no physician involvement. Before 1966, morticians, private ambulance services, or fire departments did most emergency transport services.

In 1966, federal highway traffic safety funds were granted to states to improve their EMS systems. This helped make substantial improvement in basic life support systems, especially in EMS training and communications. In November 1973, Congress passed Public Law 93-154, otherwise known as the Emergency Medical Services Systems Act, directing funds to develop regional EMS systems.

In 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) passed Congress, effectively eliminating all federal funding for EMS. The EMS grant program folded into the federal Preventive Health Block Grant, jointly administered by Department of Transportation (DOT) and Department of Health and Human Services (DHHS). Only a small portion of this money was available for EMS programs.

The Evolution of the Washington State EMS and Trauma System

1970 – 1989

In 1971, the Washington State legislature amended the Revised Code of Washington (RCW) 18.71.200 to include paramedic certification as part of the Physicians' Practice Act. This RCW was again revised in 1978 to appoint the Washington Department of Social and Health Services (DSHS) and the University of Washington as certifying agencies of paramedic personnel. It also established three levels of advanced life support personnel: I.V. technician, airway technician, and paramedic. Specific educational and skill maintenance requirements were set for each level.

In 1973, the legislature created RCW 18.73, (Emergency Medical Care and Health Services Act). This legislation established minimum baseline standards for patient care. The law provided for the state to inspect and license prehospital emergency services.

In 1979, the EMS system was further expanded and improved. RCW 18.73 was changed to provide guidelines for the continued development and improvement of EMS systems. The law created eight regional EMS councils as a key component in the state EMS planning process. About \$2.5 million biennially funded the state's regional EMS program.

In 1983, the legislature revised the EMS legislation to include First Responders. This law also gave legal standing to county Medical Program Directors (MPDs) and local EMS councils. In 1989, the legislature created the Washington State Department of Health (DOH), and moved the state's EMS oversight from DSHS to DOH.

In 1988, legislation passed requiring a study to determine the need for a trauma system in the state. The study and final report described the need for, and necessary components of, a functional and effective statewide trauma care system. This report to the 1990 legislature established the Washington State EMS and trauma care system (EMS and TCS) in RCW 70.168. The EMS system was expanded to include trauma response and care.

1990 – Forward

The statewide Emergency Medical Services and Trauma Care System Act substantially amended state law related to ambulance and aid services. It included verification of personnel and services responding to trauma cases; and, included trauma training requirements for basic life support (BLS) and advanced life support (ALS) personnel.

Requirements were established for the designation of five levels of trauma care facilities (hospitals and clinics). This act is the basis for a well-coordinated, integrated, statewide emergency medical services and trauma care system that includes prevention, prehospital care, hospital care, and rehabilitation. The DOH Office of Community Health Systems is responsible for the overall management, oversight, contracts, and compliance of the statewide EMS and trauma care system.

In 1997, the state legislature established dedicated funding for trauma care through the Trauma Care Services Fund Act. This fund is used to compensate trauma care providers for unreimbursed care of trauma patients. The sources of funding are a \$5 surcharge on all vehicle moving violations, and \$4 of a \$6.50 administrative fee on the sale or lease of a new or used vehicle. Fund collection began January 1, 1998.

Recipients include:

- Verified prehospital agencies,
- Designated trauma care services,
- Physicians who provide trauma care at designated trauma services; and,
- Designated trauma rehabilitation services.

A summary of fund performance is available from the DOH Office of Community Health Systems.

In May 2006, more than 120 stakeholders from across the state had a planning retreat to begin work on a Washington State EMS and trauma care system strategic plan. Participants completed system assessments to use in developing strategic plan goals, objectives, and strategies to move the system forward over a five year period. The five-year planning cycle

continues to guide system work. Progress is reviewed regularly, and the plan is updated every three years.

The 2010 state legislature added emergency cardiac and stroke (ECS) care to the EMS and trauma care statute. In the intent section of the law, it recognizes: “The minutes after the onset of heart attack, cardiac arrest, and stroke are as important as the ‘golden hour’ in trauma. When treatment is delayed, more brain or heart tissue dies. Timely treatment can mean the difference between returning home or becoming permanently disabled, living at home, or living in a nursing home. It can be the difference between life and death. Ensuring most patients will get lifesaving care in time requires preplanning and an organized system of care.”

The ECS system work includes more consistent training and standards for prehospital providers; expanding access to ECS care in rural and underserved areas; voluntary hospital participation and categorization by meeting national standards of care; and quality improvement through data collection, reporting, and sharing.

More information and a current list of categorized emergency cardiac and stroke hospitals are at [www.doh.wa.gov/Emergency Cardiac and Stroke System](http://www.doh.wa.gov/Emergency%20Cardiac%20and%20Stroke%20System)

Recent Legislature

In 2015, the federal Centers for Disease Control and Prevention (CDC) funded the Paul Coverdell National Acute Stroke Prevention Grant in Washington State. The grant started July 16th, 2015 and lasts until June 29, 2020. . The long-term goal of this program is to ensure that all Americans receive the highest quality of acute stroke care currently available and to reduce the number of untimely deaths attributable to stroke, prevent stroke-related disability, and prevent stroke patients from suffering recurrent strokes (See Appendix E for more detailed information).

