West Region Emergency Medical Services & Trauma Care System Strategic Plan

July 2017 - June 2019

Submitted By: West Region EMS & Trauma Care Council
Approved By: EMS & Trauma Steering Committee, May 17, 2017
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Plan Introduction

The purpose of the 2017-19 West Region Emergency Medical Services (EMS) and Trauma Care System Plan is to sustain a robust continuum of care that effectively reduces injuries and fatalities; a continuum of care which treats and rehabilitates victims of trauma and medical emergencies within the five-county area of Grays Harbor, Lewis, North Pacific, Pierce and Thurston Counties.

The West Region has seen an increase of 38,941 residents since 2014. To guarantee all 1,277,480 citizens and additional visitors receive appropriate and timely EMS, medical and trauma care, the West Region EMS & Trauma Care Council (WREMS) focuses its efforts on the following:

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

The Vision Statement of the West Region EMS and Trauma Care Council captures those efforts:

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

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

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

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

The West Region EMS & Trauma Care Council is empowered by legislative authority (RCW 70.168.100-70.168.130) and Washington Administrative Code (WAC
to plan, develop, and administer the EMS and trauma care system in the five counties that make up the Region. It is one of eight regional councils statewide composed of appointed volunteer representatives and funded primarily by the Washington State Department of Health (WA DOH).

The West Region EMS Council accomplishes comprehensive planning through a committee structure with final approval by the Council. Forty-nine Council positions represent local healthcare providers, local government agencies, and consumers from areas as metropolitan as Tacoma and as remote as the rainforest on the Olympic Peninsula (see Appendix B: WREMS Council Bylaws for a list of Council positions).

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

The Council includes an Executive Board and three standing committees which undertake the core work of the Council. The Executive Board is comprised of eight members who meet monthly and have financial oversight and draft policies and procedures.

The Injury and Violence Prevention (IVP) Committee, which meets five times a year, engages participants from all West Region counties. Meetings provide an opportunity for networking, sharing best practices and learning about other resources and prevention programs/projects.

The IVP Committee is dedicated to preventing the leading causes of injury and death in the region which are poisoning, falls, firearm, suicide, motor vehicle crashes, drowning and fire. Each year WREMS awards prevention grants. Grant programs must address one of the top five causes of injury in the region or residential fire related injuries and deaths, and use evidence based or promising strategies. The grant subcommittee uses a comprehensive selection process which includes a detailed grading system and selection criteria that evaluates a project’s supporting data, objectives, strategies and evaluation plan.

The Training, Education and Development (TED) Committee makes recommendations to the Executive Board and Council on the use of available EMS training funds in the West Region. The TED Committee is also engaged in year-long planning of the regional council’s annual EMS conference which provides high quality EMS education and training opportunities to West Region and Washington State providers. During 2015-2017, new members have been recruited to reinvigorate the TED Committee.

In an effort to have more cohesive and inclusive planning, the MPD, Joint Standards and Planning Committee will be revitalized during this plan period. The committee will resume the work of developing and updating regional patient care procedures, overseeing updates to the strategic plan, and reviewing any recommended changes to the
minimum/maximum numbers and levels of trauma designated services and verified prehospital services.

The WREMS Council supports local agencies in meeting the requirements of WAC to assure adequate availability of prehospital aid and ambulance services for each response area, based upon agency response time standards, geography, topography and population density. There are currently 86 prehospital trauma verified aid and ambulance services within the West Region with a total of 2,945 EMS providers: 2,122 are paid and 823 are volunteers. See Appendix 1 for data on West Region providers and services by county.

According to 2016 data supplied by the WA DOH, 29.07% of prehospital providers in the West Region are predominately volunteers. DOH data shows a 1.8% decrease in volunteer EMS providers in the West Region since 2015. The decline in the number of volunteers is discussed in the introduction to Goal 1 of this plan.

**Prehospital Verified Services**

<table>
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<tr>
<th>COUNTY</th>
<th>AMBV-ALS</th>
<th>AMBV-ILS</th>
<th>AMBV-BLS</th>
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Numbers are current as of the date submitted.

**Prehospital Non-Verified Services**

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Numbers are current as of the date submitted.
Fourteen designated trauma care services currently operate within the West Region. The numbers and levels of services in each county provide adequate coverage for the citizens and visitors of the region. MultiCare Allenmore Hospital in Tacoma has applied to be a Level IV trauma service in Pierce County. Allenmore’s Emergency Department has seen a 30% increase in patient volume since 2013 with an average of 1,000 lower acuity trauma patients a year. Allenmore stated at a presentation to the West Region Council in 2016 that a trauma designation will allow the facility to have a structured education and process improvement plan which will elevate the care and outcomes of their trauma patients.

Developments in trauma rehabilitation have occurred during the 2015-17 plan. MultiCare Good Samaritan Hospital is expanding its rehabilitation unit from 24 to 48 beds; the project is slated to be completed by summer 2018. CHI Franciscan and Kindred Healthcare have received state approval to build and operate a 60-bed rehabilitation hospital in Tacoma.

Overcrowding of emergency departments throughout Washington State has been partly attributed to the large number of mental health patients being held in the ED due to a lack of resources and inpatient capacity for these patients. During the 2015-17 plan, MultiCare Mary Bridge Hospital increased its number of mental health beds by twenty (20) for the regional pediatric population. Additionally, US HealthVest has proposed a 75-bed mental health facility in Thurston County. Citing a 20% increase in the number of individuals seeking mental health and substance abuse treatment in the Providence St. Peter Hospital Emergency Department, Providence Southwest Washington, together with Fairfax Behavior Health, has submitted a certificate of need to WA DOH to build an 85-bed facility in Thurston County.

The WA DOH approved an application from MultiCare Health System and CHI Franciscan Health to jointly build and operate a 120-bed not-for-profit psychiatric hospital in Tacoma. The new psychiatric hospital will be built on the MultiCare Allenmore Hospital campus, located at 1901 Union Avenue in Tacoma. Construction is expected to be completed in 2018.

In August, 2016, MultiCare Good Samaritan Hospital in Puyallup received approval from the WA DOH to add 66 new acute care beds. Those beds will be placed in the top two

<table>
<thead>
<tr>
<th>Service</th>
<th>License Type</th>
<th>Base Locations</th>
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<tbody>
<tr>
<td>Airlift Northwest</td>
<td>AIRV (trauma verified)</td>
<td>Arlington, Bellingham, Boeing Field-King County, Olympia, Yakima</td>
</tr>
<tr>
<td></td>
<td>ALS</td>
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</tr>
<tr>
<td>Lifeflight Network</td>
<td>AIRV (trauma verified)</td>
<td>Brewster, Longview, Moses Lake, Pullman, Richland, Spokane, The Dalles, Oregon</td>
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<tr>
<td></td>
<td>ALS</td>
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floors of the facility’s Dally Tower. That project, which includes expanded parking and other campus improvements, is expected to be completed by mid-2018.

Washington State’s Emergency Cardiac and Stroke System saves lives and reduces disability for heart attack, cardiac arrest, and stroke patients. EMS will take patients directly to hospitals that meet care requirements and choose to participate in the system. Fourteen hospitals in the West Region are categorized as both cardiac and stroke care facilities.

Trauma Designated Facilities

<table>
<thead>
<tr>
<th>Adult Level I</th>
<th>Adult Level II</th>
<th>Adult Level III</th>
<th>Adult Level IV</th>
<th>Adult Level V</th>
<th>Pediatric Level I</th>
<th>Pediatric Level II</th>
<th>Pediatric Level III</th>
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Numbers are current as of the date submitted. Hyperlink to DOH website: [http://www.doh.wa.gov/Portals/1/Documents/Pubs/530101.pdf](http://www.doh.wa.gov/Portals/1/Documents/Pubs/530101.pdf)

See complete list and location in Appendix 3 & 4

Categorized Cardiac & Stroke Facilities

<table>
<thead>
<tr>
<th>Cardiac Level I</th>
<th>Cardiac Level II</th>
<th>Cardiac Uncategorized</th>
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<th>Stroke Level II</th>
<th>Stroke Level III</th>
<th>Stroke Uncategorized</th>
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Numbers are current as of the date submitted. Hyperlink to DOH website: [http://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf](http://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf)

See complete list and location in Appendix 5

Accomplishments from the West Region 2015-2017 Strategic Plan

- Training, Education and Development Committee was reinvigorated by recruiting new membership and reviewing roles and responsibilities related to the 2017-19 WREMS Strategic Plan.
- An EMS Council was formed in Lewis County and the WREMS Council provided funding for leadership training.
- Funding to support prehospital training and prevention grants stayed level during the plan period.
- Operating costs reduced by $18,895 by moving the WREMS office to a fire station in Thurston County.
- Reports were delivered from the Region 3 Healthcare Coalition at all WREMS Council meetings, strengthening emergency preparedness communication between Emergency Management, EMS & hospitals in the West Region.
- West Region EMS Conferences held in February 2016 & 2017, offering high quality prehospital training to all Washington state providers.
- Nine prevention grants awarded in FY16 & eight awarded in FY17 targeting the top five causes of injury in the region during each fiscal year.
• Lewis County FD 5 & 15 now have strong injury prevention programs with partnerships in their local communities due, in part, to WREMS prevention grant funding to develop teen driving safety campaigns.

• Child window falls was identified as a concern in Pierce and Thurston County zip codes in 2015. Prevention grants were awarded to Mary Bridge Children’s Hospital and Safe Kids Thurston County for window fall prevention programs. Data from Mary Bridge Children’s Hospital shows nearly a 50% decrease in child window falls since 2015.

• West Region Stroke Quality Improvement Forum worked to increase the percent of advanced notification by EMS for stroke patients transported by EMS from scene to nearly 90% for all West Region hospitals.

• Reports were delivered from the Trauma Rehabilitation Representative at all West Region Council meetings to increase awareness of the barriers to inpatient rehab care in the West Region.

• The WA Insurance Commissioner’s Office sent a delegate to the May 3, 2017 WREMS Council meeting to listen and provide feedback regarding insurance barriers to inpatient rehab care.

