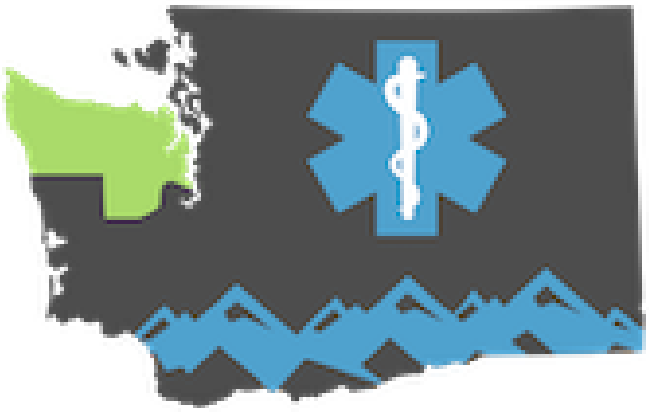
Northwest Region
Emergency Medical Services
& Trauma System

S Y S T E M P L A N

July 1, 2023 - June 30, 2025



Submitted by:
Northwest Region EMS and Trauma Care Council
1/12/23 First Draft submitted to DOH
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Introduction to plan

The Northwest Region's Strategic EMS & Trauma Care System Plan is made up of goals adapted from the State Strategic EMS & Trauma Care System Plan. (RCW 70.168.015) The objectives and strategies are developed by our local councils and then approved by the Regional Council and its stakeholders to meet the goals of Northwest Region.

The Regional Council has adopted the following:

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

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

Vision: Excellence thru integrity and honesty, Leader in the state for patient care delivery

In accordance with RCW 70.168.010 – RCW 70.168.130 and Washington Administrative Code (WAC 246.976.960) the EMS and Trauma Care Regional Council and County Councils are required to administer and facilitate EMS & Trauma Care System coordination, evaluation, planning and develop system recommendations for the WA State EMS and Trauma Steering Committee and the Department of Health (DOH).
The Northwest Region is located on the Olympic Peninsula of Washington State. It is one of eight Regional Councils statewide composed of appointed volunteer representatives and funded primarily by the Washington State Department of Health (DOH). The Region is comprised of the following Counties: Kitsap, Mason, Clallam, and Jefferson. Due to demographics Northwest Region recognizes the West Olympic Peninsula - which includes West Clallam County and West Jefferson counties as a separate Council and they operate as such. As a result, we recognize 5 local EMS councils; Clallam, Jefferson, Kitsap, Mason and West Olympic Peninsula. NW Region recognized that the unique demographics of the Region with one road leading in and out to some counties, one bridge that crosses Hood Canal, and a National Forest in the NW Corner of the Region can cause some struggles in transport of patients. There are thirty-three (33) EMS licensed & trauma verified aid and ambulance services within the Northwest Region. There are 14 SEI's, 5 SEIC's, 250 ESE's and 5 Approved Training Programs within the Northwest Region as of January 11, 2023. There are five (5) trauma services designated within the Northwest Region as of November 2022. There are five (5) Emergency Cardiac and Stroke System Hospitals within the Northwest Region as of December 2018

- Clallam County is located on the north side of the Region and is classified as Rural. Largest city is Port Angeles. Comprised of 2,671sq. miles, 65% of which is water. Clallam County is the westernmost point in both Washington and the US. Clallam County shares borders with Canada, the Pacific Ocean, and the Strait of Juan de Fuca. Also contains part of the Olympic National Park, and can be reached by US Hwy 101.

Clallam County Statistics and Resources											
Population	**Growth**		**Rural population**		**2026 projected population**		**% of population 65 years and over**				
78,209	9.4%		35.5%		78,050		31%				
	# of EMR		**# of EMT**		**# of AEMT**		**# of Paramedic**				
	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Total Paid	Total Volunteer	% Volunteer
EMS Providers	0	0	86	103	6	7	64	1	156	111	41.6%
	SEI		3		**SEIC**		2		**ESE**		83
	AID BLS		**AID ILS**		**AID ALS**		**AMB BLS**		**AMB ILS**	**AMB ALS**	**Licensed**	**ESSO**
EMS Agencies	0		0		0		3		1	4	1	1
	Trauma Level		Rehabilitation Level		Pediatric Level		Cardiac Level		Stroke Level		
Olympic Medical Center	III						II		III		
Forks Community Hospital	IV						II		III		
Training Program	Clallam County EMS and Trauma Care Council										
Training Program	West Olympic Peninsula EMS Council										
Air Medical Base	Lifeflight has a Fixed & Rotor Wing base in Port Angeles, WA										

- Jefferson County is in the middle of the Region, just below Clallam County and is classified as Rural. The largest city is the only incorporated city of Port Townsend. Comprised of 2,183sq. miles the Olympic Mountains and Olympic National Park/Forest make up 60% of the county. Eastern Jefferson County sits along the strait of Juan de Fuca, Admiralty Inlet, Puget Sound and the Hood Canal. Western Jefferson County borders sit along the Pacific Ocean. Because of the mountainous barrier, there is no road lying entirely within Jefferson County that connects the eastern and western parts. The most direct land route between the two ends of the county involves a drive of approximately 100 miles (160 km) along U.S. Route 101 through neighboring Clallam County. Can also be accessed 2 State Hwys or by Ferry from Coupeville.

Jefferson County Statistics and Resources												
Population	**Growth**		**Rural population**				**2026 projected population**				**% of population 65 years and over**	
33,605	12.4%		57.5%				33,816				39.2%	
	# of EMR		**# of EMT**		**# of AEMT**		**# of Paramedic**					
	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Total Paid	Total Volunteer	% Volunteer	
EMS Providers	0	0	35	58	5	2	22	0	62	60	49.2%	
	SEI		3		**SEIC**		0		**ESE**		26	
	AID BLS	**AID ILS**	**AID ALS**		**AMB BLS**		**AMB ILS**	**AMB ALS**		**Licensed**		**ESSO**
EMS Agencies	0	0	0		3		0	2		1		0
	Trauma Level		Rehabilitation Level		Pediatric Level			Cardiac Level		Stroke Level		
Jefferson Healthcare Hospital	IV							II		III		
Training Program	Jefferson County EMS and Trauma Care Council											

- Kitsap County is located on the eastern side of the Region and is classified as Urban. This is the 7th largest County in the State by population and the 3rd smallest in square miles. Bremerton is the largest city. The United States Navy is the largest employer in the county, with installations at Puget Sound Naval Shipyard, Naval Undersea Warfare Center Keyport, and Naval Base Kitsap (which comprises former NSB Bangor and NS Bremerton).Comprised of 566sq. miles, 30% of which is water, Kitsap County has 250 miles of saltwater shoreline and 2 islands, Bainbridge Island and Blake Island, which is a Marine State Park with 1,127 acres and 5 miles of saltwater beach shoreline. Blake Island is an unserved area. Kitsap County is connected to the eastern shore of Puget Sound by 4 Ferry routes and Highway routes connect Kitsap to the mainland via the Tacoma Narrows Bridge to the I-5 corridor, and to the neighboring Olympic Peninsula via the Hood Canal Bridge.

Kitsap County Statistics and Resources												
Population	**Growth**		**Rural population**				**2026 projected population**				**% of population 65 years and over**	
274,314	9.9%		16.7%				283,282				19.1%	
	# of EMR		**# of EMT**		**# of AEMT**		**# of Paramedic**					
	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Total Paid	Total Volunteer	% Volunteer	
EMS Providers	0	0	320	47	3	0	121	0	444	47	9.6%	
	SEI		5		**SEIC**		1		**ESE**		100	
	AID BLS	**AID ILS**	**AID ALS**		**AMB BLS**		**AMB ILS**	**AMB ALS**		**Licensed**		**ESSO**
EMS Agencies	0	0	0		1		0	7		0		0
	Trauma Level		Rehabilitation Level		Pediatric Level			Cardiac Level		Stroke Level		
St. Michael Medical Center	III							I		II		
Training Program	Kitsap County EMS and Trauma Care Council											
Air Medical Base	Airlift NW has a Rotor Wing base in Bremerton, WA on the border of Mason & Kitsap Counties											

- Mason County is located on the south-eastern side of the Region and is classified as Rural. The only incorporated city is Shelton. Comprised of 1,051sq. miles, 9% of which is water and 2 islands. Mason County encompasses the southern reach of Hood Canal and many bays and inlets of southern Puget Sound. Mason county can be reached by 3 State Routes or US Hwy. 101.

Mason County Statistics and Resources												
Population	**Growth**		**Rural population**		**2026 projected population**				**% of population 65 years and over**			
67,615	9.9%		63.7%		71,175				23.7%			
	# of EMR		**# of EMT**		**# of AEMT**		**# of Paramedic**					
	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Total Paid	Total Volunteer	% Volunteer	
EMS Providers	1	7	59	66	2	1	44	1	106	75	41.4%	
	SEI		3		**SEIC**		2		**ESE**		41	
	AID BLS	**AID ILS**	**AID ALS**	**AMB BLS**	**AMB ILS**	**AMB ALS**	**Licensed**	**ESSO**				
EMS Agencies	3	0	0	6	0	3	0	1				
	Trauma Level	Rehabilitation Level	Pediatric Level	Cardiac Level	Stroke Level							
Mason General Hospital	IV			II	III							
Training Program	Mason County EMS and Trauma Care Council											

- https://www.census.gov/quickfacts
  https://www.doh.wa.gov/Portals/1/Documents/Pubs/609003.pdf
  https://www.census.gov/quickfacts/fact/table/US/PST045219
  https://en.wikipedia.org/wiki
  https://worldpopulationreview.com/us-counties/wa/
  https://www.census.gov/quickfacts/fact/table/US/PST045222

Regional Council Members

Represent private and public healthcare providers across the EMS and Trauma Care System. The Northwest Region EMS and Trauma Care Council structure is comprised of thirty-six representatives and thirty-two alternates. Each local council has: Two local council member representatives, One pre-hospital representative, One healthcare facility representative, One communications representative. Also: Four Medical Program Directors, and Regional positions with One Local Elected Official Representative, One Consumer Representative, One National Park Service/Forest Service Representative, One Coast Guard Representative, One Navy Region NW Representative One Law Enforcement Representative; and One Healthcare Preparedness Representative. As of 1/6/23 we have 31 active members including all 3 MPD's. Local Councils are given reports by their Executive Board member. County reports are given at each Region meeting. Local Councils help to write the bi-annual strategic plan as well The Council meets 5 times per year on the 2nd Thursday in January, March, May, September and November in Sequim, Washington which is approximately the middle of the Region, or via Zoom virtual meeting platforms.

Executive Committee

Regional Council consists of the Chairperson, Vice-Chairperson, Secretary/Treasurer, most recent past Chairperson and two At-Large members. The Committee has representatives from each of the local councils. They fulfill a decision-making role on behalf of the Northwest Region EMS and Trauma Care Council to help meet the goals and objectives of the Regional Plan. The Executive Committee member reports to the local councils and keeps them current on Region happenings. The Executive Committee meets in the off months of the Council meetings when necessary and when there is pressing business to discuss.