Also in 2015, legislation (SHB 1721) was passed allowing emergency medical services ambulances and aid services to transport patients from the field to mental health or chemical dependent services. Participation is voluntary. Through a multi-disciplinary workgroup, the department developed a guideline for implementing the law; it was distributed to stakeholders in July 2016. Regions shall develop patient care procedures (PCPs) to guide medical program directors and EMS agencies to operationalize transport of patients to these alternative services. Contact your regional council office or county MPD for more information.

In 2017, legislation (ESSB 5751) passed amending RCW 18.73.150 to allow ambulance services established by volunteer or municipal corporations in rural areas to qualify to use non-medically trained people to drive ambulances, with approval from the Department of Health (department).

In 2017, legislation named, The Travis Alert Act (SHB 1258) passed which stated that the Department of Health must collaborate with other community partners and stakeholders to design a training program that will familiarize fire department and emergency medical service personnel with the techniques, procedures, and protocols for best handling situations in which persons with disabilities are present at the scene of an emergency in order to maximize the safety of persons with disabilities, minimize the likelihood of injury, and promote the safety of all persons.

Regional EMS & Trauma Care Systems

As established by RCW 70.168, there are eight EMS and trauma care regions in Washington State. The eight regions and their counties are:

- Central Region: King
- East Region: Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Whitman
- North Region: Island, San Juan, Skagit, Snohomish, Whatcom
- North Central Region: Chelan, Douglas, Grant, Okanogan
- Northwest Region: Clallam, Jefferson, Kitsap, Mason
- South Central Region: Benton, Columbia, Franklin, Kittitas, Walla Walla, Yakima
- Southwest Region: Clark, Cowlitz, Klickitat, south Pacific, Skamania, Wahkiakum
- West Region: Grays Harbor, Lewis, north Pacific, Pierce, Thurston

Regional EMS and Trauma Care Councils

Each of the eight EMS and TC regions has a regional council organized to develop, operate, plan, and help sustain the EMS and trauma system as grass-roots entities that support the statewide system.

The councils include members from local EMS and trauma care (EMS-TC) councils, other EMS-related stakeholders, and partners from across the region. Each council elects its own executive board, the makeup of which varies per its bylaws.

Regional Council Business Model

Regional councils operate as quasi-municipal entities; functional equivalents of public agencies. They are funded by both state and federal grants, and are subject to audit by the State Auditor's Office. Council members have fiduciary and legal responsibilities to the regional council as a corporate entity, as well as responsibilities defined in RCW and WAC; (RCW 70.168.120; WAC 246-976-960).

When performing their duties as defined in statute, regional EMS-TC councils act as public agencies as defined in RCW 42.30.020 (1)(c), and are subject to the Open Public Meetings Act (OPMA) RCW 42.30, and the Public Disclosure Act RCW 42.56.

Department of Health Contracts with Regional Councils

RCW 70.168 allows the Department of Health's Office of Community Health Systems to contract with regional EMS and trauma care councils in Washington State. This provides funding for assessment, planning, implementation, and tracking outcomes of regional EMS and trauma care systems. The grant-based funding is done through annual or biennial contracts. The Legislature appropriates funding for these grants from state general funds. This funding is to support the regional councils in their duties under [RCW 70.168.100](#).

The department works with regional council leadership to determine deliverables for the contract period. The scope of work in regional contracts focuses on implementing the comprehensive regional EMS-TC system strategic plans, and on advancing regional systems. These plans align with the goals of the State of Washington emergency medical services and trauma system strategic plan, yet are specific to the unique needs of each region.

Progress Reporting and Payment Process

Regional councils must follow the department's contracting requirements in the contract-grant award and agreement. This includes the general terms and conditions, statements of work, and all exhibits and reporting documents. Regional councils must notify the department, and have written approval from DOH, if they plan to subcontract these funds. The regional councils are responsible for assuring any subcontractor meets all contract requirements of the department.

On a regular schedule, regional councils submit reports to the department detailing work implementing regional plan goals, objectives, and strategies. The contract outlines the timelines and deliverables. Progress on deliverables must be made and documented for approval of payment. At the end of the contract period, each deliverable must be complete, as defined in the contract, before approval for final payment. If they are not complete, there must be an explanation about why they are not complete and a plan for completing them. A State of Washington A-19 Invoice Voucher must be done and submitted by the regional council to the department for payment of deliverables.

Regional Plans

The maintenance, improvement, and sustainability of the state's EMS and trauma care system relies on the development of the regional plans (plan). Utilizing the plan guidance distributed by the Department of Health, regional councils develop in-depth strategic documents biannually with input from local councils, county medical program directors, and stakeholders in the region. These plans outline the work the regional councils will accomplish, which includes goals objectives and strategies.