• MultiCare Good Samaritan Hospital began expansion of its rehabilitation unit from 24 to 48 beds.
Goal 1 Introduction

*Increase access to quality, affordable & integrated emergency care across the age continuum*

The WREMS Council works to integrate all facets of the emergency care system through the development and implementation of the West Region EMS & Trauma Care System Strategic Plan. A quality Emergency Care System is maintained by facilitating the exchange of information & expertise among the West Region Council membership and system stakeholders. This is accomplished through the inclusive makeup of the Council membership and its dedicated and engaged members.

The Council solicits participation in the process of reviewing the minimum and maximum numbers and levels of trauma designated services in each county from the West Region Trauma Quality Improvement Forum (QIF) where stakeholders convene from regional designated adult, pediatric and rehabilitation trauma services. A review of the numbers of trauma designated services was scheduled during the 2015-17 plan; due to incomplete regional trauma facility data, the review was postponed by the Council. The review will be conducted in fiscal year 2018 to ensure it is completed before the open trauma designation cycle for the West Region beginning in September of 2018.

There are 14 designated trauma care services currently operating within the West Region (see Appendix 3 for Approved Minimum & Maximum Numbers of Designated Trauma Care Services). In Pierce County there are seven trauma centers serving the needs of the region: Tacoma Trauma Center, a joint Adult Level II service, is shared by MultiCare Tacoma General Hospital and Franciscan St. Joseph Medical Center. Madigan Army Medical Center, located on Joint Base Lewis-McChord, also serves as an Adult Level II facility. MultiCare Mary Bridge Children’s Hospital is a Pediatric Level II facility in Tacoma. MultiCare Good Samaritan Hospital in Puyallup is an Adult Level III facility. St. Anthony Hospital in Gig Harbor and St. Clare Hospital in Lakewood are both Adult Level IV facilities. MultiCare Allenmore Hospital in Tacoma has applied to be a Level IV trauma service in Pierce County.

The remaining West Region counties house seven additional adult trauma facilities. Two Adult Level III facilities: Providence St. Peter Hospital in Olympia and Grays Harbor Community Hospital in Aberdeen. Three Adult Level IV facilities: Capital Medical Center in Olympia, Providence Centralia Hospital in Centralia and Summit Pacific Medical Center in Elma. Two Adult Level V facilities: Morton General Hospital in Morton and Willapa Harbor Hospital in South Bend.

There are 3 trauma rehabilitation centers in the West Region. MultiCare Good Samaritan in Puyallup is a Level I Adult Trauma Rehabilitation and Providence St. Peter Hospital in Olympia and St. Joseph Medical Center in Tacoma serve the West Region as Level II
Adult Trauma Rehabilitation Centers. MultiCare Good Samaritan Hospital is expanding its rehabilitation unit from 24 to 48 beds. CHI Franciscan and Kindred Healthcare have received state approval to build and operate a 60-bed rehabilitation hospital in Tacoma.

The WREMS Council supports local agencies in meeting the requirements of WAC to assure adequate availability of trauma verified prehospital aid and ambulance services for each response area, based upon agency response time standards, geography, topography and population density. Identification of need and distribution of verified aid and ambulance services is determined by local EMS county councils in Grays Harbor/N. Pacific, Lewis, Pierce and Thurston Counties. Each council has an operations committee that is responsible for recommending the minimum/maximum number of prehospital services for subsequent review and recommendation by the county EMS council. Each county’s recommendations are reviewed by the WREMS Council and forwarded to DOH for approval.

During the 2015-17 plan, the Lewis County Fire Chief’s Association (LCFCA) engaged stakeholders from the local prehospital community to participate in the development of a new county EMS council. The newly formed Lewis County EMS Council operates under the umbrella of the LCFCA and is meeting on a quarterly basis.

County evaluation of minimum/maximum number of prehospital services is conducted every two years and is done considering the following objective criteria as outlined in the WA Department of Health’s Guideline for Addressing Minimum/Maximum Levels of Trauma Verified Prehospital EMS Resources (9/22/10):

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

New applications for prehospital trauma verification are reviewed by the West Region Council in accordance with the following criteria from WAC 246-976-395(4) & (5):

- (b) How the proposed service will impact care in the region to include discussion on:
  (i) Clinical care;
  (ii) Response time to prehospital incidents;
  (iii) Resource availability; and
  (iv) Unserved or underserved trauma response areas;
(c) How the applicant's proposed service will impact existing verified services in the region.

(5) Input from local EMS/TC councils where local councils exist.

Approved minimum/maximum numbers of verified prehospital services can be found in the Appendix 1 of this Plan. There are 86 EMS trauma verified aid and ambulance services within the West Region. During the previous plan period, the WA DOH EMS & Trauma Steering Committee (EMSTC) created the Licensing and Verification Workgroup which is tasked with reviewing and improving the process for licensing and verification of EMS services. The West Region Council will observe the work of the workgroup and provide updates on key issues to the WREMS Council.

The Pierce County EMS Council (PCEMSC) noted that in August 2014, there were reports that the Department of Defense plans to cut approximately 14,459 permanents soldiers and 1,541 civilian employees on Joint Base Lewis McChord (JBLM). As of October 2016, the military number has dropped from its peak of approximately 46,000, but is now expected to remain at approximately 40,000. JBLM may reduce by a small number the civilian employees, but it is expected the number should maintain between 15,000 to 16,000.

The PCEMSC is concerned about the capability of the present Fire Department/DSHS function to continue service to McNeil Island residents, staff and visitors if there is a reduction in force or other downsizing actions. If funding for the FD/EMS service is discontinued, that leaves the island at risk for extended EMS response times and transport to definitive emergency care. Additionally, we are concerned about timely EMS care received by residents, staff and visitors of Mt. Rainier National Park (MRNP). Due to funding constraints, they are no longer designated as an Emergency Services Supervisory Organization or licensed EMS agency. There are populated areas of the national park that should not be considered ‘wilderness’, especially during peak visitation/camping months. Monthly traffic counts that pass through the Nisqually Entrance into MRNP range from over 10,000 up to over 40,000, and consider 2-3 occupants per vehicle, which puts a significant number of people at risk with limited EMS care/transport available. While Pierce County does not have influence on State and Federal properties, the county does recognize the need to speak for residents, staff and visitors in those areas.

The decline in the number of volunteers has affected not only prehospital care in rural areas of the West Region, but it has affected suburban populations as well. The reasons for this decline in volunteerism are numerous: career positions in fire departments increasing, a real or perceived belief that volunteers are not needed or are not adequate care providers, the rise in fuel costs causing volunteers to not have funds to pay for their private vehicles to respond to calls, the increased cost of training and maintenance of personnel, and various other reasons. The WREMS Council may not be able to influence this issue, but we recognize it as a continuing trend.
Mental health needs are not being met within the region, state or nation. Because mental health is not well funded at any level, access to care and hospitalization is inadequate. There are plans to build 3-4 mental health medical facilities in Lacey and Tacoma within the next two years; it is likely they will be swiftly filled to capacity and the issue of adequate care will still remain. When Emergency Departments are inundated with mental health patients, requiring one-on-one monitoring, it critically affects their ability to care for other acute medical and trauma patients in a timely manner.

Passage of the Washington SHB 1721, the legislation allowing voluntary participation of EMS ambulance and aid services to transport patients from the field to mental health or chemical dependency services, may serve to ease ED capacity issues. While the Pierce County MPD incorporated those guidelines into the recently updated mental health transport protocol, other West Region MPDs have yet to incorporate full guidelines into their county protocols. It is anticipated that this topic will be addressed in MPD, Joint Standards and Planning Committee.
## GOAL 1
*Increase access to quality, affordable & integrated emergency care across the age continuum.*

| Objective 1: Beginning in July 2017, the West Region EMS Council will implement the 2017-19 Regional EMS and Trauma System Strategic Plan. | Strategy 1. **Beginning in July 2017,** the WREMS Council’s staff will begin collaborating with stakeholders to accomplish the Washington State Department of Health (WA DOH) reporting process on implementing the 2017-19 Strategic Plan.  

**Strategy 2. By August 2017,** the WREMS Council will distribute the 2017-19 Plan to the local councils and county MPDs and post it on the Council website.  

**Strategy 3. Beginning August 2017,** the WREMS Council will provide bi-monthly progress reports to the WA DOH.  

**Strategy 4. Beginning September 2017,** and throughout the plan cycle, WREMS Council staff will provide bi-monthly progress reports to the West Region EMS Executive Board. |
|---|
| Objective 2: **During the 2017-2019 plan cycle** the West Region EMS Council will facilitate the exchange of information throughout the emergency care system. | Strategy 1. **Beginning in July 2017,** and throughout the plan cycle, WREMS Executive Board and staff will manage Council membership to ensure adequate representation.  

**Strategy 2. Beginning in July 2017,** and throughout the plan cycle, the WREMS Council will provide meeting rooms for the Regional Council, Committees and workgroups.  

**Strategy 3. Beginning in July 2017,** and throughout the plan cycle meeting agendas and minutes will be provided to regional EMS stakeholders in advance of each meeting through email.  

**Strategy 4. Beginning in July 2017,** and throughout the plan cycle, WREMS Council members will participate in EMS stakeholder meetings including: EMS & Trauma Steering Committee (EMSTC), Region 3 Healthcare Coalition, Region 5, Northwest Healthcare Response Network, and various Technical Advisory Committees (TACs) then share information with the West Region EMS Council at regularly scheduled meetings.  

**Strategy 5. Throughout the plan cycle,** WREMS Council & stakeholders will bring EMS system and patient care issues forward to the WA DOH, as necessary. |
| Objective 3: **By March 2019,** the West Region EMS Council will complete a review and | Strategy 1. **By September 2018,** the WREMS Council will obtain and begin review of directives from the WA DOH for the 2019-2021 system plan components. |
update of the Regional EMS & Trauma Care System Strategic Plan to define the system direction and work in the West Region for 2019-2021.

Strategy 2. From November 2018-March 2019, the regional designated planners will develop objectives and strategies identifying work under each plan goal to maintain, further develop or refine the regional system and will report progress to the WREMS Council at regular meetings.