Training/Education/Development (TED) Committee

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

QI Committee

This committee membership consists of representatives from each of the five trauma designated hospitals located within the Northwest Region. This group also includes MPD's and pre-hospital providers and is the core group that conducts Quality Improvement reviews and participates in the ongoing process of updating Patient Care Procedures. This group also includes Cardiac & Stroke QI, and the members from the hospitals that make up Northwest Region. This committee is organized and run by the highest level Designated Trauma Centers and Categorized Cardiac and Stroke Facilities in the Region. The QI Committee holds an annual conference where information from various data sources may be shared to inform and promote quality improvement. The Committee meets prior to the Regional Council meetings and the Executive Director acts as Administrator for this Committee.

Injury & Violence Prevention (IVP) Committee

The IVP Committee is dedicated to preventing the leading causes of injury and death in the region which have consistently been Unintentional Falls, Unintentional Poisoning, Suicide by Firearm, and Unintentional Motor Vehicle crashes. When funds allow, annual mini-grants are awarded to evidence-based injury prevention projects in Northwest Region that support data-driven projects in the leading causes of injury and death. The committee meets prior to the Regional Council meetings 3 times per year or when necessary.

Funding Committee

The Regional Council Funding Committee, in conjunction with the Executive Committee, are tasked with the review of annual training requests and office operations budgets and to form a recommendation for the Northwest Region EMS and Trauma Care Council to help meet the goals and objectives of the prehospital portion of the Regional Plan. The committee meets annually, or as needed, to formulate an operating budget prior to the May Regional Council meeting.

Protocol Committee

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

Historical Snapshot

Accomplishments and outcomes from 2021-2023 strategic plan are as follows but not limited to;

- Regionwide collaboration continues to be one of our strengths as we continue to have a large active Regional Council.
- Successfully funded our full amount in Program Grants despite Covid challenges including Initial EMT Classes, Training equipment, ALS/ILS OTEP, Web based ALS training and Injury Prevention with dollars earmarked for Naloxone leave behind kits..
- Falls program link from Prehospital contact to getting the patient into Physical Therapy based on evidence-based practice. Active participants have experienced a decrease in fall instance.
- Naloxone leave behind kits that have been distributed in Jefferson County. NW Region has submitted a grant request to distribute kits utilizing NW Region funds to distribute throughout the Region.
- Mitigation of crowded ED's and hospitals by collaborating with both hospitals as well as individual agencies. EMS providers are involved in Pre-Hospital hand-offs, and staffing the ER waiting rooms to make sure patients with changing conditions are monitored and prioritized. These are EMS providers registered as Nursing Assistants. 4 new community based or mobile integrated health programs in Jefferson, Mason & Kitsap Counties.
- Development and implementation of Behavioral Health Patient Care Protocols and Training to ensure safe and timely care of patients in Behavioral Health Crisis.

- The Region has successfully formed an operating budget that fits within DOH standards and restrictions. Fiscally responsible.
- The Region has successful formed an operating budget that fits within DOH standards and restrictions.
- The Region successfully welcomed and trained with an additional Air Medical resource- LifeFlight. LifeFlight offered ACLS, PALS, Landing zone, and Advanced Airway training to pre-hospital providers within the Region.
- Regionwide collaboration continues to be one of our strengths as we continue to have a large active Regional Council.
- Behavioral Health Summit to gather fire, EMS, law enforcement, behavioral health to build relationship, develop a standard patient care protocol for behavioral health, and align goals to ensure provider safety and the best care for patients in Behavioral Health Crisis. The Regional also began conversations to build up Emergency Operation Plans and shared information from DOH and NWHCRNW. EOC's were stood up. NW Region adapted to the changes quickly and did not miss any Meetings during this Pandemic.

Challenges and Priorities

Challenge and Priorities are as follows but not limited to;

- Office Fire
- Mitigation of crowded ED's and hospitals. We want to prioritize sustainability. Coming up with a sustainable model. This needs to be hospital driven and has been addressed in our plan. 4 new community based or mobile integrated health programs in Jefferson, Mason & Kitsap Counties.
- In the wake of the Covid NW Region is working with emergency preparedness partners to develop a DMCC network and plan for the Region. This is now a standing agenda item and discussed at every meeting.
- In NW Region there is a lack of clinical ride sites. This creates challenges within the Region. We will encourage and/or develop a Regional standard. The programs need to collaborate and develop a best practice to standardize field internship student participation.
- EMS calls and other healthcare activities due primarily to substance use disorders can result in the inefficient use of emergency resources and contribute to EMS provider burnout. The lack of adequate facilities and resources to address this population continues to be a challenge in the region.
- There is a need for local County Operating Procedures (COPs) to be revised and reformatted in a similar standardized template for consistency with the Region PCPs.
- There is a need to identify unserved and underserved areas within the region.

- Adequate sustainable funding remains a challenge for the region to fit within DOH limitations and guidelines. No funding increase or consideration for rising Healthcare costs, or cost of living, etc.
- NW Region has a large percentage of EMS volunteers. This can be a challenge to properly train and maintain skills of EMS volunteers. and also impacts transport of patients in a timely manner. We had a 9.8% decrease in Paid EMS providers and a 6.1% decrease in EMS volunteers, totaling 8.9% decrease overall in the last 2 years.
- NW Region recognizes that we have a high percentage of aging Community-dwelling older adults at 28.3%. Well in excess of the State average of 16.2% and the US average of 16.8%.
- We had a 9.8% decrease in Paid EMS providers a 6.1% decrease in volunteers, totaling 8.9% decrease overall.
- In NW Region there is a shortage of Paramedics. This is due to promotions within merging agencies, retirement, and not enough training programs available to them. The training programs are too limited to the number of providers it can hold thus making it challenging to fulfill openings within the Region.

Regional System
Goals – Objectives – Strategies
July 2023 – June 2025

- Goal 1 -

The work within goal 1 reviews and assesses existing EMS & Trauma resources. This review will gather necessary information to identify system gaps and develop a plan to address our findings. Northwest Region will use DOH Needs Assessment guidance to determine the need for minimum and maximum numbers and levels of designated trauma, pediatric and rehabilitation services, and categorized cardiac and stroke for system development.
The Regional Council along with the Training and Education Committee and the MPD's will review and update the Regional PCP's and Regional Protocols as needed and provide training.

The Regional Council will identify specific challenges for EMS workforce recruitment, retention and training and address our findings.

- Goal 1 - Maintain, assess, and increase emergency care resources.	
Objective 1: By November 2024, Develop and conduct a needs assessment to determine the number of designated and categorized hospitals, EMS services needed to support public access to emergency care services. Include the identification of any unserved or underserved areas.	**Strategy 1.** By **March 2024,** the Regional Council will request each county council collect and review data on public access to emergency care services categorized by 911-based responses & non-911 based responses (transports, other requests) and by BLS & ALS dispositions. The Regional Council may request additional data including response time of first EMS personnel to 911-based response.
	Strategy 2. By **May 2024,** the Regional Council will share results of data collected for discussion and catalog any potential unserved or underserved areas.
	Strategy 3. By **May 2024**, the Regional Council will work with each county council to update the trauma response area maps as needed and report any necessary changes to DOH.
Objective 2: By November 2023 Determine min/max numbers for verified prehospital services.	**Strategy 1.** By **September 2023,** the Regional Council will request each county council review the verified prehospital services min/max numbers.
	Strategy 2. By **November 2023,** The Regional Council will guide the county councils through the process of evaluating and/or making changes by providing DOH guidance and training as needed.

	Strategy 3. By **January 2024,** the Regional Council will review and consider any recommendation to change the min/max numbers at a region council meeting.
	Strategy 4. Throughout the plan cycle, the Regional Council will review current verified prehospital services min/max numbers in the region plan for accuracy and help resolve any found discrepancies.
	Strategy 5. Annually, Staff will ensure that county councils inform the region council when there is a change in a prehospital service (merger, closure, or addition) by conducting a survey after receiving Agency Resource Report from DOH.
Objective 3: By September 2024, Determine min/max numbers for designated trauma and rehabilitation services.	**Strategy 1.** By **September 2024,** the Regional Council will request the Region QI committee review designated trauma & rehabilitation services min/max numbers in the region plan for accuracy.
	Strategy 2. By **September 2024,** the Regional Council will review and consider recommendations by the QI committee for any changes to the designated trauma & rehabilitation services min/max numbers at a Regional Council meeting.
	Strategy 4. Annually, Staff will ensure that Hospitals inform the Regional Council when there is a change in designation.
Objective 4: By November 2024, Make recommendations to improve public access to categorized cardiac and stroke hospitals.	**Strategy 1.** By **September 2024,** the Regional Council will conduct a survey of local Councils to identify best-practices and innovative solutions to improve public access to categorized cardiac and stroke hospitals.
	Strategy 2. By **November 2024,** the Regional Council will share results of survey data collected for discussion and identification of best-practices and innovative solutions to improve public access to categorized cardiac and stroke hospitals.
	Strategy 3. By **Throughout the Plan,** the Regional Council will promote establishment & maintenance of education & QI programs provided by regional categorized cardiac and stroke hospitals. Though 'ongoing', this process needs to be robustly reviewed and the lines of (bidirectional) communications/relationships for Cardiac and Stroke need to be strengthened.
	Strategy 4. By **Throughout the Plan,** the Regional Council will promote public educational resources about cardiovascular disease with website links on the NWREMS website.
Objective 5: By Throughout the Plan, Review and update Patient Care Procedures (PCPs) and Region Protocols as needed and directed by DOH. Participate in statewide standardization of PCPs.	**Strategy 1.** By **November 2023,** the Regional Council will continue to collaborate with the RAC TAC and DOH to standardize and improve PCPs as directed and make revisions as necessary.
	Strategy 2. As needed, the Northwest Region Training/Education/Development (TED) Committee together with all County MPD's, Navy Region NW, and the Protocol Committee will work together to develop Regional Patient Care Procedures.