For the 2019-2021 plan cycle, the region will focus their work around these **five** goals:

1. Maintain, assess and increase emergency care resources.
2. Support emergency preparedness activities.
3. Plan, implement, monitor and report outcomes of programs to reduce the incidence and impact of injuries, violence and illness in the region.
4. Assess weaknesses and strengths of quality improvement programs in the region.
5. Promote regional system sustainability.

Regional Plan Review and Approval

When the regional EMS-TC system plans are drafted, they are submitted to the department. Department staff members do an internal review and ask for clarifications. Members of the EMS-TC steering committee review the plans and recommend full approval or required and suggested changes. Based on the plan reviews, the department formally approves the plans and notifies the regional councils. Plans are operational for the period defined in the approved plans. The approved regional EMS and trauma care system regional plans are then posted to the department and regional council website.

Changes and Updates to Regional Plans

The department reviews and may approve proposed changes to the regional plans. There are two types of changes: substantive and minor or technical. Substantive changes are related to patient care procedures (PCPs), minimum or maximum numbers of designated (hospital) or verified (prehospital) trauma services, higher than minimum standards, and any contested changes to the plan. All other changes are minor or technical.

For a substantive change, the region uses available data and information to write the proposed change, has it reviewed and approved by regional council members (this can be done by email, webinar, in-person, or other method, as long as there is council input) , and submits the need and justification for change to the department. Once reviewed by the department, the

proposed change is presented to the EMS-TC steering committee, which makes final recommendations to the department for approval or disapproval of any changes.

Minor or technical changes to the plan must meet current standards. The regional council shares proposed changes to stakeholders for input. If proposed changes are contested, they need to be resolved before submitting to the department. The department reviews, approves or disapproves uncontested minor or technical changes, and notifies the regional council of the action.

Regional Plan Content

Regional plans contain vital information for system planning, including but not limited to, minimum and maximum numbers of verified and designated trauma care services and regional patient care procedures (PCPs).

Min/Max

Each regional plan includes proposed minimum and maximum numbers of prehospital trauma verified services and designated trauma services (hospitals and clinics). The department grants verification and designation for set periods.

Local EMS-TC councils identify the minimum and maximum numbers of verified prehospital ground services needed in an area, and recommend them to the regional EMS-TC council. Factors to consider for minimum and maximum numbers include: call volume, population density and age distribution, response distances, goal response time, backup unit requirements on major trauma, tiered response, and preventing duplication of service.

The regional councils identify minimum and maximum numbers and levels of designated trauma care services for the regional plan. The EMS and trauma steering committee reviews minimum and maximum numbers, as well as regional plans, and recommends approval or changes to the department.

Patient Care Procedures

Regional patient care procedures (PCPs) define how each EMS-TC system operates. Regional councils develop PCPs with input from county medical program directors (MPDs) and other system stakeholders. All regional plans have PCPs to address basic system functions. Regional councils develop other PCPs as needed in the region. The EMS-TC steering committee and the department review PCPs, which are included as part of each approved regional plan.

Regional EMS and Trauma Care Council Membership

Appointment to a regional council is a formal process. Regional council member term of office is three years; council members may be reappointed every three years thereafter. The department sets no term limits.

Applicants submit new and renewal membership applications to the regional council, after the approval of the local council. Local council appointments to the regional council must reflect a balance of hospital and prehospital trauma care and emergency medical service providers, local elected officials, consumers, local law enforcement, some federal agencies such as U.S. Coast Guard, National Park Service, and local government agencies.

Membership is specified in RCW 70.168.120 (2) and the regional council by-laws. Regional councils may announce vacant positions and membership needs, but do not recommend potential members to the department. That is the role of the local EMS-TC council. In areas where there is no local council, regional council members may recommend people for membership.

Click [here](#) for the latest application for regional council membership request for appointment.