Strategy 3. By March 2019, the designated planners will present a completed draft of the 2019-2021 West Region Strategic Plan to the WREMS Council, and subsequently to the WA DOH.

Objective 4: By June 2018, the WREMS Council will determine minimum and maximum numbers and levels of trauma designated services to coincide with the Washington State Department of Health open trauma designation cycle for the West Region beginning September 2018.

Strategy 1. By September 2017, the WREMS Executive Board will solicit input, based on a review and analysis of trauma registry data, from stakeholders regarding Regional Designated Adult, Pediatric and Rehabilitation Trauma Service’s needs.

Strategy 2. By May 2018, the WREMS Executive Board will review input from stakeholders for current designated Trauma Services designations and make recommendations for minimum and maximum numbers, levels and locations to the West Region EMS Council.

Strategy 3. By June 2018, the WREMS Council will make recommendations regarding minimum and maximum numbers, levels and locations of designated Trauma Services to the Washington State Department of Health (WA DOH).

Objective 5: By January 2019, the WREMS Council will utilize the WA DOH standardized methodology to determine minimum and maximum numbers and levels of verified prehospital service types in each county and provide recommendations to the WA DOH.

Strategy 1. By September 2017, the WREMS Executive Board will request local councils and MPDs review minimum and maximum numbers and levels of trauma verified prehospital services and make recommendations for any changes using the standardized methods provided by DOH to determine optimal prehospital system recommendations to the WREMS Council for approval.

Strategy 2. By December 2018, the WREMS Executive Board will review input and any changes made by county councils to minimum and maximum numbers and levels of trauma verified prehospital services and make recommendations to the WREMS Council.

Strategy 3. By January 2019, the WREMS Council will make recommendations for the minimum and maximum numbers and levels of trauma verified prehospital services from each county to the DOH in time for a review, if necessary, by the DOH EMS & Trauma Steering Committee meeting in January 2019 for inclusion in the 2019-21 strategic plan.
Strategy 4: **Beginning July 2017**, and throughout the plan cycle, the WREMS Executive Board and staff will observe the work of the DOH EMSTC’s Licensing and Verification Workgroup and provide updates on key issues to the WREMS Council.

**Objective 6: By January 2019,** the West Region EMS Council will review and update Regional Patient Care Procedures (PCPs) and local council County Operating Procedures (COPs) and make recommendations to the WA DOH.

Strategy 1. **By September 2018,** the WREMS Executive Board will review and update the Regional PCPs and COPs using input from the local councils and MPDS. The Board will verify that the Regional PCPs and COPs are aligned with current evidence-based documents and recommend updates and revisions as needed to the WREMS Council.

**Strategy 2. By December 2018,** the WREMS Council will review recommendations from the Executive Board and solicit DOH approval for any updated PCPs and COPs in time for a review by the DOH EMSTC meeting in January 2019, if needed.
Goal 2 Introduction

*Prepare for, respond to and recover from all-hazards threats*

The West Region EMS Council (WREMS) has contracted with the Washington State Department of Health Office of Emergency Preparedness and Response (EPR) Program to receive federal funds to provide administrative support and perform planning tasks for Region 3 since 2001. Council staff plan closely with Thurston County Public Health staff to implement the work of the Region 3 Healthcare Preparedness Coalition (“HPC” or “Coalition”). Region 3 is one of the nine Public Health Emergency Preparedness and Response Regions in WA and includes Grays Harbor, Lewis, Mason, Pacific, and Thurston Counties. Region 3’s boundaries are similar to the Regional EMS & Trauma System’s boundaries except that it excludes Pierce County (Region 5), and includes Mason County (Northwest EMS & Trauma Region) and the southern half of Pacific County.

The WREMS Council recognizes the need for close collaboration with the Region 3 Healthcare Preparedness Coalition, healthcare planners in Region 5, local public health and emergency management, and the Northwest Healthcare Response Network (NWHRN) to aid the region in continuing to make progress on disaster preparedness. The Council is committed to a “whole community” approach to preparing for, responding to, and recovering from an all-hazards event.

The WREMS Council is not an operational agent in the response function of this goal, but it is an agent for collaboration and communication. The Council has positions for both an Emergency Management and a Public Health representative. Both positions were filled during the last plan cycle but will require a new recruitment effort. Region 3 preparedness updates are a standing agenda item at WREMS Council meetings and are delivered by either Council or Thurston County Public Health staff.

The American College of Emergency Physicians (ACEP) produced a “National Emergency Care Report Card” in 2014 which delivered low marks to Washington State in disaster preparedness within the emergency care environment. The Council will specifically work on the indicator for sharing Emergency Support Function 8 (ESF-8) plans with EMS by inviting local emergency management to Council meetings to contribute information and updates on ESF-8 plans. Collaborative ESF #8 preparedness planning provides opportunities to work together to ultimately assure safer, more resilient, and better-prepared communities.

**Region 3**

Community and healthcare system preparedness in Region 3 continues to grow due to collaboration at the regional level. Region 3 partnerships formed the Region 3 Healthcare Preparedness Coalition (“HPC” or “Coalition”) in 2007. Today the Region 3 HPC has a membership of 65 participants from all five counties who represent disciplines from hospitals, public health, tribal nations, community health clinics, local emergency
management, and the military. In 2017-19 the HPC will be reaching out to engage long-term care facilities and dialysis centers.

The Region 3 HPC is comprised of a twelve member Executive Committee which monitors the budget, projects, contract deliverables, and recommends the annual work plan for approval by the Coalition membership. The HPC is governed by a charter with bylaws and has five meetings a year. There are three subcommittees that support work specific to hospital medical surge, public health emergency preparedness, and regional training and exercise development. The Coalition provides preparedness training and education, and opportunities to drill and exercise. It maintains a grant program to provide funding for preparedness and response training to facilities and agencies to enhance their capabilities to fulfill a local and regional role during disasters.

The Region 3 HPC maintains a Healthcare System Response Plan for All Hazards Preparedness and Response. The Plan includes medical surge operations, equipment cache management and deployment, and policy and procedures for the regional Disaster Medical Control Center (DMCC) at Providence St. Peter Hospital. The DMCC conducts regional coordination between hospitals and EMS in the event of a minor or mass casualty incident or disaster that requires hospital evacuation and/or threatens to overwhelm both the local and regional medical system and its services. This coordination is also done with MultiCare Good Samaritan Hospital in Region 5, Pierce County. During this new plan cycle, the R3 HPC will be expanding its healthcare response plan to include public health which has maintained a separate plan. The Coalition Executive Committee will update its strategic plan to be in line with new federal guidelines for healthcare coalitions.

Ongoing planning priorities for the HPC in the next two years will be on enhancing capabilities in community and healthcare system preparedness and response with an emphasis on improving situational awareness for the healthcare in Region 3 during a catastrophic event. The Coalition will continue its work to strengthen coordination and define operations between EMS and the DMCC during a disaster. The Coalition is committed to supporting a resilient healthcare system that saves lives during disaster that exceed the day-to-day capacity and capability of existing health and emergency response systems.
**GOAL 2**  
*Prepare for, respond to, & recover from all-hazards threats.*

| Objective 1: From July 2017-June 2019, the WREMS Council will continue planning and collaboration with health care partners in Public Health Region 3 for emergency preparedness. | Strategy 1. From July 2017-June 2019, WREMS staff will provide administrative support to the Region 3 Healthcare Preparedness Coalition (HPC) and perform planning tasks and contract responsibilities as outlined in the Region 3 HPC Charter.  
*Note: this strategy is for reporting purposes only. Reimbursement for this activity is through the WA State Department of Health Public Health Emergency Preparedness Office.* |
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<tr>
<td>Strategy 2. Annually, by September 1, the WREMS Executive Board will determine dates to invite local emergency management to Council meetings to contribute information and updates on ESF-8 plans.</td>
<td>Strategy 3. Annually, by September 1, the WREMS Executive Board will determine dates to invite representatives from Region 3 and 5’s Disaster Medical Control Centers to Council meetings to discuss the role of EMS in their DMCC plans.</td>
</tr>
<tr>
<td>Strategy 4. Beginning in July 2017, the WREMS Council members and staff will be encouraged to complete IS 100, 200 and 700 National Incident Management System (NIMS) courses by June 2019. Free training is available at: <a href="https://training-fema.gov/nims/">https://training-fema.gov/nims/</a></td>
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Objective 2: From July 2017-June 2019, the WREMS Council will collaborate with emergency management partners to support all-hazards preparedness and response planning.

<table>
<thead>
<tr>
<th>Strategy 1. Quarterly during the 2017-19 plan cycle, a representative from the Region 3 Healthcare Preparedness Coalition will be invited to prepare regular reports and updates for WREMS Council meetings.</th>
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<tbody>
<tr>
<td>Strategy 2. Annually, by September 1, the WREMS Executive Board will determine dates to invite local emergency management to Council meetings to contribute information and updates on ESF-8 plans.</td>
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Goal 3 Introduction

Promote programs & activities that reduce preventable injuries, disability and premature death due to trauma

According to Washington State Department of Health (DOH) data, in 2015, 891 people died from preventable traumatic injuries in the West Region. The most common cause of injury and death in the West Region is poisoning, followed by falls, firearm, suicide, motor vehicle crashes, drowning, and fire. Data is used to prioritize work, make decisions regarding injury prevention grant awards, and to evaluate the efficacy of prevention programs and activities. Data tables for fatal and nonfatal injuries in the West Region can be found in Appendix A.

By supporting evidence based or promising prevention strategies and sharing information and resources with regional stakeholders, the number of injuries, disabilities and fatalities due to trauma can be reduced.

Regional Councils have strong support from DOH staff who share a wealth of expertise, resources, and information. State meetings provide an opportunity to collaborate with other regional prevention leads in planning and address prevention issues at the state level. DOH staff coordinate valuable training and educational webinars on hot topics and new & emerging issues. This information is disseminated to regional stakeholders.