	Strategy 3. As needed, the Regional Council will maintain the PCPs & Protocols and make available electronically on the Region's website.
	Strategy 4. By **November 2023,** the Regional Council will provide training on the development and purpose of COPs with DOH guidance.
	Strategy 5. County MPD's will participate in Dept. of Health statewide standardization of PCPs.
Objective 6: By March 2024, Identify specific challenges for <u>EMS workforce</u> in the region including recruitment and retention of EMS providers (both paid and volunteer). Truth out and summarize the challenges. Prioritize the challenges and suggest solutions. Provide a report to the DOH of this work.	**Strategy 1.** By **January 2024,** the Regional Council will identify all EMS agencies in the Region and survey to identify specific challenges to EMS workforce recruitment and retention, including assessing changes in occupational longevity of the volunteer and career workforce.
	Strategy 2. By **January 2024,** the Regional Council will partner with DOH in projecting EMS call volume & staffing needs over next 10 & 20 years in the region.
	Strategy 3. By **March 2024** the Regional Council will report findings from survey to DOH.
Objective 7: By May 2024, Identify specific challenges for <u>EMS services</u> (both paid and volunteer) within the region. Truth out and summarize the challenges. Prioritize the challenges and suggest solutions. Provide a report to DOH of this work.	**Strategy 1.** By **March 2024,** the Regional Council will identify all EMS agencies in the Region and survey to identify specific challenges to providing services.
	Strategy 2. By **May 2025,** the Regional Council will discuss & summarize themes from survey & brainstorm solutions.
	Strategy 3. By **May 2025**, the Regional Council will report findings from survey to DOH.
	Strategy 4. By **September 2025,** the Regional Council will host one-day Regional data analytics conference, providing training for agencies how to measure performance analytics & how to use these data to improve services.
	Strategy 5. By **September 2025,** the Regional Council will connect stakeholders seeking further consultation on performance & staffing goals with the Region's liaison who maintains a list of consulting partners.
	Strategy 6. By **September 2025**, the Regional Council will catalog alternate care models (including co-responder programs) in the Region and connect agencies to learn from each other.
	Strategy 7. By **Throughout the Plan,** the Regional Council will support alternate transport initiatives that reduce unit-hour utilization of EMS transport resources.
Objective 8: By September 2024, Identify specific challenges for <u>EMS training programs & instructors</u>. Truth out and	**Strategy 1.** By **May 2024,** the Regional Council will identify all training programs and instructors (formal & informal) in the Region and survey to identify specific challenges to training & education.

summarize the challenges. Prioritize the challenges and suggest solutions. Provide a report to DOH of this work.	**Strategy 2.** By **September 2024,** the Regional Council will d**iscuss** & summarize themes from survey & brainstorm solutions in the Training Committee.
	Strategy 3. By **September 2024,** the Regional Council will **Report** findings from survey to DOH.
	Strategy 4. By **September 2024,** the Regional Council will compile list of training programs and instructors (contacts and expertise) to facilitate partnership & collaboration.
	Strategy 4. By **As needed,** the Regional Council will host one-day Regional educational conference to connect rural instructors with education experts to improve teaching methods.
Objective 9: By March 2025, Identify organizations within the region that may be able to become approved as a Pearson Vue testing facility for the DOH approved national cognitive examination.	**Strategy 1.** By **January 2025**, the Regional Council will develop a list of higher education facilities in region that currently are Pearson Vue testing facilities for both in-person & virtual locations.
	Strategy 2. By **January 2025**, the Regional Council will develop a list of higher education facilities in region that are not currently Pearson Vue testing facilities and meet criteria.
	Strategy 3. By **March 2025**, the Regional Council will report findings of potential sites for new Pearson Vue testing facilities to Region partners and DOH EMS Education and Training Team.

- Goal 2 -

Work within goal 2 is to collaborate with emergency preparedness partners to ensure emergency preparedness response, and resiliency systems are in place in the event of a medical or disaster incident. Our work in the 2023-2025 planning period includes, Disaster planning, training/exercises, Pandemic Disease planning, DMCC planning, Regional Patient Care Procedures, and response plans.

The Regional Council will work closely within the 5 Local EMS & Trauma Care Councils, MPDs, EMS providers, trauma services, public health, emergency management, and other EMS and trauma stakeholders to assure a multi-disciplinary approach to EMS and trauma care system development. The Region staff will disseminate emergency preparedness information with the Council by partnering with emergency management programs.

The Northwest Region participates in continued collaborative planning processes as needed to ensure that key stakeholders remain informed of system issues and have the opportunity to be involved in resolving both local and regional system concerns. We will continue to work with emergency Preparedness partners and include them in our planning, training and procedure development.

- Goal 2 - Support emergency preparedness, response, and resilience activities	
Objective 1: By January 2025, Work with the health care coalition to identify roles and responsibilities for regional councils and coalitions during a medical surge or disaster event.	**Strategy 1.** By **September 2023**, the Regional Council will invite emergency preparedness representatives to participate on county and region councils.
	Strategy 2. By Throughout the Plan, the Regional Council will encourage participation in disaster planning & training opportunities by sharing information on upcoming events. (training classes, full scale drills, tabletop exercises)
	Strategy 3. By Throughout the Plan, the Region staff will distribute pre-hospital Emergency Preparedness information on the Region website
Objective 2: By November 2024, Identify ways to improve the regional EMST council participation and coordination with local, state, regional public health, health care coalitions, local emergency managers. This includes identifying relevant partners, developing	**Strategy 1. By May 2025**, the Region will coordinate and facilitate with emergency preparedness partners to complete a DMCC plan for the Region.
	Strategy 2. By May 2025, the Region will incorporate the DMCC plan into the Regional Plan and patient care procedures.

relationships, identifying activities where regional EMST council participation will improve emergency preparedness, response and resiliency of the emergency care system.	
Objective 3: By January 2025, Identify activities, strategies, goals, to improve emergency care system preparedness, response and resilience, to public health emergencies, all hazards incidents, planning and exercise activities to the extent possible with existing resources.	**Strategy 1. By May 2025**, the Region will coordinate and facilitate with emergency preparedness partners to complete a DMCC plan for the Region.
	Strategy 2. By May 2025, the Region will incorporate the DMCC plan into the Regional Plan and patient care procedures.
Objective 4: By January 2025, Work with the DOH to develop guidance for patient care procedures for all hazards, disaster triage, DMCC/WMCC, special pathogens transport, and other emergency preparedness topics as identified. Develop and revise PCPs in accordance with DOH guidance	**Strategy 1. By May 2025**, the Region will coordinate and facilitate with emergency preparedness partners to complete a DMCC plan for the Region.
	Strategy 2. By May 2025, the Region will incorporate the DMCC plan into the Regional Plan and patient care procedures.
	Strategy 3. By March 2025, Regional staff will work with emergency preparedness partners to facilitate a pandemic disease plan for the Region.
	Strategy 4. By March 2025, the Region will identify mechanisms to coordinate patient flow during a pandemic within the Region and maximize critical care resources.
Objective 5: By November 2024, Monitor for disaster, MCI, and special pathogens related drills and exercises, advocate for EMS to be included in exercises and drills, communicate opportunities for EMS to participate.	**Strategy 1.** By **September 2023**, the Regional Council will invite emergency preparedness representatives to participate on county and region councils.
	Strategy 2. By Throughout the plan, the Regional Council will encourage participation in disaster planning & training opportunities by sharing information on upcoming events. (training classes, full scale drills, tabletop exercises)
Objective 6: By November 2024 Work with DOH to develop a situational	**Strategy 1.** By **November 2024,** The Region will work with NWHRN to share Regional and local healthcare situational awareness provided by the Coalition. This information will be shared at a localized level with the Council.

awareness report that can be used to help inform partners of EMS situational awareness during surge events.	**Strategy 2.** By **January 2025,** The Region will work with DOH as they develop Situational Awareness Guidance.
Objective 7: By Throughout the plan, coordinate with and participate in emergency preparedness and response to all hazards incidents, patient transport, and plan initiatives to the extent possible of existing resources.	**Strategy 1: Throughout the plan cycle**, the Regional Council will invite emergency preparedness representatives to participate on county and region councils.
	Strategy 2. Throughout the plan cycle, the Regional Council will encourage participation in disaster planning & training opportunities by sharing information on upcoming events. (training classes, full scale drills, tabletop exercises)
	Strategy 3. Throughout the plan cycle, the Region staff will distribute pre-hospital Emergency Preparedness information on the Region website

- Goal #3 -

The work within goal 3 promotes injury and violence prevention (IVP) programs. This work will be achieved by sharing best practices, disseminating IVP related activities, information, and opportunities, as well as participation on the State IVP TAC. IVP grants awarded to the local County EMS & Trauma Care Councils will support projects, locally identified as needed and are practical achievable.
The Northwest Region of EMS is currently working to establish programs to reduce the incidence and impact of injuries, violence and illness in the Region. The programs that are being established and used are; the community paramedic program, Nalaxolone leave behind kits and the fall prevention program which is currently operating in many EMS agencies/counties within the region.

- Goal #3 - Plan, implement, monitor and report outcomes of programs to reduce the incidence and impact of injuries, violence and illness in the Region.	
Objective 1: By March 2025, Promote best available or promising practices and programs.	**Strategy 1.** By **January 2024**, the Regional Council shall conduct a survey to identify all activities and programs provided by member agencies that impact the occurrence of and/or reduce the incidence of injuries, violence and illness within the Region.
	Strategy 2. By **Throughout the Plan**, The Regional Council will request IVP best practices information and links from the IVP TAC to post on the Region Website.
	Strategy 3. By **March 2024**, The Regional Council Staff will request fatal and nonfatal hospitalization data from DOH to share at the IVP meeting and will post on the Region Website.
Objective 2: Annually, Document interventions and outcomes and provide a report of the findings to the EMS and Trauma Steering Committee.	**Strategy 1. March 2025,** once activities and programs have been identified quantitative and qualitative approaches shall be employed to define the impact those activities and programs have on patient outcomes. This report shall be widely distributed amongst member agencies and WA DOH.
Objective 3: Throughout the plan, Build sustainable prevention partnerships with pre-hospital	**Strategy 1.** By **March 2025**, Activities and programs with measurable positive impacts shall be promoted within the Region through the implementation of ongoing educational activities.

- Goal #4 -

The work within goal 4 will identify the challenges and barriers our prehospital providers experience while using the WEMSIS data collection system. Then our Council will use this information to develop an effective quality improvement resource in the region. The Regional Council, as the lead organization, works closely with the Clallam, Jefferson, Kitsap, Mason, and West Olympic county EMS & Trauma Care Councils, their respective MPDs, and other EMS and trauma stakeholders to assure a multi-disciplinary approach to EMS and trauma care system development and data collection. These activities improve the widespread availability of trusted, complete, and accurate data for member seeking to use it for performance improvement.

By identifying our system reporting gaps we can provide educational training to improve data quality not only in the Region but statewide.

- Goal #4 - Assess weaknesses and strengths of quality improvement programs in the region.	
Objective 1: Identify strategies to increase EMS service participation in the state EMS data registry and improve the quality of data.	**Strategy 1.** By **September 2023,** the Region will request from DOH Research Analysis & Data a comprehensive breakdown of reporting quality for each agency within the Region.
	Strategy 2. By **September 2023,** the Region will analyze the WEMSIS reporting data and identify common errors or omissions most consistent throughout the region.
	Strategy 3. By **September 2023,** the Region will provide DOH Research Analysis & Data with a list of topics to address in a WEMSIS workshop to train local EMS Agency Supervisors on how to improve reporting consistency in common under-reported areas.
	Strategy 4. By **November 2023,** the Region will work with DOH Research Analysis & Data section to determine the feasibility of establishing WEMSIS educational workshops throughout the region.
Objective 2: Implement strategies to increase EMS service participation in the state EMS data registry and improve the quality of data.	**Strategy 1.** By **December 2023,** the Region will confirm DOH's ability to provide WEMSIS educational workshops and work with DOH to schedule dates and locations for WEMSIS workshops to be conducted throughout the region.
	Strategy 2. By **March 2024,** the Region will develop a survey to be distributed to WEMSIS educational workshop attendees to elicit information and provide feedback for how beneficial the training was and areas to address in future workshops.
Objective 3: Assess the effectiveness WEMSIS educational workshops had	Strategy 1: By **September 2024,** the Region will review data provided by WA DOH to analyze the degree of improvement in participation and improvement in data quality pertaining

throughout the region by analyzing the EMS service participation in the state EMS data registry and the improvement in the quality of data reported.	to WEMSIS reporting 180 days after completion of the WEMSIS education workshops.
	Strategy 2: By **November 2024,** the Region will work with the DOH Research and Data Analysis to develop an on-demand video tutorial outlining best practices throughout the region that leads to consistency and quality WEMSIS reporting.