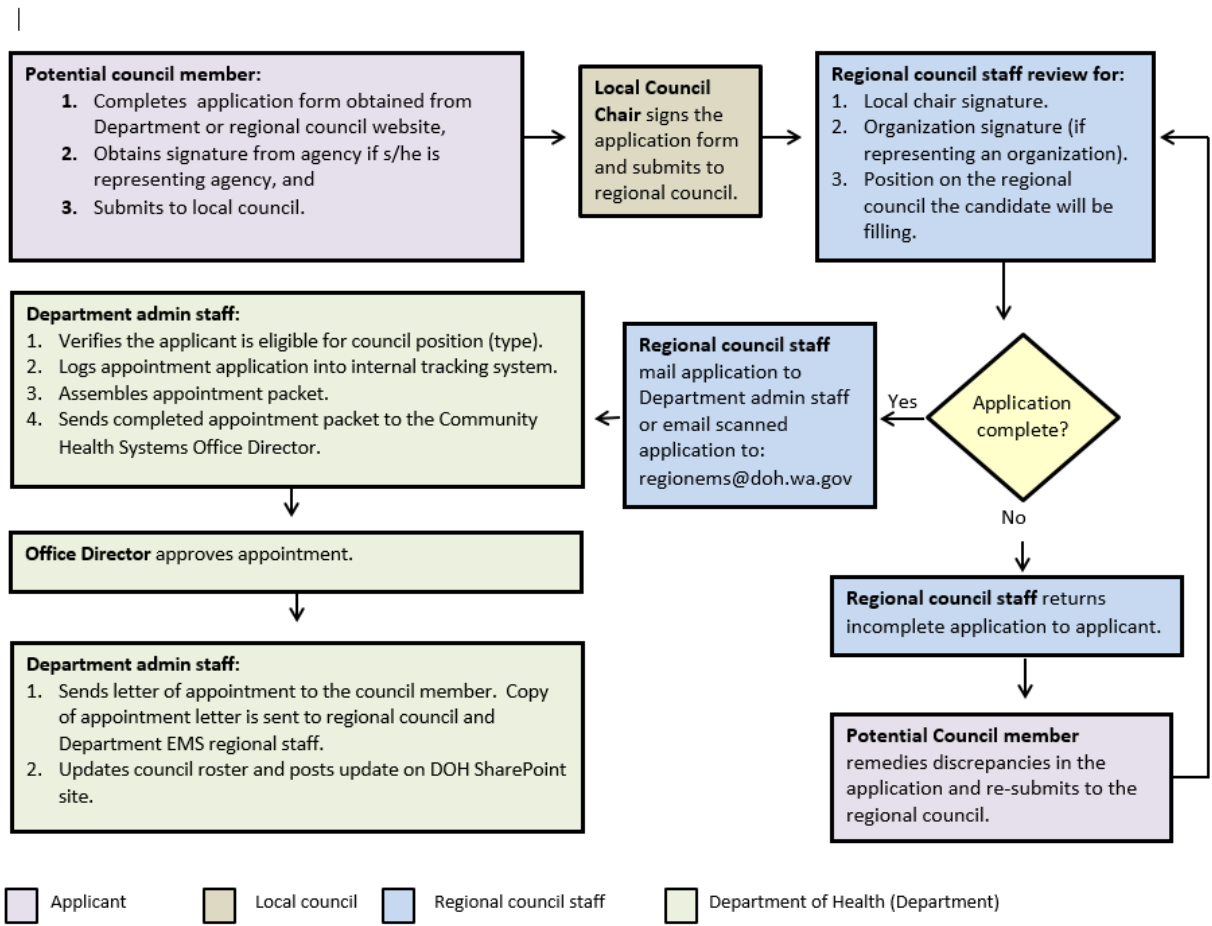
Regional Council Member Appointment Process

The regional council membership process works to ensure members appointed to the council are connected to the local council or community they represent. The process for council appointment is:

- 1) People seeking appointment to a regional council need to download and complete the membership application. Application is on the department and regional council websites.
- 2) Applicants who will represent a local agency must get the signature of the appointing authority.
- 3) The applicant must get the local council chair to sign the application form.
- 4) The local council chair sends the application to regional council.
- 5) Regional council staff review for local council signature, organization signature (if needed), and confirm position the candidate will fill. Regional staff members mail, or scan and email, the completed application to the department. Incomplete applications are returned to the applicant.
- 6) Department staff members log the application into the department internal tracking system, and compile an appointment packet for the Office Director of the Office of Community Health Systems.
- 7) The Department of Health's Office Director for the Office of Community Health Systems makes membership appointments.

- 8) Department staff members send letter of appointment to the council member. A copy of the letter is sent to the regional council, and to the department EMS and TC regional support staff.

Regional Council Member Appointment Process



Updated: 7/19/2016 -FINAL

Regional Council Member Responsibilities

Responsibility to the general public:

Make the best decisions to ensure the EMS and trauma system functions in a timely, safe, and appropriate manner. Ensure regional council work is carried out in a fiscally responsible manner. The public needs to know about the work of the regional EMS-TC council, and needs an avenue to resolve issues that arise in the system. The councils must hold open public meetings. Meetings will be advertised and announced in advance, with minutes taken and made public.

Responsibility to an agency or organization you are representing:

Act as a liaison between the regional EMS-TC council, and the agency or organization the member represents; and share information, challenges, and outcomes with each to improve

and sustain the regional system. Council members must consider the needs of the overall EMS-TC system to work well for the whole region.

Responsibility to the Department of Health:

Provide unbiased recommendations to maintain, improve, and sustain a high-quality, statewide EMS-trauma care system. Regional council members monitor finances of the regional council by reviewing and approving the annual budget, and distribution of regional resources, most of which the department contracts to the region.

Responsibility to other council members:

Attend meetings regularly, listen to other members, consider their views and contributions, and work to make decisions and solve problems in the best interests of an effective and efficient regional system that supports the statewide system.

General regional council member responsibilities:

- Be an active member of the organization you represent on the regional council.
- Routinely share information from the regional council to their local council, and vice versa.
- Regularly attend regional council meetings.
- Engage and actively participate in regional council committees and workgroups.
- Help develop and implement the regional plan and track its progress.
- Be accountable for work required in the regional plan.
- Be accountable for deliverables required in regional contracts with the Department of Health.