The West Region (WREMS) has a part-time Injury and Violence Prevention (IVP) Coordinator on staff. The IVP Coordinator serves as a liaison between DOH and regional stakeholders, and serves as a point of contact for community members who are seeking resources. Information on current trends and injury prevention information on a wide variety of topics is sent out via email to a distribution list of approximately 160 prevention partners.

The West Region includes many rural areas with limited resources. Building and strengthening partnerships is vital to injury prevention; it helps rural areas feel less isolated, increases capacity, and reduces duplication of efforts. The West Region IVP Committee meets five times per year. Meetings include an educational component and an update report from DOH. The meetings provide an opportunity for networking, building partnerships, sharing best practices and learning about resources and prevention programs that participants can take back and adopt or adapt in their own community.

Each year WREMS awards prevention grants. Grant funds are used to develop or strengthen injury prevention programs in local communities and must address one of the top five causes of injury in the region or residential fire related injuries and deaths, which has recently been identified as an area of concern. Grant programs must use evidence based or promising strategies. A subcommittee reviews all prevention grant requests for
proposal submitted for consideration. The grants are a valuable resource for rural, underserved areas. A relatively small grant can have a big impact in reducing the number of injuries, disabilities and deaths due to trauma. WREMS prevention grants make it possible for organizations to develop a successful prevention program which can then be eligible for additional grant funds from other sources.

The annual West Region EMS Conference includes a Prevention Workshop. The workshop provides a half-day of education on new and emerging trends for EMS providers and injury prevention partners in the region and across the state. The WREMS IVP Coordinator is actively involved year-round in coordinating and planning, with oversight by the IVP Committee.

In 2015, child window falls was identified as a concern; 4 of the 10 Washington zip codes with the highest incidence of falls were in the West Region. MultiCare Mary Bridge Children’s Hospital (MBCH) took the lead for window fall prevention in the region, targeting high risk areas and low income families. WREMS Prevention grants were awarded to both MBCH and Safe Kids Thurston County for window fall prevention programs. The programs are showing to be successful; 2016 MBCH data for child window fall patients shows a nearly 50% decrease from 2015.

WA State is currently experiencing an opioid abuse and overdose crisis. The WREMS IVP Coordinator participates in webinars and conference calls for the purpose of gaining a better understanding of the opioid crisis and efforts at the state level to address this issue. Information from DOH and the WA Poison Center is disseminated to regional constituents. Administration of nasal Narcan by EMTs was one of the skills practice sessions during the 2017 WREMS Conference.

County Specific Assessment

Many of the regional programs listed below were developed or strengthened by WREMS Prevention grants. The WA Poison Center is available for training and resources for poisoning prevention throughout the state.

**Grays Harbor & North Pacific Counties:** Top causes of injury & death are falls, poisoning, motor vehicle crashes and suicide. Grays Harbor & North Pacific counties are rural with limited resources. Projections from DOH show 30% - 43% of the population in Pacific County will be 65+ years by 2020. The Olympic Area Agency on Aging serves as a resource for senior fall prevention; however, due to loss of funding they had to discontinue their Reducing Falls at Home program. Sustainable senior fall prevention programs are needed in Grays Harbor and North Pacific counties. Youth Suicide Prevention Program provides suicide prevention training in Grays Harbor & North Pacific counties at no cost.

**Lewis County:** Top causes of injury & death are falls, poisoning, motor vehicle crashes and suicide. According to US Fire Administration data, in 2016 Lewis County had the
highest rate of fire related deaths, per capita, in the state, and the fourth highest rate in 2015. The IVP Coordinator is researching data and best practices for addressing this concern. Lewis County is rural with limited resources. The newly developed Lewis County EMS Council is supportive of injury prevention. In 2015-17 Lewis County made great strides in building strong partnerships within the community and creating a culture of safety. Lewis County Fire Districts 5 & 15 developed successful programs for young driver safety and older adult falls prevention. The Lewis County Drowning Prevention Coalition was formed in the summer of 2016 and is actively involved in public education. Lewis County Public Health has a strong child passenger safety program which serves low income families.

**Pierce County:** Top causes of injury & death are falls, suicide, poisoning, and motor vehicle crashes. Many fire departments in Pierce County have mature injury prevention programs. Evidence based exercise programs for reducing senior falls are offered throughout the county. MBCH has a strong child passenger safety and child window fall prevention program. In late fall, 2016, MBCH opened a 20+ bed pediatric mental health wing. MultiCare and CHI Franciscan are collaborating on construction of a new mental health facility in Tacoma in 2018.

**Thurston County:** Top causes of injury & death are falls, suicide, poisoning, drowning and motor vehicle crashes. During 2015-17, Providence Health and Services became a leader in senior fall prevention in Thurston County. In August, 2015, Providence opened the Geriatric Center of Excellence. Tai Ji Quan: Moving for Better Balance classes are offered at the Lacey and Olympia Senior Centers. Lewis Mason Thurston Area Agency on Aging serves as a resource for senior fall prevention. Safe Kids Thurston County has several robust child injury prevention programs; special emphasis is placed on serving low income families.
**GOAL 3**  
*Promote programs & activities that reduce preventable injuries, disability and premature death due to trauma.*

<table>
<thead>
<tr>
<th><strong>Objective 1:</strong> Annually during the 2017-19 plan cycle, the WREMS Council will utilize a regional process to identify prevention needs and support evidence-based or promising strategies and programs.</th>
<th><strong>Strategy 1. Annually, by August,</strong> the Injury and Violence Prevention (IVP) Committee of the WREMS Council will review relevant injury and mortality data from DOH and other sources, as available, to determine the leading causes of traumatic injury and death in the West Region and use this information as criteria for funding local programs and activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 2. Annually, by September,</strong> the IVP Committee of the WREMS Council will identify evidence-based or promising injury prevention programs and activities and provide funding to regional injury prevention partners as funding is available.</td>
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<td><strong>Strategy 3. Throughout the grant year,</strong> funding recipients will report on the progress of their programs to the WREMS Council.</td>
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<td><strong>Strategy 4. Annually, by June 30,</strong> grant recipients will submit documentation on interventions and outcomes.</td>
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<tr>
<td><strong>Strategy 5. Throughout the grant year,</strong> the WREMS Council will provide bi-monthly progress reports to DOH.</td>
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<tr>
<th><strong>Objective 2:</strong> During the 2017-19 plan cycle, the WREMS IVP Coordinator will utilize resources from WA State Dept of Health and the WA Poison Center which address the opioid crisis and share with regional stakeholders.</th>
<th><strong>Strategy 1. Throughout the 2017-19 Plan Cycle,</strong> IVP Coordinator will utilize DOH resources including meetings, educational opportunities, and data, as available, to gain a better understanding of the opioid crisis, and efforts at the state and regional level to address this issue.</th>
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<tr>
<td><strong>Strategy 2. Throughout the 2017-19 Plan Cycle,</strong> IVP Coordinator will share information and resources from DOH and WA Poison Center with regional stakeholders regarding opioid misuse, efforts to address the opioid crisis, and evidence based and promising strategies.</td>
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<tr>
<td><strong>Strategy 3. Throughout the 2017-19 Plan Cycle,</strong> IVP Coordinator will begin reaching out to state and regional partners to identify emerging concepts for MIH/Community Paramedicine programs in the state and region.</td>
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<tr>
<td><strong>Strategy 2. By January, 2019,</strong> IVP Coordinator will seek guidance from the WREMS Board/Council regarding MIH/Community Paramedicine in WREMS Prevention work.</td>
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<th><strong>Objective 3:</strong> During the 2017-19 plan cycle, WREMS IVP Coordinator will reach out to state and regional partners to identify emerging concepts for Mobile Integrated Health Care (MIH)/Community Paramedicine programs in the state and region.</th>
<th><strong>Strategy 1. By October, 2017,</strong> IVP Coordinator will begin reaching out to state and regional partners to identify emerging concepts for MIH/Community Paramedicine programs in the state and region.</th>
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<td><strong>Strategy 2. By January, 2019,</strong> IVP Coordinator will seek guidance from the WREMS Board/Council regarding MIH/Community Paramedicine in WREMS Prevention work.</td>
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<tr>
<td>Objective 4: During the 2017-19 plan cycle, the WREMS Council will collaborate to educate the public, partners and policy makers on the Emergency Care System.</td>
<td><strong>Strategy 1. Throughout the plan cycle,</strong> the WREMS Council will make current Emergency Care system information available to stakeholders on the WREMS website and by email.</td>
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<td><strong>Strategy 2: By June 2018,</strong> WREMS staff will update the format of the regional website based upon ‘wise practices’ shared at the Regional Advisory Committee Technical Advisory Committee (RAC TAC) in 2016.</td>
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Goal 4 Introduction

Promote & enhance continuous quality improvement of emergency care systems for the West Region

The Council administratively supports the independent collaborative regional quality improvement (QI) work of the region’s two Quality Improvement Forums (QIF). The purpose of the Trauma QIF and the Cardiac and Stroke QIF is to improve patient outcomes, identify areas for improvement, educate providers and build coordination between services. Both QI Forums are governed by plans (see Appendix C) which call for confidential quarterly meetings, a membership of both hospitals and EMS agencies, and the sharing of case reviews and data.

Designated trauma facilities, categorized cardiac and stroke facilities and EMS agencies participate at QI meetings and review regional data. Data for the Trauma QIF is regularly supplied through the WA State Trauma Registry. The Stroke QI utilizes “Get with the Guidelines-Stroke Registry” developed by the American Heart Association/American Stroke Association. The Cardiac QI uses the Clinical Outcomes Assessment Program (COAP) a program of the Foundation for Health Care Quality.

A comprehensive review of regional EMS data continues to be problematic due to low participation in the WA Emergency Medical Service Information System (WEMSIS), the state’s prehospital data repository for electronic patient care records. Many West Region agencies have barriers to participation in the program due to lack of funds to train and employ personnel to input data. Some agencies use electronic patient care reports that do not interface with WEMSIS; a process needs to be developed whereby this data can be shared without the expense and time of entering it twice.

In an effort to enhance regional participation in WEMSIS, the WREMS Council will request county EMS councils to query local prehospital agencies who are not reporting data to WEMSIS on the barriers to participating, and how the WREMS Council can provide assistance and support.