- Goal #5 -

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

The Region will continue to support and fund educational programs within the region and establish Program grant contracts addressing both Prehospital training and Injury Prevention. Rural educational programs will also continue to be our focus as we consider hosting a leadership Course, EMS instructor development. In addition, we will offer a course in Provider Wellness.

Northwest Region will also continue to maintain a robust Regional Council and encourage involvement.

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

course prioritizing rural EMS providers.	
Objective 3: By June 2025 Consider hosting a wellness course.	**Strategy 1.** By **June 2025** The Region will explore opportunities to host a wellness course for providers.
Objective 4: By June 2025 Support EMS instructor development.	**Strategy 1.** By **June 2025** The Region will explore opportunities to host a class that supports EMS instructor development.
Objective 5: By June 2025 Promote opportunities to improve sustainable practices for rural EMS systems. Consider using DOH education materials that have been developed to support rural EMS sustainability.	**Strategy 1.** By **Throughout the plan cycle,** the Region will work with the DOH/RAC to support sustainable practices as available.
	Strategy 2. As needed, staff will continue to communicate information and opportunities from the DOH Rural EMS Workgroup with the Membership and throughout the Region.
	Strategy 3. By **September 2024**, The Region will appoint a council member to attend Rural EMS meetings and report back to the Council.
Objective 6: By Throughout the plan period Manage regional council membership to ensure all medical, and other partners and stakeholders, are represented.	**Strategy 1. Throughout the plan period,** the region council will work with the Region Stakeholders to identify gaps in membership.
	Strategy 2. Throughout the plan period, the Regional Council will provide new council members orientation information including the region council handbook, bylaws, etc.
	Strategy 3. Throughout the plan period as needed region staff will ensure that Council members are current with required OMPA training.
	Strategy 4. By **May annually**, the Regional Council will work with council members to ensure reappointment applications are submitted to the DOH prior to the September expiration.
Objective 7: By Throughout the plan period, Manage work and deliverables required by the DOH contract.	**Strategy 1. Throughout the plan period**, the Regional Council will submit deliverables and supplemental documents per DOH contract requirements.
	Strategy 2. Throughout the plan period, the Regional Council will maintain a website with pertinent Regional and county council information per DOH requirements and beyond.
	Strategy 3. Biennially, the Regional Council will write Objectives and Strategies for the Strategic Plan per DOH guidelines.

	Strategy 4. Throughout the plan period, the Region Staff, will coordinate and hold regularly scheduled meetings for the Council, subcommittees and workgroups.
	Strategy 5. Throughout the plan period, the Region will ensure that County Councils coordinate and hold regularly scheduled meetings. Region staff or Executive Board member will attend meetings in person or send a Region report prior to the scheduled council meeting.
	Strategy 6. Throughout the plan period, a Regional Council representative will participate in EMS & Trauma related meetings, committees, and workgroups and TACS including; County Council meetings, State EMS Steering Committee, Regional Advisory Committee (RAC), DOH Office of Community Health meetings, WAC revision, and Regional QI meeting, Regional IVP, etc
	Strategy 7. Monthly the Regional Council financial transactions will be conducted in accordance with the council fiscal accounting policies and procedures Manual.
	Strategy 8. By May annually, the Regional Council will create and approve an annual budget for the following fiscal year.
	Strategy 9. Biennially, the Regional Council will cooperate with the State Auditor's Office to facilitate the audit process.

APPENDICES

Appendix 1. Adult and Pediatric Trauma Designated Hospitals and Rehabilitation Facilities

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

Current as of November 2022
https://dog.wa.gov.sites.default.files.2022-02/530101.pdf

Appendix 2. Approved Minimum and Maximum (Min/Max) Numbers of Trauma Designated Hospitals by level.

Approved Minimum/Maximum of Designated Trauma Care Services (General Acute Trauma Services)			
Level	**State Approved**		**Current Status**
	Min	**Max**	
II	1	1	0
III	2	2	2
IV	2	3	3
V	3	4	0
II P	0	0	0
III P	1	1	0
II R	0	0	0

Numbers as of November 2021
Designated Trauma Facility Regional Minimum/Maximum Numbers (wa.gov)

Appendix 3. Approved Minimum and Maximum (min/max) numbers for Trauma Rehabilitation Facilities.

Approved Minimum/Maximum of Designated Rehabilitation Trauma Care Services			
Level	**State Approved**		**Current Status**
	Min	Max	
I			
II	**0**	**0**	**0**
III*	**0**	**0**	**0**

(There are no restrictions on the number of Level III Rehab Services.)
Numbers as of November 2021.
Designated Trauma Facility Regional Minimum/Maximum Numbers (wa.gov)

Appendix 4. Washington State Emergency Cardiac and Stroke (ECS) System Categorized Hospitals.

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

Numbers as of June 2022.
https://dow.wa.gov/sites/default/files/2022-02/345299.pdf?uid=63fe807365cba

Appendix 5. EMS Resources, Prehospital Verified Services, Prehospital Non-Verified Services.

Credential #	Credential Status	Agency Name	City	Expiration Date	Agency Type	Care Level	Ground Vehicle		Personnel		
Clallam County *Indicates West Olympic Peninsula							# AMB	# AID	# BLS	# ILS	# ALS
AID.ES.60704710	ACTIVE	Norpoint Medical	Port Angeles	3/31/2024	AID	BLS	0	3	2	0	1
AMBV.ES.00000055	ACTIVE IN RENEWAL	Clallam 2 Fire Rescue and Clallam County Fire District No. 2	Port Angeles	3/31/2023	AMBV	ALS	3	0	32	1	5
AMBV.ES.00000056	ACTIVE IN RENEWAL	Clallam County Fire District #3	Sequim	3/31/2023	AMBV	ALS	6	4	46	1	30
AMBV.ES.00000057	ACTIVE IN RENEWAL	Clallam County Fire Protection District No.4	Joyce	3/31/2023	AMBV	BLS	2	0	13	2	4
AMBV.ES.00000058	ACTIVE IN RENEWAL	*Clallam County Fire District 5	Clallam Bay	3/31/2023	AMBV	BLS	2	0	4	0	0
AMBV.ES.00000060	ACTIVE	Port Angeles Fire Department	Port Angeles	5/31/2023	AMBV	ALS	3	6	19	0	14
AMBV.ES.00000066	ACTIVE	*Clallam County Hospital District #1	Forks	5/31/2024	AMBV	ILS	3	2	17	4	0
AMBV.ES.00000067	ACTIVE	Olympic Ambulance Service	Sequim	5/31/2024	AMBV	ALS	13	0	51	2	10
AMBV.ES.00000068	ACTIVE	*Neah Bay Ambulance Service	Neah Bay	5/31/2024	AMBV	BLS	3	0	2	3	1
ESSO.ES.60295051	ACTIVE	Port Angeles Police Department	Port Angeles	5/31/2023	ESSO		0	0	2	0	0
Jefferson County				**Clallam County totals**					**188**	**13**	**65**
AMBV.ES.00000209	ACTIVEIN RENEWAL	East Jefferson Fire and Rescue	Port Townsend	2/28/2023	AMBV	ALS	9	6	47	4	16
AMBV.ES.00000211	ACTIVE IN RENEWAL	Port Ludlow Fire and Rescue	Port Ludlow	2/28/2023	AMBV	ALS	4	7	12	0	3
AMBV.ES.00000212	ACTIVE	Brinnon Fire Department	Brinnon	2/28/2024	AMBV	BLS	2	3	13	2	1
AMBV.ES.00000213	ACTIVE IN RENEWAL	Discovery Bay Volunteer Fire and Rescue	Port Townsend	2/28/2023	AMBV	BLS	2	4	6	1	0
AMBV.ES.60404294	ACTIVE	Quilcene Fire Rescue	Quilcene	2/28/2024	AMBV	BLS	2	0	13	0	1
AMB.ES.61340294	ACTIVE	Olympic Ambulance Service, Inc.	Sequim	6/30/2025	AMB	ALS	1	0	0	0	0
				Jefferson County totals					**91**	**7**	**21**

Credential #	Credential Status	Agency Name	City	Expiration Date	Agency Type	Care Level	Ground Vehicle		Personnel		
Kitsap County							# AMB	# AID	# BLS	# ILS	# ALS
AMBV.ES.00000320	ACTIVE	Central Kitsap Fire and Rescue	Silverdale	7/31/2024	AMBV	ALS	8	0	89	0	24
AMBV.ES.00000321	ACTIVE	Bainbridge Island Fire Department	Bainbridge Island	7/31/2023	AMBV	ALS	5	0	43	0	8
AMBV.ES.00000324	ACTIVE	South Kitsap Fire and Rescue	Port Orchard	10/31/2023	AMBV	ALS	8	0	67	0	27
AMBV.ES.00000326	ACTIVE	North Kitsap Fire and Rescue	Kingston	10/31/2023	AMBV	ALS	5	0	35	0	10
AMBV.ES.00000330	ACTIVE	Bremerton Fire Department	Bremerton	9/30/2023	AMBV	ALS	5	0	46	1	19
AMBV.ES.00000332	ACTIVE	Poulsbo Fire Department	Poulsbo	9/30/2024	AMBV	ALS	7	19	36	2	17
AMBV.ES.00000342	ACTIVE	Olympic Ambulance	Bremerton	4/30/2023	AMBV	ALS	9	0	33	0	14
AMBV.ES.00000343	ACTIVE	Bremerton Ambulance	Bremerton	4/30/2023	AMBV	BLS	3	0	16	0	2
ESSO.ES.60421581	ACTIVE	Kitsap County Sheriff's Office	Port Orchard	10/31/2022	ESSO		0	0	0	0	1
Mason County				**Kitsap County totals**					**365**	**3**	**121**
AIDV.ES.00000430	ACTIVE	Mason County Fire District #12	Matlock	01/31/2023	AIDV	BLS	0	1	4	0	0
AIDV.ES.00000431	ACTIVE	Mason County Fire District #13	Elma	01/31/2025	AIDV	BLS	0	3	8	0	0
AIDV.ES.00000434	ACTIVE	Mason County Fire District #17	Lilliwaup	01/31/2025	AIDV	BLS	0	3	8	0	0
AMBV.ES.00000423	ACTIVE	Mason County FPD #3	Grapeview	08/31/2024	AMBV	BLS	2	0	7	1	0
AMBV.ES.00000424	ACTIVE	Mason County Fire 4	Shelton	08/31/2023	AMBV	BLS	2	3	17	0	0
AMBV.ES.00000425	ACTIVE	Central Mason Fire and EMS	Shelton	08/31/2024	AMBV	ALS	7	0	29	1	25
AMBV.ES.00000426	ACTIVE IN RENEWAL	Mason County Fire District #6	Union	01/31/2023	AMBV	BLS	1	5	8	0	0
AMBV.ES.00000435	ACTIVE	Mason County Fire District #18	Hoodsport	01/31/2025	AMBV	BLS	3	4	15	1	1
AMBV.ES.60231480	ACTIVE	West Mason Fire	Shelton	01/31/2025	AMBV	BLS	2	1	14	0	0
AMBV.ES.60437165	ACTIVE	North Mason Regional Fire Authority	Belfair	08/31/2024	AMBV	ALS	5	0	17	0	12
AMBV.ES.60453257	ACTIVE	Mason County Fire District #11	Shelton	01/31/2023	AMBV	BLS	0	2	5	0	0
AMBV.ES.60920474	ACTIVE IN RENEWAL	Olympic Ambulance Service In	Lacey	1/30/2023	AMBV	ALS	2	0	0	0	4
ESSO.ES.60336509	ACTIVE	Mason County Sheriff's Office	Shelton	1/31/2024	ESSO		0	0	0	0	2
				Mason County totals					**132**	**3**	**44**