[Regional Council Executive Board](#)

Each council elects its own executive board. Executive board makeup varies by region, according to its bylaws. Officers typically include chair, vice chair, and secretary-treasurer.

In addition to the general responsibilities of regional council membership, executive board members:

- Have fiduciary oversight of the regional council work, budget and finances, contracts, grants, etc.
- Help develop and oversee the annual regional budget and fiscal actions, how money is gained, and how it is spent.
- Act reasonably, prudently, and in the best interests of the regional council, to avoid negligence and fraud.
- Stays informed and ask questions.
- Avoid conflicts of interest.
- Develop and implement clear and concise administrative policies and/or procedures.

- Provide operational direction and guidance to the regional council.
- Actively monitor implementation and outcomes of the regional plan.
- Sign all contracts.
- Are responsible for oversight of contractual deliverables.
- Hold regional staff members accountable for submitting contract deliverables to the department, on time and complete, in accordance with contract requirements.
- Executive board members review the regional executive director’s performance.

Local EMS and Trauma Care Councils

If a county or group of counties creates a local EMS-TC council, by rule (WAC 246-976-970), it must include, at least: hospital and prehospital providers, local elected officials, consumers, local law enforcement, local government agencies, physicians, and prevention specialists involved in the delivery of EMS-TC. Local council by-laws establish the standards for their membership, membership appointments, and council operations. In areas with no local EMS-TC council, the regional council performs the required duties with help from local providers.

Local Council Member Responsibilities

Responsibility to the general public:

Make the best decisions to ensure the local EMS-TC system functions in a timely, safe, and appropriate manner. Inform the public about the work of the local council, and have an avenue to resolve issues that may arise in the system. The councils must hold open public meetings, with the meetings advertised and announced in advance, and minutes taken and made public.

Responsibility to a represented agency or organization:

Actively participate in the organization they represent, and be a liaison between the local EMS-TC council and the entity they represent. Share information and challenges between the local council and their member organizations to improve the regional system.

Responsibility to other council members:

Attend meetings regularly, listen to other members, consider their views and contributions, and work together to make decisions and solve problems in the best interests of an effective and efficient local, regional, and statewide system.

In addition to responsibilities in Chapter 70.168 RCW and WAC 246.976.970, local council members must:

1. Participate in determining the minimum and maximum number of verified prehospital agencies needed in the county for the regional EMS and trauma plan.
2. Recommend to DOH appointment of potential regional council members.

Council Training Resources

An excellent resource about legal, fiscal, program, and other responsibilities for regional council members is Washington Nonprofits: <https://washingtonnonprofits.org/>

The Department of Health encourages council members to review and become familiar with your many responsibilities advising a regional council.

Ethics, Confidentiality and the Open Public Meetings Act (OPMA) Training

Department of Health appoints regional council members under RCW 70.168.120. Even though councils are considered quasi-governmental agencies, state law considers EMS and trauma regional council members to be state officers who are expected to adhere to the ethics of public service. More about public service ethics is in [RCW 42.52](#).

When regional and local councils meet to do business, they are public governing bodies as defined in RCW 42.30.020, and are subject to [Open Public Meetings Act \(OPMA\)](#). Any official business, such as discussions, public testimony, reviews, considerations, deliberations, or final actions or votes done by a regional or local council are actions defined in RCW 42.30.020, and meetings must be open to the public.

In 2014, the Washington State legislature enacted the Open Government Trainings Act. This law requires all members of governing bodies (including local and regional councils) to complete mandatory OPMA training within 90 days of assuming their duties, and to receive a refresher training every four years. Specific training materials are not proscribed in the law.

Ways to complete the online OPMA training:

- On the Attorney General of Washington's website at:
 - <https://www.atg.wa.gov/open-government-training>
- WA State Attorney General You Tube Page
 - <https://www.youtube.com/watch?v=9yTtVGToW1A>
- Coordinated group trainings at each regional council

Trauma Service Verification and Facility Designation

Prehospital agencies apply to the Department of Health department) to be a trauma-verified service. The department also designates hospitals and other health care facilities that apply to meet Washington State trauma care standards to provide trauma care.

Prehospital: Trauma Service Verification

The department's Office of Community Health Systems (OCHS) administers the trauma verification application and evaluation process for basic, intermediate, and advanced life support aid and ambulance services. Ground service verification decisions, for both aid and ambulance agencies, are based on county and regional system needs. Applications for verified trauma services must be within the minimum and maximum numbers in the approved regional plan. Air medical verified services needs are determined statewide.

- All related trauma verification documents are found [here](#) on the department website.
- The department's GIS mapping tool, which can assist in identifying trauma response areas, can be found [here](#) on the department website.