Current challenges to the Regional Cardiac and Stroke QI Program are, in part, a consequence of the absence of regulation of the categorization process or QI participation. It is a voluntary system with no funding at the regional or state level. The West Region Cardiac and Stroke QIF has seen an increase in hospital participation at meetings during the last plan cycle; there is still the need for EMS participation. The Stroke QI goal to increase the percent of advanced notification by EMS for stroke patients transported by EMS from the scene to the hospital has been successful. Data shows prehospital providers in the West Region have a high rate of accuracy in pre-notification of stroke.
**GOAL 4**  
*Promote & enhance continuous quality improvement of emergency care systems for the West Region.*

| Objective 1: During the 2017-19 plan cycle, the WREMS Council will review regional emergency care system performance. | Strategy 1. On a quarterly basis throughout the contract year, the WREMS Council will review meeting reports from the West Region Quality Improvement Forums for Trauma, Cardiac, and Stroke.  
Strategy 2. When appropriate, the WREMS Council will share recommended opportunities for improvement from the QIF to the Training, Education and Development Committee (TED), IVP Committee, and the WREMS Council. WREMS Committees will disseminate among West Region agencies/facilities.  
Strategy 3. During the 2017-19 plan cycle, the West Region EMS Quality Improvement Forums facility. (QIF) will review Trauma, Cardiac and Stroke data.  
Strategy 4. When appropriate, ‘lessons learned’ will be posted on the West Region website. West Region staff will explore methods to inform constituents of the availability of the information. |
|---|---|
| Objective 2: During the 2017-19 plan cycle, the West Region EMS Quality Improvement Forums facility. (QIF) will review Trauma, Cardiac and Stroke data. | Strategy 1. Throughout the plan cycle, the WREMS Council will continue to assist the West Region Trauma, Cardiac and Stroke QIFs in meeting preparation.  
Strategy 2. Annually in May, participating members of the Trauma, Cardiac and Stroke QIFs will establish yearly schedules of meetings to review regional data to allow for comprehensive system evaluation. |
| Objective 3: Throughout the plan cycle, the West Region Cardiac Quality Improvement Forum (QIF) will improve sensitivity and specificity of STEMI activation from all hospital admit sources, to include EMS transports and facility transfers. | Strategy 1. Throughout the plan cycle, the Cardiac QIF will collect, calculate and assess under/over activation of ST-segment elevation myocardial infarction (STEMI).  
Strategy 2. By October 2017, the WREMS Council will request the Cardiac QI create a process for sharing hospital information on STEMI under/over activations with West Region prehospital agencies.  
Strategy 3. Beginning in January 2018, hospitals participating in the Cardiac QIF will share STEMI under/over activation with prehospital agencies for the purpose of quality improvement. |
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<tr>
<th>Objective 4: Throughout the plan cycle, the West Region Stroke QIF will monitor the work of the Coverdell Stroke Program in Pierce and Pacific Counties.</th>
<th><strong>Strategy 1. Beginning in December 2017</strong>, the West Region Stroke QIF will invite participants in the Coverdell Stroke Program to attend regional Stroke QIF meetings to share progress and challenges.</th>
</tr>
</thead>
</table>
| **Objective 5: During the 2017-19 plan cycle**, the WREMS Council will monitor regional WEMSIS participation in an effort to increase data submission. | **Strategy 1. During the 2017-19 plan cycle**, the WREMS Executive Board will request West Region county EMS councils to query local prehospital agencies not participating in WEMSIS on the barriers to participating, and how the WREMS Council can provide assistance and support.  
**Strategy 2. During the 2017-19 plan cycle**, local councils will report to the WREMS Executive Board the prehospital agencies not submitting data to WEMSIS and their barriers to participating. The Board will share this information with the Council and DOH to discuss avenues to provide assistance and support. |
Goal 5 Introduction

Work toward sustainable emergency care funding, enhance workforce development, & demonstrate impact on patient outcomes

The WREMS Council adheres to a timeline for developing, reviewing, approving and implementing its annual fiscal budget. Over the years, financial resources for the EMS and Trauma System have been declining. The Council’s contract with DOH has been reduced by nearly half in the past 10 years. The Council has been a responsible steward of public funds and continues to practice cost efficiencies and look for creative opportunities to cut costs.

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

The Council also funds its annual EMS conference which provides high quality EMS education and training opportunities to West Region and Washington State providers. The Council has produced the three-day conference for the past 32 years. Rising costs, diminishing funds, and the advent of statewide online training, threaten the sustainability of continuing the educational conference in the years ahead.

The WREMS Council recognizes enhanced education for Senior Evaluator and Instructors (SEIs) as critical for the sustainability of the EMS system. An example of enhancing workforce development is to improve EMT graduation numbers. The Council is committed to providing annual training and development for SEIs.

Along with funding EMS training, the Council is dedicated to funding data-driven injury prevention projects which target the leading causes of trauma injury and death in the region. (See Goal 3 for more information regarding the WREMS Injury and Violence Prevention Program.)
**GOAL 5**
Work toward sustainable emergency care funding, enhance workforce development, & demonstrate impact on patient outcomes.

<table>
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<tr>
<th>Objective 1: During the 2017-19 plan cycle, the WREMS Council will work to identify cost saving practices.</th>
<th>Strategy 1. <strong>By April of each plan year</strong>, the WREMS Council Executive Board will develop a draft budget which takes into consideration cost efficiencies.</th>
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<td>Strategy 2. <strong>Annually</strong>, at the WREMS Council’s Budget Meeting, the Executive Board will present the next fiscal year’s draft budget for Council member review and approval.</td>
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<tr>
<td>Objective 2: Annually, by June, the WREMS Council will utilize a process to identify needs and allocate available funding to support Prehospital training.</td>
<td>Strategy 1. <strong>Annually</strong>, at the WREMS Council’s Budget Meeting, Council members will review needs and approve educational funding levels for each local EMS council.</td>
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<td>Strategy 2. <strong>Annually</strong>, in March, the West Region Training and Education Committee will query local EMS councils and MPDs regarding how to best provide EMS education and training opportunities in the West Region.</td>
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<td>Strategy 3. <strong>Annually, by September</strong>, the WREMS Council staff will initiate contracts with local EMS councils to distribute funds for coordination and delivery of OTEP and CME EMS training.</td>
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<td>Strategy 4: <strong>Annually, by June</strong>, the WREMS Council will facilitate SEI training and development by scheduling at least one SEI workshop a year.</td>
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<td>Strategy 5. <strong>Annually, by June</strong>, the WREMS Council will conduct an EMS conference which provides EMS education and training opportunities within the West Region and is available to all Washington State and out of state providers.</td>
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<tr>
<td>Objective 3: During the 2017-19 plan cycle, the West Region EMS Council will continue to work with the WA DOH and the State Auditor’s Office to ensure the Regional Council business structure and practices remain compliant with RCW.</td>
<td>Strategy 1. <strong>Annually, at the beginning of the plan year</strong>, the WREMS Council will provide DOH with a regional budget.</td>
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<td>Strategy 2. <strong>Annually, in November</strong>, the WREMS Council will provide the Washington State Auditor’s Office with the previous year’s financial information and required schedules.</td>
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Goal 6 Introduction

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

There are 3 trauma rehabilitation centers within the West Region. MultiCare Good Samaritan Hospital in Puyallup is a Level I Trauma Rehabilitation Service and is recognized as one the best rehab centers in the nation. Franciscan St. Joseph Medical Center in Tacoma and Providence St. Peter Hospital in Olympia both serve the West Region as Level II Adult Trauma Rehabilitation Centers.

Trauma Registry data presented at the January 2015 DOH EMS & Trauma Steering Committee (EMSTC) showed the percentage of trauma patients discharged to acute rehabilitation centers is declining in our state. Data showed only a small percentage of the trauma patients who need rehab care will receive it. Data further shows patients who receive rehab care are almost 9 times more likely to be discharged home or to an Adult Family Home. Those that do not receive proper rehab care are often discharged to a skilled nursing facility where they experience a higher mortality rate.

Developments in trauma rehabilitation bed availability have occurred in Pierce County during the 2015-17 plan. MultiCare Good Samaritan Hospital is expanding its rehabilitation unit from 24 to 48 beds; the project is slated to be completed by summer 2018. CHI Franciscan and Kindred Healthcare have received state approval to build and operate a 60-bed rehabilitation hospital in Tacoma.

**Trauma Rehab Issues Addressed in the 2015-17 West Region Plan**

The 2015-17 West Region Plan addressed the protracted process for determining eligibility for Department of Social and Health Services (DSHS) funding of outpatient rehab. This problem is no longer an issue, at this time, since the Affordable Health Care Act has made it possible for the majority of rehab patients to be placed in a program immediately.

The 2015-17 West Region Plan also addressed the need for trauma rehab stakeholders to develop a mechanism with DSHS Aging and Long Term Care and Home/Community Services to fast track assessments which determine appropriate level of care and placements of complex trauma patients. Meetings were held between the Health Care Authority (HCA) and the Brain Injury Association of Washington (BIAWA) and work is being done with informed personnel on a case by case basis, based on needs. This issue continues to be monitored by stakeholders.

The HCA and BIAWA also met during the last plan period to discuss funding obstacles in discharging Traumatic Brain Injury (TBI) patients back to their communities rather
than a skilled nursing facility. Better HCA staff training on brain injury has been discussed. This issue continues to be monitored by stakeholders, as well.

The work outlined above has been incorporated into the statewide work of the EMSTC Rehab TAC.