Numbers as of 1/10/2023

Total Prehospital Verified Services by County*						
County	AMBV-ALS	AMBV-ILS	AMBV-BLS	AIDV-ALS	AIDV-ILS	AIDV-BLS
Clallam	4	1	3	0	0	0
Jefferson	2	0	3	0	0	0
Kitsap	7	0	1	0	0	0
Mason	3	0	6	0	0	3

Numbers as of 1/10/2023

Total Prehospital Non-Verified Services by County*							
County	AMB-ALS	AMB-ILS	AMB-BLS	AID-ALS	AID-ILS	AID-BLS	ESSO
Clallam	0	0	0	0	0	1	1
Jefferson	1	0	0	0	0	0	0
Kitsap	0	0	0	0	0	0	1
Mason	0	0	0	0	0	0	1

Numbers as of 1/10/2023

There are a total of 1,061 EMS providers; 768 of which that are Paid providers and 293 of which are volunteers as of January 4, 2023:

	# of EMR		# of EMT		# of AEMT		# of Paramedic				
County	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	Paid	Volunteer	TOTAL PAID	TOTAL VOLUNTEER	PERCENT VOLUNTEER
Clallam	0	0	86	103	6	7	64	1	156	111	41.6%
Jefferson	0	0	35	58	5	2	22	0	62	60	49.2%
Kitsap	0	0	320	47	3	0	121	0	444	47	9.6%
Mason	1	7	59	66	2	1	44	1	106	75	41.4%
NWREGION	1	7	500	274	16	10	251	2	768	293	27.6%

Appendix 6. Approved Minimum and Maximum Numbers for Trauma Verified EMS Services

Approved Minimum/Maximum of Verified Trauma Services by Level and Type in each County					
County	**Verified Service Type**	**Care Level**	**State Approved Minimum #**	**State Approved Maximum #**	**Current Status (total # verified for each service type)**
Clallam	AIDV	BLS	1	2	0
		ILS	0	0	0
		ALS	1	2	0
	AMBV	BLS	5	6	3
		ILS	0	0	1
		ALS	3	4	4
Jefferson	AIDV	BLS	1	2	0
		ILS	0	1	0
		ALS	0	0	0
	AMBV	BLS	5	5	3
		ILS	1	2	0
		ALS	2	2	2
Kitsap	AIDV	BLS	2	4	0
		ILS	0	1	0
		ALS	0	0	0
	AMBV	BLS	5	6	1
		ILS	0	1	0
		ALS	5	7	7
Mason	AIDV	BLS	6	7	3
		ILS	0	0	0
		ALS	1	1	0
	AMBV	BLS	6	8	6
		ILS	0	0	0
		ALS	3	3	3

Numbers as of 1/10/2023

Air Ambulance Service Plan (wa.gov)

APPENDIX 7. Approved Trauma Response Areas for Verified EMS Services

Trauma Response Area by County				
County	Trauma Response Area Number	Name of Agency Responding in Trauma Response Area	Description of Trauma Response Area's Geographic Boundaries	Number of Verified Services in the response area
Clallam	#1	Port Angeles Fire Department	The current city limits of Port Angeles	1 AMBV-ALS
Clallam	#2	Clallam County Fire District #2	Area surrounding the City of Port Angeles on three sides, South, West and East. Bordered to south by Olympic National Park	1 AMBV-LS
Clallam	#3	Clallam County Fire District #3	Bordered on the west by response area 2, north by the Strait of Juan De Fuca, to the east by Jefferson County, to the south by Olympic National Park. Includes the City of Sequim	2 AMBV-ALS
Clallam	#4	Clallam County Fire District #4	Along Highway 112 between Port Angeles and Clallam Bay. Bordered by the Strait of Juan De Fuca, south by Olympic National Park	1 AMBV-BLS
Clallam	#5	Clallam County Fire District #5	Clallam Bay area. From mile marker 7 on Highway 112 on the west side, to mile marker 34 on the east	1 AMBV-BLS
Clallam	#6	Clallam County Hospital District #1	Forks township and surrounding rural/wilderness area	1 AMBV-ILS
Clallam	#7	Neah Bay Ambulance	The Makah Indian Nation and surrounding wilderness	1 AMBV-BLS
Clallam	#A		Olympic National Park	1 AIDV-BLS

Trauma Response Area by County				
County	Trauma Response Area Number	Name of Agency Responding in Trauma Response Area	Description of Trauma Response Area's Geographic Boundaries	Number of Verified Services in the response area
Clallam	#B-O	Clallam County Fire District #2	All areas included in trauma Response Area Number 2	1 AMBV-BLS
Clallam	#B		All other areas in Clallam County	4 AIDV-BLS
Jefferson	#1	Jefferson County Fire District #1	The area between Port Ludlow and Port Townsend and Marrowstone Island	1 AMBV-ALS
Jefferson	#2		Quilcene area bordered on the west by Olympic National Park, north by Highway 104, to the east at mile marker 3 on Coyle Road	1 AMBV-BLS 1 AMBV-ALS
Jefferson	#3	Jefferson County Fire District #3	Easternmost part of County including Port Ludlow, a long stretch of Highway 104, and Hood Canal Bridge response	1 AMBV-ALS
Jefferson	#4	Jefferson County Fire District #4	Southeastern portion of the County bordering Mason County to the south and Olympic National Park to the east. Includes long stretch of Highway 101 along Hood Canal	1 AMBV-BLS 1 AMBV-ALS
Jefferson	#5	Jefferson County Fire District #5	Northwestern Portion of County including Discovery Bay inlet. Bordered on the west by Clallam County	1 AMBV-BLS 1 AMBV-ALS
Jefferson	#7		Northern part of the County including the City of Port Townsend. Bordered on the east by Discovery Bay, and the	1 AMBV-BLS 1 AMBV-ALS

Trauma Response Area by County				
County	Trauma Response Area Number	Name of Agency Responding in Trauma Response Area	Description of Trauma Response Area's Geographic Boundaries	Number of Verified Services in the response area
			west by the Port of Port Townsend.	
Jefferson	#8		Ranges from the Coyle Peninsula to Quilcene Bay at mile marker 3 on Coyle Road.	1 AMBV-BLS 1 AMBV-ALS
Jefferson	#A		Olympic National Park	1 AIDV-BLS
Jefferson	#B		Fort Warden – Federal land, South and West of the Strait of Juan de Fuca	
Jefferson	#C		Indian Island – Federal land surrounded by the Straight of Juan de Fuca	
Jefferson	#D		Ft. Flagler – Federal park land, Northern tip of Marrowstone Island	
Kitsap	#1	Central Kitsap Fire and Rescue	The Central portion of the county including the City of Silverdale, bordered on the west by the Hood Canal, the east by Port Orchard Bay, to the South by Mason County and has Subbase Bangor to the north.	1 AMBV-ALS
Kitsap	#1A	Central Kitsap Fire and Rescue	Now to be included in Trauma Response area #1.	1 AMBV-ALS
Kitsap	#2	Bainbridge Island	Bainbridge Island	1 AMBV-BLS 1 AMBV-ALS
Kitsap	#3	Bremerton Fire	The City of Bremerton	2 AMBV-BLS 1 AMBV-ALS
Kitsap	#3A		Surrounded by Dyes Inlet to the North and East up to and including the City of Bremerton	2 AMBV-BLS 1 AMBV-ALS
Kitsap	#5	Navy Region NW	Navy Base Bangor	1 AMBV-BLS

Trauma Response Area by County				
County	Trauma Response Area Number	Name of Agency Responding in Trauma Response Area	Description of Trauma Response Area's Geographic Boundaries	Number of Verified Services in the response area
Kitsap	#7	South Kitsap Fire and Rescue)	The South Eastern Portion of the County bordered on the east by Colvos Passage and the Hood Canal, to the north Dyes Inlet and The City of Bremerton, and to the south and east by Mason County	1 AMBV-ALS
Kitsap	#10	North Kitsap Fire and Rescue	The northern portion of the County and the Kitsap Peninsula including Kingston, The S'Klallam Indian Nation Reservation, the east half of The Port Madison Indian Reservation and Hansville on the northernmost point of the Kitsap Peninsula	1 AMBV-ALS
Kitsap	#18	Poulsbo Fire Department	The City of Poulsbo and surrounding areas from Liberty Bay to the Hood Canal on the west	1 AMBV-ALS
Kitsap	#18A	Poulsbo Fire Department	South of Puget Sound, west of Bangor Airforce Base Trauma Response area #5 and South to Mt. View Road. Includes the West portion of Pt. Madison Indian Reservation. Up to and including the Trauma Response area #18	1 AMBV-ALS
Kitsap	#A		Keyport Federal Military Base with Puget Sound to the North and East. North of Trauma	

Trauma Response Area by County				
County	Trauma Response Area Number	Name of Agency Responding in Trauma Response Area	Description of Trauma Response Area's Geographic Boundaries	Number of Verified Services in the response area
			Response area #1 and south of #10	
Kitsap	#B		Department of Natural Resources land	
Kitsap	#C		Department of Natural Resources land	
Kitsap	#D		State Land	
Kitsap	#E		Blake Island, Tribal Land	
Mason	#1	Mason County Fire District #1	The Hoodsport area, bordered on the West by Olympic National Park and the Lake Cushman area, to the east by the Hood Canal, to the north at Lilliwaup and to the south at Potlatch	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#2	North Mason Regional Fire Authority	Northeastern portion of the county, bordered on the west by the Hood Canal, to the north and east by Kitsap County. Also covers a portion of 106 along the Hood Canal	1 AMBV-ALS
Mason	#3	Mason County Fire District #3	The Grapeview area bordered to the east and south by case inlet, to the north and west by Highway 3	1 AMBV-BLS 1 AMBV-ALS AIDV-ILS
Mason	#4	Mason County Fire District #4	The southeastern portion of the county. Bordered on the North by Hammersly Inlet, to the west by the City of Shelton to the south by Thurston County and to the east by Totten Inlet	1 AMBV-BLS 1 AMBV-ALS