Trauma Service Designation: Hospital/Health Care Facility

Designated trauma services are part of the comprehensive statewide EMS and trauma care system. Trauma service designation standards and processes for each level are in WAC 246-976-580 and WAC 246-976-700. There are five levels of designated trauma care services. In order of resource needs they are level I (highest), II, III, IV, and V. The minimum and maximum number and levels of designated trauma services needed in the regional systems is determined by each regional council and is part of each regional strategic plan.

Applicant health care facilities send a letter of intent to apply, followed by a complete application. The department reviews the application, does an on-site review (level I, II, and III only), fully or provisionally designates the facilities, and notifies regional councils when facilities are designated. The department manages the designation process using a regional approach. A published 3-year designation schedule is available on the EMS and Trauma webpage.

Law requires the department use an external review team for levels I, II, and III designations. The review team and department designation staff members evaluate the facility's capability to meet requirements and provide trauma care. Designation of level IV and V does not require the external team, and is generally based on staff review. Trauma service designation is a competitive process established in RCW 70.168, based on the final minimum and maximum numbers of designated trauma services in regional plans. In a competitive situation, the agency designates the health care facilities it considers most qualified to provide trauma care services. Designation is for three years. Detailed information about the designation process is available at:

<http://www.doh.wa.gov/PublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/TraumaSystem/TraumaDesignation.aspx>

Trauma Rehabilitation Service Designation

Designated trauma rehabilitation services are part of the comprehensive statewide EMS and trauma care system. Trauma rehabilitation service designation standards are in WAC 246-976-800. Trauma rehabilitation designations include two levels of adult and one level of pediatric trauma rehabilitation services. All designated trauma rehabilitation services are required to be fully accredited with the Commission on Accreditation of Rehabilitation Facilities (CARF) which is a nationally recognized organization that sets vigorous standards of care. CARF accreditation ensures trauma services are functioning at the highest level and patients are receiving quality care.

Every three years, facilities voluntarily apply for designation. Applicant rehabilitation facilities send a letter of intent to apply, followed by a complete application. The department reviews the application, fully or provisionally designates the facilities, and notifies regional councils when facilities are designated. The department manages the designation process using a regional approach. A published 3-year designation schedule is available on the EMS and Trauma webpage.

Trauma rehabilitation service designation is a competitive process established in RCW 70.168, based on the final minimum and maximum numbers of designated rehabilitation trauma services in regional plans. In a competitive situation, the agency designates the rehabilitation facilities it considers most qualified to provide trauma care services. Designation is for three years. Detailed information about the designation process is available at:

<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/TraumaSystem/TraumaRehabilitation>

Appendices

Appendix A: Hyperlinks to Washington State EMS-Trauma System Legislation

- [EMS-Trauma System - Revised Code of Washington \(RCW\)](#)
- [EMS-Trauma System - Washington Administrative Code \(WAC\)](#)

Appendix B: Regional Advisory Committee Technical Advisory Committee Information

The Regional Advisory Committee (RAC) is a technical advisory committee to the state EMS and Trauma Care Steering Committee. It includes regional executive directors and chairs from each of the EMS-TC regional councils, is staffed by the department, and meets every other month.

RAC TAC CHARTER

Reviewed and approved January 2018

Mission: Advise the EMS and Trauma Steering Committee on EMS and trauma issues, share information across regional systems, and coordinate among regions to sustain an effective statewide EMS & trauma care system.

Purpose: Support the EMS and trauma care system as outlined in the State Strategic Plan.

Objectives:

- The RAC will assist State EMS & and Trauma Steering Committee and DOH with accomplishing work of the EMS and Trauma Strategic Plan.
- The RAC will serve as a conduit for sharing information between the EMS and Trauma Steering Committee, technical advisory committees, and local and regional EMS and trauma care systems.

Membership:

- Membership is limited to persons from those regions of the State of Washington, as defined in RCW 70.168.110 and by DOH.
- The designee and alternate designee shall be selected by each regional council.

Leadership:

- The RAC Chair will be appointed by the EMS and Trauma Steering Committee.
- The RAC Vice-Chair will be a RAC member and will lead the TAC in the Chair's absence.
- In the absence of the RAC Chair or Vice-Chair, DOH will facilitate the meeting.

Elections:

- RAC TAC members in attendance at a regular meeting may vote to appoint the Vice-Chair reviewed on an annual basis, or when necessary, with no term limit.

Member Responsibilities:

- Attend and participate in all RAC TAC meetings.
- Attend State Steering Committee, TACs & system stakeholder meetings, including those meetings designated by the RAC TAC.

Meetings:

- A quorum will be a simple majority
- Meetings will be conducted in accordance with Washington Statute and Rule – Open Public Meetings Act.
- The meetings will be scheduled every other month on the day before the EMS and Trauma Steering Committee meeting, and otherwise as needed.
- DOH will be responsible for the meeting venue, arrangements, and agenda.
- Each Regional Council will have one vote .
- The RAC Chair votes only in case of a tie.
- Updates from each region, other TAC meeting, and any stakeholder meetings will be shared, as available.
- DOH will staff the meetings, including taking minutes.

- DOH will maintain and archive approved minutes.