**Trauma Rehab Issues in the 2017-19 West Region Plan**

The work outlined for the 2017-19 cycle calls for a closer look at the outpatient rehab care available in the West Region. It is vital that trauma rehabilitation patients be referred to outpatient rehab care in their own communities; however, many rural areas do not have access to these services. The WREMS Council recognizes that Grays Harbor, Lewis and North Pacific Counties are underserved. The Rehab TAC is working on surveying all rehab facilities in WA State for services they provide or their surrounding areas provide. The WREMS Council will establish a trauma rehabilitation committee to explore strategies to address the need for rehab outpatient clinics in underserved communities within the West Region.
**GOAL 6**  
*Sustain a region wide system of designated trauma rehabilitation services to provide adequate capacity and distribution of resources to support high quality trauma rehabilitation.*

<table>
<thead>
<tr>
<th>Objective 1: <strong>During the 2017-19 plan cycle,</strong> the West Region EMS Council will integrate trauma rehabilitation information/issues into Regional Council meetings.</th>
<th><strong>Strategy 1.</strong> Quarterly during the 2017-19 plan cycle, the Trauma Rehabilitation Representative of the West Region Council will prepare regular reports and updates for the West Region EMS Council meetings from the DOH EMS and Trauma Steering Committee’s Trauma Rehabilitation TAC.</th>
</tr>
</thead>
</table>
| **Objective 2: By September 2017,** the WREMS Council will establish a trauma rehabilitation committee. | **Strategy 1.** By April 2018, The West Region Trauma Rehabilitation Committee will meet to explore strategies to address the need for rehab outpatient clinic services in underserved communities within the West Region.  
**Strategy 2. By June 2018,** the West Region Trauma Rehabilitation will report their strategies to the WREMS Council. |
Appendix 1
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<thead>
<tr>
<th>County</th>
<th>Credential #</th>
<th>Credential Status</th>
<th>Agency Name</th>
<th>City</th>
<th>Expiration Date</th>
<th>Agency Type</th>
<th>Care Level</th>
<th># AMB</th>
<th># AID</th>
<th># Fixed</th>
<th># Rotary</th>
<th># BLS</th>
<th># ILS</th>
<th># ALS</th>
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<tr>
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**NOTE:** Vehicle and personnel numbers for West Region private ambulance services are considered proprietary information and have been redacted.
Approved minimum & maximum numbers of verified trauma services by Level and Type by County.

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<td>State Approved Minimum Number</td>
<td>State Approved Maximum Number</td>
<td>Current Status (Total # verified for each Service Type within the whole county)</td>
</tr>
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<td>-------------------------------</td>
<td>------------------------------</td>
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</tr>
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<td>Aid - BLS $\Phi \Omega$</td>
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<td>7</td>
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<td>Aid –ILS</td>
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<td>Aid – ALS $\Phi$</td>
<td>0</td>
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<td>Amb – ILS</td>
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<tr>
<td></td>
<td>Amb - ALS $\Omega$</td>
<td>1</td>
<td>17</td>
<td>15</td>
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</table>

$\Phi$ Any current BLS agency may submit an application to upgrade to ALS.

$\Omega$ Any current Fire Department which provides EMS (city, town, county) may submit an application to upgrade to Amb-ALS within their own jurisdiction. Any new ambulance service must offer to serve the underserved areas as reviewed by the Pierce County EMS Council at the time of licensure application. It is a goal that the response time to any location within the underserved area must be equal to that of an urban service area if the underserved area is urban per WAC; otherwise the response time must be at the suburban service area time of fifteen minutes eighty percent of the time according to the Pierce County Aid and Ambulance Rules and Regulations. The offer to serve an area should be at a rate commensurate with and in consideration of recent history and the local economy.

<table>
<thead>
<tr>
<th>County</th>
<th>Verified Service Type</th>
<th>State Approved Minimum Number</th>
<th>State Approved Maximum Number</th>
<th>Current Status (Total # verified for each Service Type within the whole county)</th>
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<td>Thurston</td>
<td>Aid – BLS</td>
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<td>6</td>
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<td>Aid – ILS</td>
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<td>Amb – BLS</td>
<td>7</td>
<td>9</td>
<td>9</td>
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<tr>
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<td>Amb – ILS</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Amb - ALS</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 2
Prehospital Trauma Response Areas by County

The type and number column of this table accounts for the level of care available in a specific trauma response area that is provided by verified services. Some verified services (agencies) may provide a level of care in multiple trauma response areas therefore the total type and number of verified services depicted in the table may not represent the actual number of State verified services available in a particular county; it may be a larger number in the table. The verified service minimum/maximum table will provide accurate verified service numbers for counties.

**Key: For each level the type and number are indicated**

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

Pacific County* (agencies within the GHEMS system)

*Aid-BLS = A-1
Ambulance-ALS = F-1

**Interactive Emergency Medical Care Map**

<table>
<thead>
<tr>
<th>County</th>
<th>Trauma Response Area Number</th>
<th>Description of Trauma Response Area’s Geographic Boundaries</th>
<th>Type and # of Verified Services available in each Response Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grays Harbor</td>
<td># 1</td>
<td>Encompasses the geographic boundaries of GHFD # 1, GHFD # 5, City of Elma FD and City of McCleary FD. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.</td>
<td>A-3 F-1</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td># 2</td>
<td>Encompasses the geographic boundaries of GHFD # 2 and Montesano FD. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.</td>
<td>D-1 F-1</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td># 3</td>
<td>Encompasses the geographic boundaries of Aberdeen FD, Cosmopolis FD, Hoquiam FD, GHFD # 6, GHFD # 10, GHFD # 15, GHFD #17. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.</td>
<td>A-5 F-2</td>
</tr>
<tr>
<td>County</td>
<td>Trauma Response Area Number</td>
<td>Description of Trauma Response Area’s Geographic Boundaries</td>
<td>Type and # of Verified Services available in each Response Areas</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td># 4</td>
<td>Encompasses the geographic boundaries of South Beach Ambulance, Westport FD, GHFD # 3, GHFD # 11, GHFD # 14 and encompasses Pacific County FD # 5 to milepost 17 on Highway 105. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.</td>
<td>A-3 F-1</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td># 5</td>
<td>Encompasses the geographic boundaries of Ocean Shores FD, Taholah FD, GHFD # 7, GHFD # 8, GHFD # 16. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.</td>
<td>D-3 E-1 F-1</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td># 6</td>
<td>Encompasses the geographic boundaries of GHFD # 4 and Quinault Nation Ambulance. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.</td>
<td>D-1 E-1</td>
</tr>
<tr>
<td>County</td>
<td>Trauma Response Area Number</td>
<td>Description of Trauma Response Area’s Geographic Boundaries</td>
<td>Type and # of Verified Services available in each Response Areas</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lewis</td>
<td># 1</td>
<td>Within the current city limits of the City of Centralia and urban growth area</td>
<td>F-2</td>
</tr>
</tbody>
</table>
| Lewis  | # 2                          | Within the current boundaries of the City of Chehalis and urban growth area                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D-1
                                                                 |                                                                | F-1                                                              |
| Lewis  | # 3                          | Area 3 is located in the NW corner of Lewis County bordering Thurston County to the North, Grays Harbor County and Pacific County to the West, and on the South by an imaginary line proceeding due West from the intersection of US Highway 12 and I-5 and on the east by Interstate 5.                                                                                                                                                                                                                                                 | A-1
                                                                 |                                                                | D-1
                                                                 |                                                                | F-4                                                              |
| Lewis  | # 4                          | Area 4 is bordered on the east side of Interstate 5, bordering Thurston County to the North and US Highway 12 to the south, the eastern border is the community of Mossyrock.                                                                                                                                                                                                                                                                                                                  | D-2
                                                                 |                                                                | E-1                                                              | F-4                                                              |
| Lewis  | # 5                          | Area 5 is located West of Interstate 5 and South of an imaginary line running west from US Highway 12 and Interstate 5 to Pacific Co, then South to Cowlitz County.                                                                                                                                                                                                                                                                                                                                                                                                  | A-1
                                                                 |                                                                | D-2                                                              | F-2                                                              |
| Lewis  | # 6                          | Area 6 is located East of Interstate 5 and North of the Cowlitz Co line bordering US Highway 12 to the North and Mossyrock to the East.                                                                                                                                                                                                                                                                                                                                                                                                                | D-2
                                                                 |                                                                | E-1                                                              | F-2                                                              |
| Lewis  | # 7                          | Area 7 is east from Mossyrock to Kiona Creek 5 miles west of Randle on Us Highway 12, then North to the Pierce Co line and South to the Cowlitz Co and Skamania Co line.                                                                                                                                                                                                                                                                                                                                                                            | D-2
<pre><code>                                                             |                                                                | E-1                                                              |                                                                 |
</code></pre>
<p>| Lewis  | # 8                          | East on US Highway 12 from Kiona Creek to the Summit of White Pass at milepost 151 at the Yakima Co line, south to the Skamania Co and Yakima Co lines and North to the Pierce Co line/Nisqually River including the Mt Rainier wilderness area.                                                                                                                                                                                                                                                                                                           | E-2                                                              |</p>
<table>
<thead>
<tr>
<th>County</th>
<th>Trauma Response Area Number</th>
<th>Description of Trauma Response Area’s Geographic Boundaries</th>
<th>Type and # of Verified Services available in each Response Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Pacific</td>
<td># 1</td>
<td>City of Raymond, City of South Bend, Pacific County FD # 3, # 6, # 7 &amp; # 8 and all adjoining forest lands, both public and private. Encompasses FD # 5 to milepost 17 on Highway 105 and any adjoining forest lands, both public and private. Encompasses area of Pacific County in and around the community of Brooklyn in the northeast corner of Pacific County.</td>
<td>A-1, F-1</td>
</tr>
<tr>
<td>County</td>
<td>Trauma Response Area Number</td>
<td>Description of Trauma Response Area’s Geographic Boundaries</td>
<td>Type and # of Verified Services available in each Response Areas</td>
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<tr>
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<td>-----------------------------</td>
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<td>---------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Pierce | # 1                         | **Area #1 (North)**
Area 1 is bordered by Kitsap County in NE by an imaginary line running along 160th St east to Colvos Passage at water, then west along 160th St KPN to NW corner at Kitsap/Mason/Pierce counties border where the imaginary line goes south along 198th Ave KPN to water at Rocky Bay in Case Inlet to Thurston county border at Nisqually River at Nisqually Beach, then follows water line north to Chambers Creek Rd W, then east to Waller Rd, then north to River Rd, then east to Freeman Rd E, then north to Yuma St, then east to Meridian-Hwy 161 then north to an imaginary line bordering King County running west along 384th St through city of Milton to Pacific Hwy, then north to a point at 7th St Ct NE where it runs NNW to a point at Water St in Dash Point. There it enters the water and crosses the Puget Sound to meet the point at Colvos Passage. | A-1
D-3
F-8 |
| Pierce | # 2                         | **Area #2 (South)**
Area 2 is bordered by Thurston County in SW at the Nisqually River at Nisqually Beach, then follows water line north to Chambers Creek Rd W, then along an imaginary line east to Waller Rd, then south along an imaginary line along Mountain Hwy to 260th, then west to 8th Ave E, then south along an imaginary line to Thurston county border at Nisqually River, then west along Nisqually River to Nisqually Beach. | A-1
C-1
D-2
F-3 |
<table>
<thead>
<tr>
<th>County</th>
<th>Trauma Response Area Number</th>
<th>Description of Trauma Response Area’s Geographic Boundaries</th>
<th>Type and # of Verified Services available in each Response Areas</th>
</tr>
</thead>
</table>
| Pierce | # 3                         | **Area #3 (East)**  
Area #3 is bordered by Thurston County in SW at a point where an imaginary line running south along 8<sup>th</sup> Ave E would then intersect the Nisqually River, it then follows the Nisqually River east to a Thurston, Pierce, and Lewis Counties junction at Hwy 7 in Elbe, then continues east along Nisqually River to Mt. Rainier Nat'l Park at end of Hwy 706 along imaginary line east to Yakima County border, then NE along imaginary line bordering Yakima, Kittitas, King, Pierce Counties junction at Green River, then west along Green Water River to junction with White River continuing NW along White River to a point in Muckleshoot Indian Reservation where the imaginary line goes along imaginary line along 1<sup>st</sup> Ave E west through Auburn, then along County Line west to 384<sup>th</sup> St west to Meridian-Hwy 161, then south to Yuma St, then west to Freeman, then south River Rd, then west to Waller Rd, then south along an imaginary line along Mountain Hwy to 260th, then west to 8<sup>th</sup> Ave E, then south along an imaginary line to Thurston county border at Nisqually River. | A-3  
D-1  
F-4 |