Trauma Response Area by County				
County	Trauma Response Area Number	Name of Agency Responding in Trauma Response Area	Description of Trauma Response Area's Geographic Boundaries	Number of Verified Services in the response area
Mason	#5	Mason County Fire District #5	The large central portion of the county, bordered to the south by the City of Shelton and Hammersly Inlet. Covers a long portion of Highway 3 and also contains Harstene Island	1 AMBV-ALS
Mason	#6		Union area along the Hood Canal to the north and bordered by the Skokomish Tribal Reservation on the west.	1 AMBV-BLS 1 AMBV-ALS
Mason	#8	Mason County Fire District #8	The Tahuya area bordered on 3 sides by the Hood Canal	1 AMBV-BLS 1 AMBV-ALS
Mason	#9	Mason County Fire District #9	Covers the west-central portion of the county, from Potlatch to the southern end of the Skokomish Tribal Reservation. Bordered on the west by Olympic National Forest	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#11	Mason County Fire District #11	Northwest of the City of Shelton, includes a portion of Highway 101 and Sanderson Field	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#12	Mason County Fire District #12	Matlock area, large southwestern portion of the County. Bordered to the west and south by Grays Harbor County. Also shares border with Olympic National Forest to the North and Northeast	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS

Trauma Response Area by County				
County	Trauma Response Area Number	Name of Agency Responding in Trauma Response Area	Description of Trauma Response Area's Geographic Boundaries	Number of Verified Services in the response area
Mason	#13	Mason County Fire District #13	South-central area of the County, southern border to Grays Harbor County, northern at Lost Lake. Small northeastern area borders the City of Shelton	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#16		Dayton Area. Borders Shelton to the east. Ends at Mile 1 on airport Road to the north, mile 9 of Shelton-Matlock Road to the west.	1 AIDV-BLS 1 AMBV-BLS 1 AMBV-ALS
Mason	#17	Mason County Fire District #17	Northwestern area along Highway 101. Borders Jefferson County to the North, Hood Canal to the east, Olympic National Park to the West and Lilliwaup to the south	1 AIDV-ALS 1 AMBV-BLS 1 AMBV-ALS
Mason	#18	Mason County Fire District #18	Lake Cushman Area. Surrounded on all sides By Olympic National Park and Forest areas, except small access area which abuts Hoodsport	1 AMBV-BLS 1 AMBV-ALS
Mason	#15	Mason County Fire District #5	City of Shelton	1 AIDV-BLS 1 AMBV-ALS
Mason	#A		Olympic National Park North of Fire District #12, Surrounding Fire District #18	1 AIDV-BLS
Mason	#B		Olympic National Park	
Mason	#C		Department of Natural Resources Land. South of Fire District #6, East of Fire District #9 and North of Fire District #5	

Trauma Response Area by County				
County	Trauma Response Area Number	Name of Agency Responding in Trauma Response Area	Description of Trauma Response Area's Geographic Boundaries	Number of Verified Services in the response area
Mason	#D		McNeil Island Prison	

Interactive Emergency Medical Care Map

EMS and Trauma Regional and County Maps | Washington State Department of Health

APPENDIX 8. Approved EMS Training Programs and Testing Sites

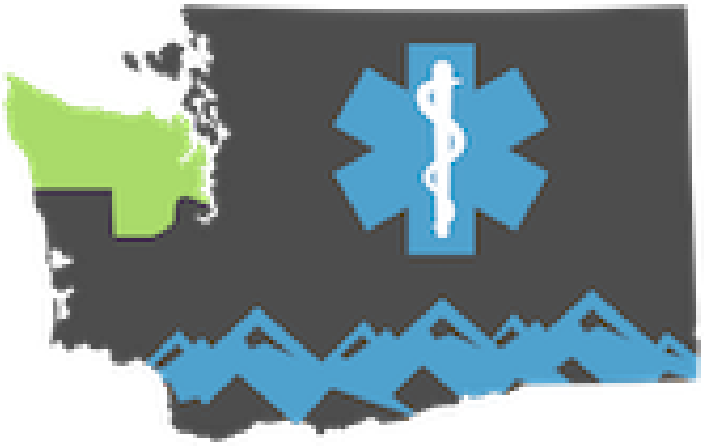
Credential #	Status	Expiration Date	Facility Name	Site City	Site County
TRNG.ES.60119539-PRO	APPROVED	05/31/2027	Clallam County EMS	Port Angeles	Clallam
TRNG.ES.60765973-PRO	APPROVED	05/31/2023	West Olympic Peninsula EMS Council	Clallam Bay	Clallam
TRNG.ES.60101345-PRO	APPROVED	05/31/2023	Jefferson County EMS and Trauma Care Council	Port Townsend	Jefferson
TRNG.ES.60113452-PRO	APPROVED	05/31/2023	Kitsap County EMS and Training Care Council	Silverdale	Kitsap
TRNG.ES.60126227-PRO	APPROVED	05/31/2027	Mason County EMS and Trauma Care Council	Shelton	Mason

As of November 29, 2022.

Appendix 9. Patient Care Procedures (PCPs)

PATIENT CARE PROCEDURES

Northwest Regional Emergency Medical Services & Trauma Care Council



Bremerton, WA 98312

Effective: 5/14/15

REVISED By:
Northwest Region EMS & Trauma Care Council Training Education & Development Committee

ADOPTED By:

Northwest Region EMS & Trauma Care Council

_____
Keith Bogues, Chairperson

Contents

INTRODUCTION

The Northwest Region's Patient Care Procedures are designed to serve as a guide to Medical Program Directors, trauma verified EMS agencies, 9-1-1 centers and EMS personnel as to how and when to activate the Northwest Region's Trauma System. These procedures apply to Clallam, Jefferson, Kitsap and Mason Counties.

The following Regional Patient Care Procedures are intended as an approach toward the rapid treatment of major trauma patients in the Northwest Region.

OBJECTIVE OF THE TRAUMA SYSTEM

The objective of the Northwest Region EMS & Trauma System is to identify and transport patients, based on medical need, to the most appropriate hospital facility in an expedient manner.

Major trauma patients from the following categories are considered at high risk for morbidity and mortality therefore need immediate transfer or transport to the appropriate Level I or Level II trauma center.

Central Nervous System Injuries

Head injury with any of the following:

- Open, penetrating, or depressed skull fracture
- CSF leak
- Severe coma
- Deterioration in Glasgow Coma Score of 2 or more points
- Lateralizing signs
- Unstable spine
- Spinal cord injury

Chest

Suspected great vessel or cardiac injuries
Major chest wall injury
Patient who may require positive pressure ventilation

Pelvis

Pelvic ring disruption with shock requiring more than 5 units transfusion
Evidence of continued hemorrhage
Compound/open pelvic injury with head injury

Multiple System Injury

Severe facial injury with head injury
Chest injury with head injury
Abdominal or pelvic injury with head injury
Burns with head injury

Specialized Problems

Burns over 20 percent of the patient's body surface area involving airway
Carbon monoxide poisoning
Barotrauma

Secondary Deterioration (Late Sequelae)

Patient requiring mechanical ventilation

Sepsis

Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation system(s)

Osteomyelitis

EMT's and/or Paramedics shall use the State of Washington's Prehospital Trauma Triage (Destination) Procedures [Addendum 1] and be knowledgeable of the steps required to activate the Trauma System. In general, major trauma patients who meet the major trauma criteria listed above should be immediately transported or transferred to Harborview Medical Center in Seattle.

ACTIVATION OF TRAUMA SYSTEM

Upon evaluation of the patient(s) and determination of the need for a trauma team, the Paramedic, EMT, or appropriate medical personnel shall contact medical control at the nearest or most appropriate designated trauma center and request the activation of the Trauma System.

Once identified, trauma patients should be treated, transported and trauma data collected as quickly as possible. In all cases, the goal of the Northwest Region Trauma System is to have all trauma patients delivered to the most appropriate medical receiving facility within 60 minutes from the time of arrival of EMS on scene of the trauma incident.

PATIENT CARE PROCEDURE – Dispatch

Standard

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

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

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

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

First Response (80 percent of the time)

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

Transport Response Time (80 percent of the time)

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

Procedure

A verified licensed ambulance and/or aid service shall be dispatched to all emergency and trauma incidents in the Northwest Region.

The highest level trauma verified ambulance in the response area should be dispatched to transport all known or suspected major trauma patients who meet, or are suspected to meet, the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1].

PATIENT CARE PROCEDURE – Response Times

Standard

All verified licensed ambulance and aid services shall respond to emergency medical and trauma incidents in a timely manner in accordance with the Northwest Region Plan and State WAC 246-976-390(10) [Addendum 4] and WAC 246-976-390(11) - Verification of Trauma Care Services [Addendum 5].

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

First Response (80 percent of the time)	
Urban Areas	8 minutes
Suburban Areas	15 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

Transport Response Time (80 percent of the time)	
Urban Areas	10 minutes
Suburban Areas	20 minutes
Rural/rural-suburban	45 minutes
Wilderness/Marine/Frontier	As soon as possible

Procedure

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

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

PATIENT CARE PROCEDURE – Triage and Transport

Standard

All verified licensed ambulance/transport and aid services shall comply with the Northwest Region EMS & Trauma System Plan, Simple Triage and Rapid Treatment (START Triage) Protocol [Appendix 6] and the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1] and transport trauma patients to the most appropriate designated trauma center.

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

Procedure

The first trauma care providing agency to determine that the patient needs definitive medical care or meets the State of Washington Trauma Triage (Destination) Procedures [Addendum 1] criteria, shall ensure immediate contact with a Level I or Level II trauma designated facility or the agency's on-line medical control.

The receiving facility must be provided with the following information, as outlined in the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1]:

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

The first EMS person to determine that a patient meets the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1].

An air ambulance transport should be considered for transport by agencies in the Northwest Region when transport by ground will be greater than 30 minutes, unless weather conditions do not allow for such use, as outlined in the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1].

PATIENT CARE PROCEDURE – Transport guidelines

Standard

All EMS Agencies should follow their Medical Program Director's patient care protocols and /or guidelines for the care and transport of medical and non-major trauma patients. If it is unclear as to where a medical or non-major trauma patient should be transported, contact medical control at your nearest resource hospital for directions; otherwise follow off-line medical control of patients as outlined in your standing orders, patient care protocols, and/or guidelines provided by your Medical Program Director. For the care and transport of identified Major trauma patients EMS Agencies should use the most current State of Washington Prehospital Trauma Triage (Destination) Procedures according to the Department of Health [Addendum 1].

Procedure

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

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

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

DATA COLLECTION

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

PATIENT CARE PROCEDURE – Interfacility Transport

Standard

All designated trauma facilities shall have transfer agreements for the identification and transfer of trauma patients.

All interfacility transfers shall be in compliance with current OBRA/COBRA and EMTALA regulations and must be consistent with RCW 70.170.060(2) [Addendum 7].