Appendix C: Resources

Washington State EMS and trauma system information on the Department of Health website:

Contact Us	How to contact Health Services Quality Assurance.
EMS Topics A-Z	Alphabetical list of EMS and trauma systems web content.
EMS Systems	Overview of Washington State’s emergency medical services systems.
EMS and Trauma System	EMS and trauma mission, background and links to other trauma programs.
ECS System	Information about Washington State’s Emergency Cardiac and Stroke System.
Trauma Designation	Trauma facility designation.
Agency and Vehicle Licensing	Agency and facilities licensing and verification.
Certification and Recertification	EMS medical services education for provider certification and recertification.
Publications (EMS and Trauma)	EMS and trauma publications.
WEMESIS	Washington’s EMS information system for prehospital data.
Injury and Violence Prevention	Injury and violence prevention information.
Hearings Information	Information on health profession discipline hearing process.
Geographic Information System (GIS) Map	Interactive resource map for hospital designation, response areas and EMS education

Regional Council Planning and Procedure Resources

- [Prehospital trauma triage procedure](#)
- [Prehospital cardiac destination procedure](#)
- [Prehospital stroke destination procedure](#)
- [Current EMS and trauma care system regional plans](#)

Appendix D: Definitions

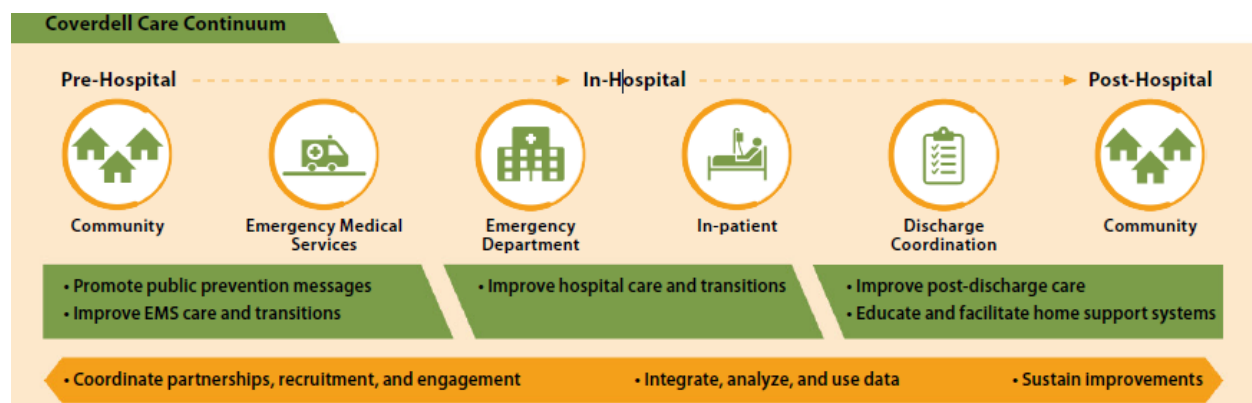
- [Definitions from RCW 70.168.015](#)
- [Definitions from WAC 246-976-010](#)

Appendix E: Coverdell Program

Paul Coverdell National Acute Stroke Program

The [Paul Coverdell National Acute Stroke Program](#) (PCNASP) is administered by the Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention. It's named after Georgia Senator Paul Coverdell who died from a stroke while in office. The long-term goal of PCNASP is to ensure that all Americans receive the highest quality of acute stroke care currently available and to reduce the number of untimely deaths attributable to stroke, prevent stroke-related disability, and prevent stroke patients from suffering recurrent strokes.

PCNASP supports a systems approach using data-driven quality improvement to reach this goal. Stroke systems of care improve care and support for stroke patients throughout their health care journey—from the first symptoms of stroke through the transition from Emergency Medical Services (EMS) to hospital care and from rehabilitation to follow up with primary care physicians to prevent complications and second strokes.