---

West Region EMS & Trauma Care Council  
2017-19 Strategic Plan  
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<table>
<thead>
<tr>
<th>County</th>
<th>Trauma Response Area Number</th>
<th>Description of Trauma Response Area’s Geographic Boundaries</th>
<th>Type and # of Verified Services available in each Response Areas</th>
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<td>City of Olympia jurisdictional boundaries</td>
<td>D-2 F-3</td>
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<td>Thurston #2</td>
<td>City of Tumwater jurisdictional boundaries &amp; FD# 15</td>
<td>D-2 F-3</td>
<td></td>
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<td>D-2 F-3</td>
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<td>Thurston #6</td>
<td>FD# 17 jurisdictional boundaries</td>
<td>D-3 F-3</td>
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<td>City of Tenino jurisdictional boundaries &amp; FD# 12 jurisdictional boundaries</td>
<td>A-1 D-2 F-3</td>
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<td>Thurston #8</td>
<td>Town of Bucoda jurisdictional boundaries</td>
<td>A-1* D-2 F-3 *=non-verified BLS aid</td>
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<td>FD# 16 jurisdictional boundaries</td>
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<td>WTRA FD# 11 jurisdictional boundaries &amp; FD# 1 jurisdictional boundaries</td>
<td>D-5 F-3</td>
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<td>FD# 5 jurisdictional boundaries</td>
<td>D-5 F-3</td>
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<td>County</td>
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<td>Description of Trauma Response Area’s Geographic Boundaries</td>
<td>Type and # of Verified Services available in each Response Areas</td>
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</table>
| Thurston | # 12 | FD# 6 jurisdictional boundaries | A-1  
D-2  
F-3 |
| Thurston | # 13 | FD# 7 jurisdictional boundaries | D-3  
F-3 |
| Thurston | # 14 | FD# 8 jurisdictional boundaries | A-1  
D-2  
F-3 |
| Thurston | # 15 | FD# 9 jurisdictional boundaries | D-5  
F-3 |
| Thurston | # 16 | WTRA  
FD# 11 jurisdictional boundaries  
FD# 1 jurisdictional boundaries | D-5  
F-3 |
| Thurston | # 17 | FD# 13 jurisdictional boundaries | A-1  
D-2  
F-3 |
West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 3
Approved Minimum/Maximum numbers of Designated Trauma Care Services (General Acute Trauma Services)

<table>
<thead>
<tr>
<th>Level</th>
<th>State Approved</th>
<th>Current Status</th>
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<td>III</td>
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<td>IV</td>
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<tr>
<td>V</td>
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<tr>
<td>II Pediatric</td>
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<td>1</td>
</tr>
<tr>
<td>III Pediatric</td>
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<td>0</td>
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<table>
<thead>
<tr>
<th>Trauma Designation</th>
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<th>City</th>
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<tbody>
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<td>Adult</td>
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</tr>
<tr>
<td>II</td>
<td>Madigan Army Medical Center</td>
<td>Joint Base Lewis-McChord</td>
</tr>
<tr>
<td>II Pediatric</td>
<td>Tacoma Trauma Center (joint)</td>
<td>Tacoma</td>
</tr>
<tr>
<td>II Pediatric</td>
<td>St. Joseph Medical Center</td>
<td>Tacoma</td>
</tr>
<tr>
<td></td>
<td>Tacoma General Hospital (joint)</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>I R Good Samaritan Hospital</td>
<td>Puyallup</td>
</tr>
<tr>
<td>III</td>
<td>Grays Harbor Community Hospital</td>
<td>Aberdeen</td>
</tr>
<tr>
<td>III II R</td>
<td>Providence St. Peter Hospital</td>
<td>Olympia</td>
</tr>
<tr>
<td>IV</td>
<td>Capital Medical Center</td>
<td>Olympia</td>
</tr>
<tr>
<td>IV</td>
<td>Providence Centralia Hospital</td>
<td>Centralia</td>
</tr>
<tr>
<td>IV</td>
<td>St. Anthony Hospital</td>
<td>Gig Harbor</td>
</tr>
<tr>
<td>IV</td>
<td>St. Clare Hospital</td>
<td>Lakewood</td>
</tr>
<tr>
<td>IV</td>
<td>Summit Pacific Medical Center</td>
<td>Elma</td>
</tr>
<tr>
<td>V</td>
<td>Morton General Hospital</td>
<td>Morton</td>
</tr>
<tr>
<td>V</td>
<td>Willapa Harbor Hospital</td>
<td>South Bend</td>
</tr>
<tr>
<td>II Pediatric</td>
<td>St. Joseph Medical Center</td>
<td>Tacoma</td>
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</table>
Appendix 4
Approved Minimum/Maximum numbers of Designated Rehabilitation Trauma Care Services in the Region

<table>
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<th>Level</th>
<th>State Approved</th>
<th>Current Status</th>
</tr>
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<td>Min</td>
<td>Max</td>
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<tr>
<td>I Rehab</td>
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</tr>
<tr>
<td>III* Rehab</td>
<td>1</td>
<td>5</td>
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*There are no restrictions on the number of Level III Rehab Services
West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 5
### A. Emergency Cardiac and Stroke System Categorization Status

<table>
<thead>
<tr>
<th>Cardiac Level</th>
<th>Stroke Level</th>
<th>Hospital</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>III</td>
<td>Allenmore Hospital</td>
<td>Tacoma</td>
<td>Pierce</td>
</tr>
<tr>
<td>I</td>
<td>II</td>
<td>Capital Medical Center</td>
<td>Olympia</td>
<td>Thurston</td>
</tr>
<tr>
<td>II</td>
<td>II</td>
<td>Grays Harbor Community Hospital</td>
<td>Aberdeen</td>
<td>Grays Harbor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Madigan Army Medical Center</td>
<td>Tacoma</td>
<td>Pierce</td>
</tr>
<tr>
<td>II</td>
<td>III</td>
<td>Summit Pacific Medical Center</td>
<td>McCleary</td>
<td>Grays Harbor</td>
</tr>
<tr>
<td>II</td>
<td>III</td>
<td>Morton General Hospital</td>
<td>Morton</td>
<td>Lewis</td>
</tr>
<tr>
<td>I</td>
<td>II</td>
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West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 6
West Region Patient Care Procedures

Who To Contact

**Grays Harbor and N. Pacific Counties**
- Medical Program Director: Daniel Canfield, DO (360) 533 6038
- Grays Harbor County EMS Council: Sharryl Bell (360) 532 2067

**Lewis County**
- Medical Program Director: Patrick O’Neill, MD (360) 561 2353
- Lewis County Fire Chief’s Assoc: Gregg Peterson (360) 880 4552

**Pierce County**
- Medical Program Director: Clark Waffle, MD (253) 798 7722
- Pierce County EMS Coordinator: Norma Pancake (253) 798 7722

**Thurston County**
- Medical Program Director: Larry Fontanilla, MD (360) 704 2787
- Thurston County Medic One: Kurt Hardin (360) 704 2783

**Department of Health**
- Office of Health Systems Quality Assurance: Catie Holstein (360) 236 2841

**To Request Additional Copies**
- West Region EMS & Trauma Care Council (360) 705 9019
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Patient Care Procedure #1

Medical Branch Director or Group Supervisor at the Scene

OBJECTIVE
To define who is the Medical Branch Director or Group Supervisor at the EMS scene, and to define line of command when multiple providing agencies respond.

PROCEDURE
The regional standard shall be for the incident command system to be used at all times. Per the incident command system, the Medical Branch Director or Group Supervisor will be designated by the incident commander. The Medical Branch Director or Group Supervisor should be the individual with the highest level medical certification who is empowered with local jurisdictional protocols.

Law enforcement will be responsible for overall scene security.

QUALITY ASSURANCE
Departure from this policy shall be reported to the MPD in the jurisdiction of the incident.
Patient Care Procedure #2

Responders & Response Times

OBJECTIVE
To geographically define urban, suburban, rural, & wilderness, and the required prehospital response time for those areas.