Procedure

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

Interfacility transfer of A major Trauma Patient

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

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

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

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

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

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

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

Further orders may be given by the receiving physician.

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

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

PATIENT CARE PROCEDURE – Transport of Patients Outside of Base Area

Standard

All verified licensed ambulance and aid services shall comply with the Northwest Region EMS & Trauma System Plan and the State of Washington Prehospital Trauma Triage (Destination) Procedures [Addendum 1] and transport trauma patients to the most appropriate designated trauma center or facility.

Procedure

Patients transferred out of any local base coverage area (from either the base hospital or the field) are initially the responsibility of local on-line medical control. Prehospital personnel will follow local prehospital protocols. Initial orders, which are consistent with local prehospital protocols, will be obtained from base station on-line medical control.

When the transport service crosses into destination jurisdiction, the destination on-line medical control shall be contacted and given the following information:

1. Brief history
2. Pertinent physical findings
3. Summary of treatment (per protocols and per orders from base medical control)
4. Response to treatment
5. Current condition

The destination medical control physician may add further orders provided they are within the capabilities of the transport personnel.

The nearest trauma center base station will be contacted during the transport should the patient'' condition deteriorate and/or assistance is needed. The transport unit may divert to the closest trauma center as dictated by the patient's condition.

PATIENT CARE PROCEDURE – Activation of Air Ambulance for Field Response to Major Trauma

Standard

All verified licensed ambulance and aid services shall comply with the Northwest Region EMS & Trauma System Plan and the State of Washington Prehospital Trauma Triage (Destination) Procedures as defined in WAC 246-976-390 - and transport trauma patients to the most appropriate designated trauma center or facility.

Procedure

The decision to activate air ambulance service for field response to major trauma shall be made by the highest certified responder from the scene with on-line medical control consultation. Where Incident Command System (ICS) is used, the commander shall be an integral part of this process.

Air ambulance services requested to respond into the Northwest Region will follow their policies for accepting a field mission and their Rotary Wing Primary Service Area criteria

REGIONAL CARE OF THE CRITICALLY ILL AND INJURED CHILD - Triage and Transfer Guidelines

(Adopted by the Governor's EMS & Trauma Care Steering Committee on July 19, 1995)

Consideration should be given to early transfer of a child to the regional pediatric trauma center when required surgical or medical subspecialty care of resources are unavailable. These include, but are not limited to the following:

1. Hemodynamically stable children with documented visceral injury being considered for "observational" management. Although the efficacy of this approach in selected cases has been well documented, two significant caveats always apply:
   a) Hemodynamic instability mandates immediate operative intervention, and
   b) Non-operative care is safe only in an environment that provides both close clinical observation by a surgeon experienced in the management of childhood trauma and immediately available operative care.
2. Children with abnormal mental status. In all but the infant, outcome from closed head injury has been shown to be significantly better for the child than for the adult. Although the quality and timeliness of initial resuscitation are the most important determinants of outcome from brain injury, continued comprehensive management in specialized units with multi-disciplinary pediatric critical care teams may provide a more rapid and complete recovery.
3. Infants and small children. Severely injured infants and small children are the most vulnerable and, frequently, the least stable trauma victims, because they require the special resources and environment of a regional pediatric trauma center, transfer should occur as soon as safely feasible.
4. Children with injuries requiring complex or extensive reconstruction. These services are traditionally most available in hospitals capable of functioning as a regional pediatric trauma center. It is especially important that children with impairments requiring long-term follow-up and supportive care have this provided or at last coordinated by the regional pediatric trauma center. Longitudinal follow-up of the injury-related disability is an essential requirement of the regional pediatric trauma center's trauma registry.
5. Children with polysystem trauma requiring organ system support. This is especially important for those patients requiring ventilatory, cardiovascular, renal, or nutritional support. Because these problems usually occur synchronously and require precise interdisciplinary coordination, they are best managed in comprehensive facilities such as regional pediatric trauma centers.

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

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

    Should be transferred to a Regional Burn Center.

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

Adopted from: Resources for Equal Care of the Injured Patient: 1993

Committee on Trauma: American College of Surgeons

STATE OF WASHINGTON

PREHOSPITAL TRAUMA TRIAGE (DESTINATION) PROCEDURE

Purpose

The Trauma Triage Procedure was developed by the Centers for Disease Control in partnership with the American College of Surgeons, Committee on Trauma. The guidelines have been adopted by the Department of Health (DOH) based on the recommendation of the State EMS and Trauma Steering Committee.

The procedure is described in the attached algorithm. The guidelines represent the current best practice for the triage of trauma patients. The algorithm allows EMS and Trauma Responders to quickly and accurately determine if the patient is a major trauma patient. Major trauma patients must be taken to the highest appropriate level trauma facility in the defined system within 30 minutes transport time (Air or Ground).

The "defined system" is the trauma system that exists within an EMS and Trauma Care Region.

Explanation of Procedure

Any certified EMS and Trauma responder can identify a major trauma patient and activate the trauma system. This may include asking for Advanced Life Support response or air medical evacuation.

Step (1) Assess the patient's vital signs and level of consciousness using the Glasgow Coma Scale. Step 1 findings require activation of the trauma system. They also require rapid transport to the highest, most appropriate trauma center within 30 minutes' transport time (ground or air). If unable to manage the patient's airway, consider meeting up with an ALS unit or transporting to the nearest facility capable of definitive airway management.

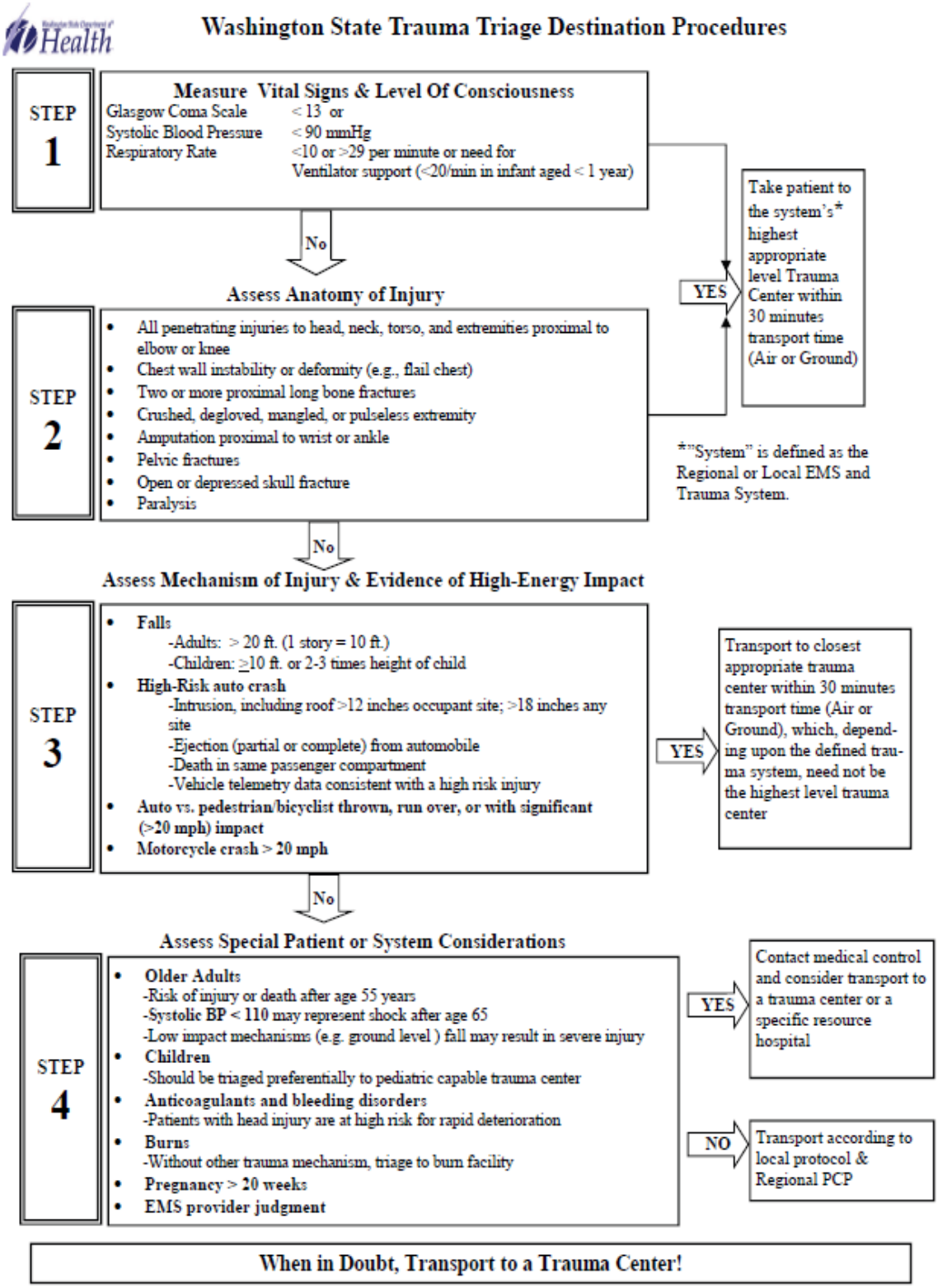
Step (2) Assess the anatomy of injury. Step 2 findings require activation of the trauma system. They also require rapid transport to the highest, most appropriate trauma center within 30 minutes transport time (ground or air). The presence of the specific anatomical injuries even with normal vital signs, lack of pain or normal levels of consciousness still require calling medical control and activating the trauma system.

Step (3) Assess biomechanics of the injury and address other risk factors. The conditions identified are reasons for the provider to transport to a trauma center. The destination trauma center need not be the highest-level trauma center. Medical control should be contacted as soon as possible.

Step (4) has been added to assess special patients or system considerations. Risk factors coupled with "Provider Judgment" are reasons for the provider to contact Medical Control and discuss appropriate transport for these patients. In some cases, the decision may be to transport to the nearest trauma center.

Regional Patient Care Procedures (PCP's) and Local County Operating Procedures (COPS) provide additional detail about the appropriate hospital destination. PCP's and COP's are intended to further define how the system operates. The Prehospital Trauma Triage procedure and the Regional Patient Care Procedures work in a "hand in glove" fashion to address trauma patient care needs.

Addendum 1 http://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf



http://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf

State of Washington
Prehospital Cardiac Triage Destination Procedure

Why triage cardiac patients?

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

How do I use the Cardiac Triage Destination Procedure?