Coverdell Program Objectives

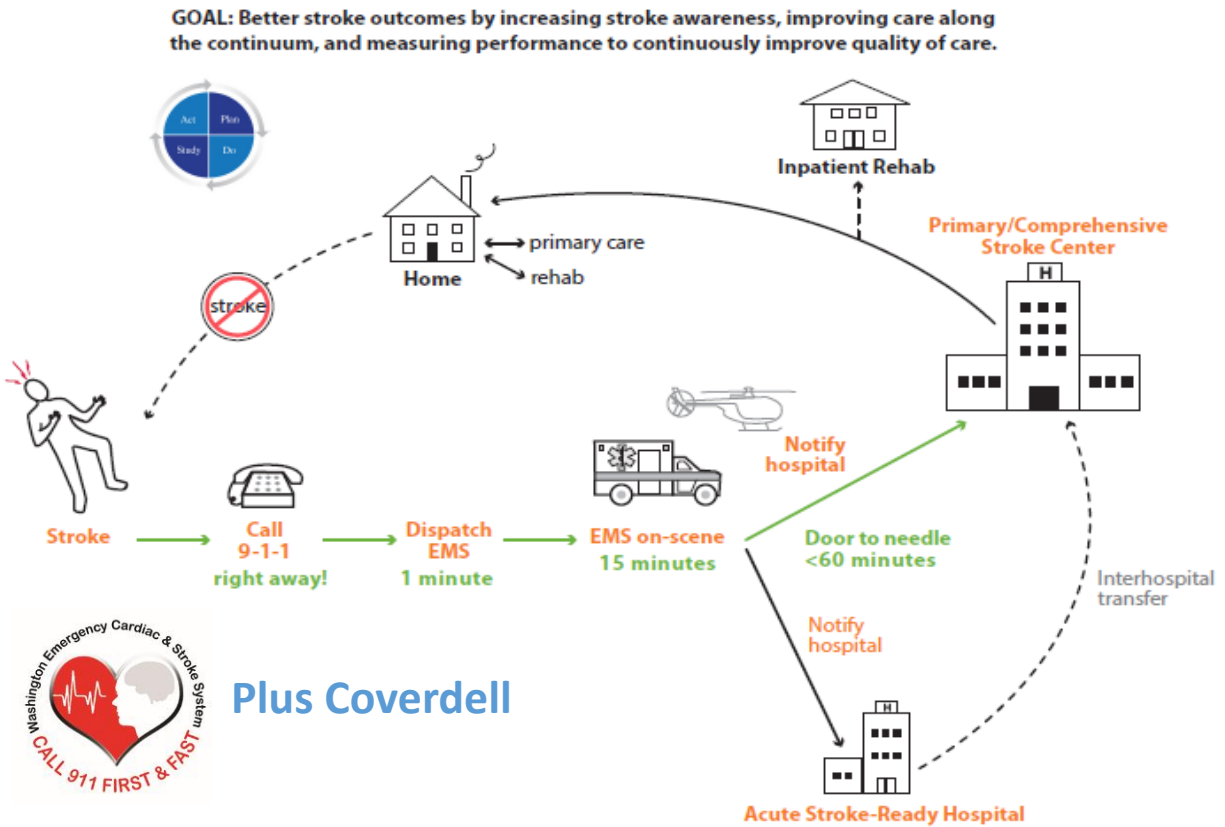
- Measure, track, and improve the quality of care and access to care for stroke patients from onset of stroke symptoms through rehabilitation and recovery.
- Decrease the rate of premature death and disability from stroke.
- Eliminate disparities in stroke care.
- Support the implementation of comprehensive stroke systems across the continuum of care.
- Improve access to rehabilitation and opportunities for recovery after stroke.
- Increase the workforce capacity and scientific knowledge of stroke care within stroke systems of care.

Washington Coverdell Stroke Program (WACSP)

The Washington State Department of Health received a five-year grant (2015-2020) of \$750,000/year, from the Centers for Disease Control to develop a state Coverdell Stroke Program. We are one of 9 states funded to do this work. The program is named after Georgia Senator Paul Coverdell who died from a stroke while in office. The long-term goal of the program is to ensure that all Americans receive the highest quality of acute stroke care currently available and to reduce the number of untimely deaths attributable to stroke, prevent stroke-related disability, and prevent stroke patients from suffering recurrent strokes.

The Washington Coverdell Stroke Program (WACSP) goal is to reduce death and disability from stroke and eliminate disparities in care and outcomes by working with the public and partners across the healthcare continuum to recognize stroke and get evidence-based treatment rapidly through a robust,

well-coordinated system. The grant enables us to support and build on the stroke component of our existing Emergency Cardiac and Stroke System.



Our primary strategies to improve stroke care and outcomes are:

- Partner with and support EMS, hospitals, and other healthcare providers to do data-driven quality improvement.
- Provide training to increase workforce knowledge and expertise.
- Strengthen our [state stroke system](#).
- Build an integrated stroke registry, using existing data sources where possible, that links EMS, hospital, and post-acute data to measure performance and outcomes across the system.
- Educate the public and care providers on the signs and symptoms of stroke, and the importance of time to treatment and calling 9-1-1 at the first signs of stroke.
- Support for internal and regional stroke care quality improvement and stroke awareness activities.

Our Commitment to Coverdell Partners:

- Recognize your organization on our website and in other program communications as a WACSP Partner working to provide the best stroke care for people in your community.
- Provide hospital/regional/state performance reports on required and other relevant indicators.
- Facilitate a Stroke Coordinator Network.
- Offer regular quality improvement forums, professional education opportunities, and regional stroke workshops.

- Support organizational and regional quality improvement across the continuum of care through performance reporting and assistance with developing data-driven quality improvement initiatives.
- Assist with community stroke awareness initiatives and materials.
- Provide opportunities to apply for funds to support local/regional improvement efforts, as funds are available.

Program Coordination and Contacts:

WACSP is located in the Emergency Care System Section, Office of Community Health Systems (CHS), Health Systems Quality Assurance Division of the Department of Health. The Emergency Cardiac and Stroke System and the EMS and Trauma System are also managed here, facilitating coordination between the systems.