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

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

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

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

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

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

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

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

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

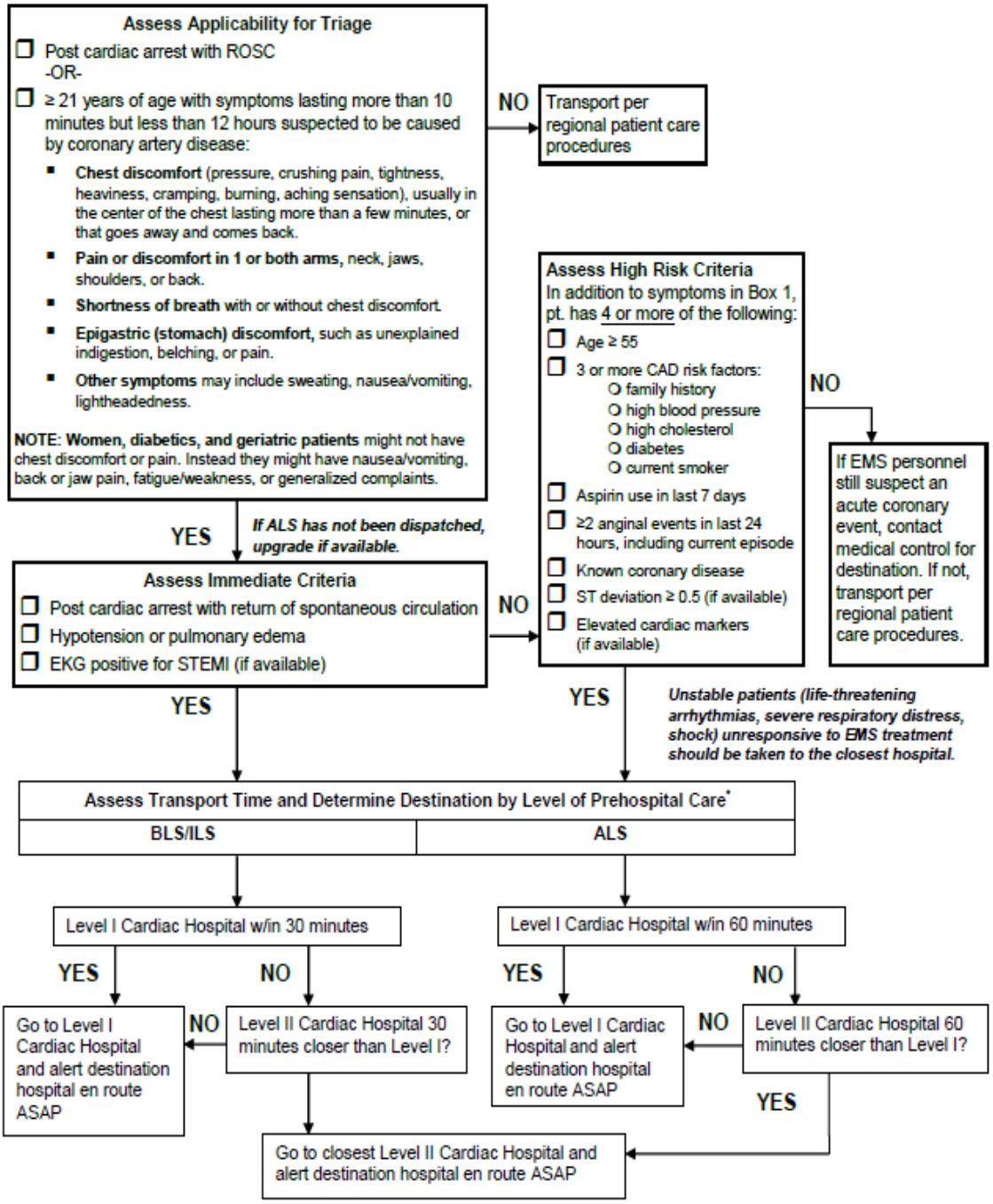
ALS examples: A) minutes to Level I minus minutes to Level II = 45: go to Level I
B) Minutes to Level I minus minutes to Level II = 68: go to Level II

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

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

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

State of Washington
Prehospital Cardiac Triage Destination Procedure



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

April 2011

https://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf

Washington State Department of Health

State of Washington
Prehospital Stroke Triage Destination Procedure

STEP 1: Assess Likelihood of Stroke

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

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

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

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

If FAST negative, transport per regional/county operating procedures

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

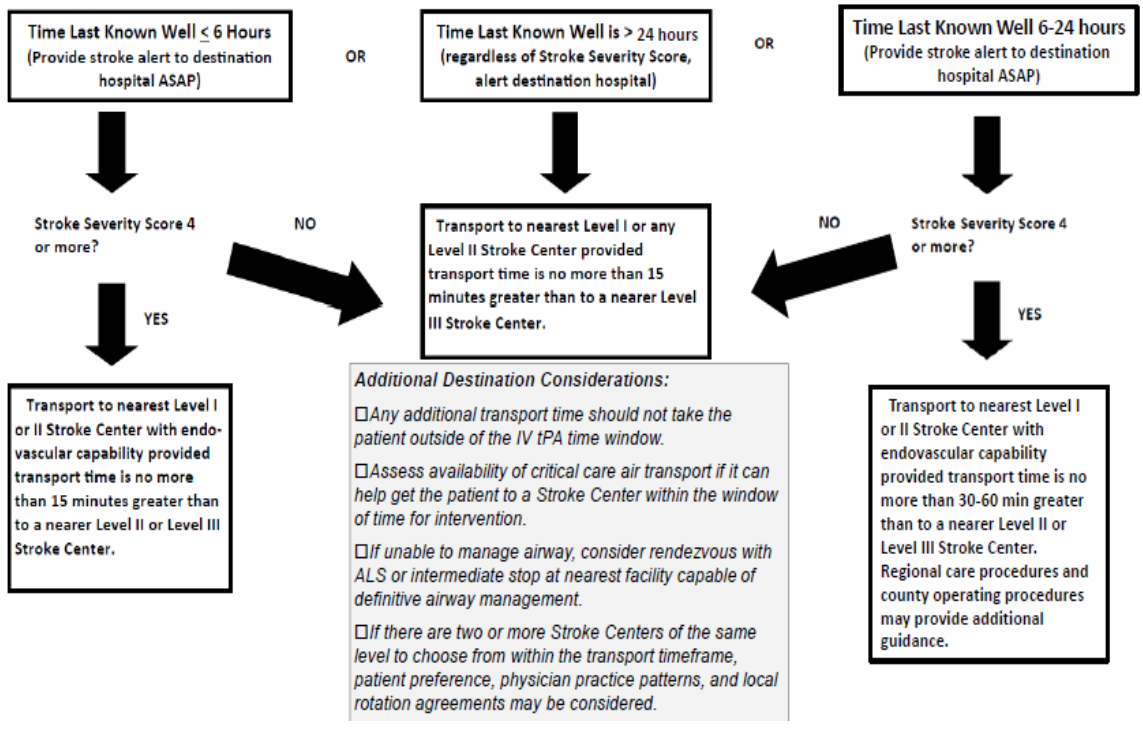
Facial Droop:	Absent	0	Present	1		
Arm Drift:	Absent	0	Drifts	1	Falls Rapidly	2
Grip Strength:	Normal	0	Weak	1	No Grip	2

Total Stroke Severity Score = **(max. 5 points)**

STEP 4: Determine Destination: Time Last Known Well + Stroke Severity Score - ***See Back Page***

February 2019

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



The purpose of the Prehospital Stroke Triage and Destination Procedure is to identify stroke patients in the field and take them to the most appropriate hospital, which might not be the nearest hospital. Stroke treatment is time-critical – the sooner patients are treated, the better their chances of survival and recovering function.
For strokes caused by a blocked blood vessel in the brain (ischemic, the majority of strokes), clot-busting medication (tPA) must be administered within 4.5 hours from the time the patient was last known well, a treatment that can be given at WA DOH Level 1, 2 or 3 stroke centers (for a list of categorized hospitals, please click here).
If a patient presents to EMS with a severe stroke, they are more likely to have blockage of a large vessel and can benefit from mechanical clot retrieval (thrombectomy). Thrombectomy must begin by 24 hours since last known well, and is a more complex intervention, only available in Level I and a small number of Level II stroke centers.
There are 3 key elements to determine the appropriate destination hospital:
FAST stroke screen to identify a patient with a high probability of stroke.
Stroke Severity Score to determine if a patient meets criteria for "severe" stroke.
Time since Last Known Well (LKW) which helps determine eligibility for tPA and thrombectomy.

STEPS to determine destination:
Do a FAST Stroke Screen Assessment: (Facial droop, Arm drift, Speech changes, Time since LKW) is a simple way to tell if someone might be having a stroke. If FAST is negative, stroke is less likely, and standard destination procedures apply. If FAST is positive (face or arms or speech is abnormal), it's likely the patient is having a stroke and the EMS provider moves on to assessing stroke severity.
Assess severity: The stroke severity assessment scores the FAST stroke screen. Patients get points for deficits:
Facial droop gets 1 point if present, 0 points if absent;
Arm drift (have patient hold arms up in air) gets 2 points if an arm falls rapidly, 1 point if slowly drifts down and 0 points if the arms stay steady;
Grip strength gets 2 points if no real effort can be made, 1 point if grip is clearly there but weak, and 0 points if grips seem of full strength.
Add up the points: A score > 4 is interpreted as "severe."
Determine time since LKW: It is important to use the LKW time as opposed to when symptoms were first noticed. If a patient woke up in the morning with symptoms and was well when they went to bed, time LKW is the time they went to bed. If stroke symptoms occur when the patient is awake, LKW could be the same time the symptoms started if the patient or a bystander noticed the onset. LKW time could also be prior to symptoms starting if a patient delays reporting symptoms or, for example, someone discovers a patient with symptoms but saw them well 2 hours prior.

Determine Destination:
Time since LKW < 6 hours and “Severe” (score > 4): This group benefits from preferential transport to a thrombectomy stroke center. The patient should be taken directly to the nearest thrombectomy stroke center provided it is no more than 15 extra minutes travel compared to the nearest stroke center.
Time since LKW is > 24 hours (regardless of severity score): These patients should be taken to nearest Level I or II stroke center provided it is no more than 15 minutes greater than to a nearer Level III stroke center.
Time since LKW 6-24 hours but NOT “Severe”: These patients should be taken directly to the nearest Level I or Level II stroke center provided it is no more than 15 extra minutes travel compared to a nearer Level 3 stroke center.

Time since LKW 6-24 hours AND “Severe”: Transport to nearest Level I or II Stroke Center with endovascular capability provided transport time is no more than 30-60 min greater than to a nearer Level II or Level III Stroke Center. Regional care procedures and county operating procedures may provide additional guidance.
Notification: Immediately notify the destination hospital of incoming stroke. If the patient is within 6 hours LKW, call a stroke alert according to county operating procedures or locally determined protocol.
Document: key medical history, medication list and next of kin phone contacts; time on scene; FAST assessment and results (or reason why not); blood glucose level; LKW time (including unknown); and whether the hospital was notified from the field and if it was a stroke alert.

https://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf

Appendix 10.

A. County Operating Procedures (COPs) - website links to the individual COP's can be found below:

Mason County - http://www.masoncountyems.com/
Clallam County - https://www.nwrems.org/clallam
Jefferson County - https://www.nwrems.org/jefferson
Kitsap County - http://www.kitsapcountyems.org/
West Olympic Peninsula - https://www.nwrems.org/west-olympic-peninsula

B: Non-fatal Injury Hospitalization
Nonfatal By Year (wa.gov)

Fatal Injuries Data
Injury Deaths - ACH and State Dashboards | Washington State Department of Health