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

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

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

Verified aid services shall provide personnel on each trauma response including:

(a) Aid service, basic life support: At least one individual, Emergency Medical Responder (EMR) or above;
(b) Aid service, intermediate life support: At least one Advanced Emergency Medical Technician (AEMT);
(c) Aid service, advanced life support: At least one paramedic.

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

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

Verified ambulance services shall provide personnel on each trauma response including:

(a) Ambulance, basic life support: At least two certified individuals -- one EMT plus one EMR;
(b) Ambulance, intermediate life support: At least two certified individuals One AEMT, plus one EMT;
(c) Ambulance, advanced life support-Paramedic: At least two certified individuals -- one paramedic and one EMT.
Patient Care Procedure #2 (continued)

IMPLEMENTATION

Per WAC 246-976-430(2) verifiedprehospital services that transport trauma patients shall:

(a) Provide an initial report of patient care to the receiving facility at the time the trauma patient is delivered as described in WAC 246-976-330.

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

QUALITY ASSURANCE

The response times and all agencies that do not meet the state standard will be reviewed by the local MPD and referred to West Region Quality Improvement Forum as necessary. Response times will be tracked over a two-year period and the standards reevaluated based on input from the MPDs and responder agencies.
Patient Care Procedure #3

Medical Control - Trauma Triage/Transport

OBJECTIVES
To define the anatomic, physiologic, and mechanistic parameters mandating trauma systems inclusion.
To define the anatomic, physiologic, and mechanistic parameters mandating designated trauma facility team activation.

PROCEDURES
See the attached State of Washington Prehospital Trauma Triage Destination Procedure and the Pierce County Prehospital Trauma Triage Destination Procedure

IMPLEMENTATION
As of March 1, 1996, the region will utilize the resources of designated trauma facilities as they are designated within the region.
Providers will transport trauma activation patients according to the regional trauma facility designation plan as the plan is implemented.

QUALITY ASSURANCE
Per WAC 246-976-430, each prehospital agency is required to participate in the state data system by submitting a completed patient care report to the facility to which the patient was transported. The West Region Quality Improvement Forum will review trauma team activation and surgeon activation, as reported by the State Trauma Registry. This will include procedures and guidelines.
Medical controls will keep accurate recorded communications (log book or tape) for auditing as needed by local communication boards/local EMS councils and MPDs. Departure from this policy will be reported to the West Region Quality Improvement Forum.
Patient Care Procedure #4

Air Transport Procedure

OBJECTIVES
To define who may initiate the request for on scene emergency medical air transport services.

To define under what circumstances nonmedical personnel may request air transport on scene service.

To define medical control/receiving center communication and transport destination determination.

To reduce prehospital time for transport of trauma patients to receiving facility.

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

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

1) Hoisting is needed; 2) Helicopter transport will reduce the prehospital time to the greatest extent regarding the trauma triage procedures requirements.

Do not consider air transport when transport by helicopter to the receiving facility exceeds 30 minutes and exceeds the time for ground transport to another designated trauma or appropriate receiving facility. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility as needed. See Plan Introduction or most current Washington State list of designated trauma care service facilities. Activation of the helicopter does not predetermine the destination.

Steps 1 and 2 require prehospital personnel to notify medical control and activate the trauma system. Activation of the trauma system in Step 3 and Step 4 is determined by medical control.

When BLS/ALS responds, medical control contact should be made as early as possible by BLS/ALS ground personnel for the purpose of medical control and to confirm transport destination. The medical control should contact the receiving facility.

When the use of a helicopter is believed by the field personnel to be the most expeditious and efficacious mode of transport, contact of local online medical control and activation of the trauma system will be concurrent to the activation of the helicopter.
Medical control will consider the following in confirming patient destination: location, Estimated Time of Arrival (ETA) of helicopter, availability of ground transportation, proximity of other designated trauma receiving centers, their current capabilities and availability.

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

QUALITY ASSURANCE
The West Region Quality Improvement Forum will review reports by air transport agencies of launches including cancels, transports, and destinations, as provided by the State Trauma Registry.
Patient Care Procedure #5

Hospital Resource - Interfacility Transfer

OBJECTIVE

To establish recommendations for transport of patients from one designated trauma facility or undesignated medical facility to a designated trauma facility, consistent with established West Region guidelines.

PROCEDURE

All interfacility transfers will be in compliance with current OBRA/COBRA regulations.

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

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

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

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

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

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

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

The destination medical center will be given the following information:

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

Further orders may be given by the receiving physician.

TRAINING

Hospital personnel will be oriented to regional transfer requirements and familiarized with OBRA requirements.

QUALITY ASSURANCE

The numbers of and reasons for interfacility transfers will be reviewed by the West Region Quality Improvement Forum as needed, based on data reports supplied by the
State Trauma Registry. Inclusion indicators will be developed by the Forum in accordance with state and federal guidelines, as well as regional standards.
Patient Care Procedure #6

Prehospital Report Form

OBJECTIVE
To define the regional requirements for reporting prehospital patient data.

PROCEDURE
All Patient Care Reports shall be consistent with the requirements specified in WAC 246.976.330. Furthermore, the Regional Standard for reporting Trauma Patient Data shall be consistent with WAC 246.976.430.

All completed patient care forms will include the following information:

1. Applicable components of system response time as defined in WAC 246.976.330:
   a. At the time of arrival at the receiving facility, a minimum of a brief written or electronic patient report including agency name, EMS personnel, and:
      • Date and time of the medical emergency;
      • Time of onset of symptoms;
      • Patient vital signs including serial vital signs where applicable;
      • Patient assessment findings;
      • Procedures and therapies provided by EMS personnel;
      • Any changes in patient condition while in the care of the EMS personnel;
      • Mechanism of injury or type of illness.

Within twenty-four hours of arrival, a complete written or electronic patient care report that includes at a minimum:

- Names and certification levels of all personnel providing patient care;
- Date and time of medical emergency;
- Age of patient;
- Applicable components of system response time;
- Patient vital signs, including serial vital signs if applicable;
- Patient assessment findings;
- Procedures performed and therapies provided to the patient; this includes the times each procedure or therapy was provided;
- Patient response to procedures and therapies while in the care of the EMS provider;
- Mechanism of injury or type of illness;
- Patient destination.
Patient Care Procedure #6 (continued)

2. Applicable components of system response time as defined in WAC 246.976.430:

**Incident Information:**
- Transporting EMS agency number
- Unit en route date/time
- Patient care report number
- First EMS agency on scene identification number
- Crew member level
- Method of transport
- Incident county
- Incident zip code
- Incident location type

**Patient Information:**
- Name
- Date of birth, or Age
- Sex
- Cause of injury
- Use of safety equipment (occupant)
- Extrication required

**Times:**
- Unit notified by dispatch date/time
- Unit arrived on scene date/time
- Unit left scene date/time

**Vital Signs:**
- Date/time vital signs taken
- Systolic blood pressure (first)
- Respiratory rate (first)
- Pulse (first)
- GCS eye, GCS verbal, GCS motor, GCS total, GCS qualifier

**Treatment:**
- Procedures performed
- Procedure performed prior to unit’s care

The transporting agency will report additional Trauma Data elements to the receiving facility within 10 days as described in WAC 246.976.430.

Licensed services must make all patient care records available for inspection and duplication upon request of the county MPD or Department of Health.
Patient Care Procedure #7

EMS/Medical Control - Communications

OBJECTIVES
To define methods of expedient communication between prehospital personnel and medical control and receiving centers.
To define methods of communication between medical controls and regional designated trauma facilities and other facilities.

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

IMPLEMENTATION
The State of Washington, the West Region EMS & Trauma Care Council, and regional designated trauma facilities will coordinate with prehospital and hospital EMS providers to create the most effective communication system based on the EMS provider's geographic and resource capabilities. Communication between the EMS prehospital provider and the receiving center can be direct (provider to center) or indirect (provider to medical control to designated trauma facility). Local medical control will be responsible for establishing communication procedures between the prehospital provider(s) and receiving hospital(s).

QUALITY ASSURANCE
Significant communication problems affecting patient care will be investigated by the provider agency and reported to the West Region Quality Improvement Forum for review. The agency will maintain communication equipment and training needed to communicate in accordance with WAC.

The West Region Quality Improvement Forum will address the issues of communication as needed.
Patient Care Procedure #8

EMS All Hazards-Mass Casualty Incident (MCI) Response

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

To provide for the standardization/integration of Mass Casualty Incident (MCI) Plans between counties throughout the West Region.

To enhance the response capability of EMS agencies between counties throughout the West Region during an All-Hazards-MCI incident.

PROCEDURE
Pre-hospital EMS responders will follow, at a minimum, the Washington State DOH “Mass Casualty-All Hazards Field Protocols” during an All Hazards-MCI incident. Prehospital EMS responders will additionally follow any other All Hazards-MCI protocols/procedures set forth by the County Medical Program Director.

The General EMS All Hazards-Mass Casualty Incident (MCI) Algorithm on page 53

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

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

1. Mass Casualty-All Hazards Field Protocols website address: [www.doh.wa.gov/emstrauma](http://www.doh.wa.gov/emstrauma)
2. West Region Patient Care Procedure # 8, All Hazards-Mass Casualty Incident Response
3. Pierce County Disaster Patient Care Guidelines [http://www.piercecountywa.org/ems](http://www.piercecountywa.org/ems)
5. Pierce County Burn Plan [http://www.piercecountywa.org/ems](http://www.piercecountywa.org/ems)
7. WMD Emergency Medical Services Training (EMS) face-to-face at [http://cdp.dhs.gov/coursesems.html](http://cdp.dhs.gov/coursesems.html)
8. FEMA’s NIMS training link: [http://www.training.fema.gov/NIMS/](http://www.training.fema.gov/NIMS/)

QUALITY ASSURANCE

Significant problems affecting patient care will be investigated by the provider agency(ies) and reported to the West Region Quality Improvement Forum for review. A Regional After Action Review will be conducted post an All Hazards – Mass Casualty Incident to identify issues to resolve prior to any subsequent event.
Prehospital Mass Casualty Incident (MCI) General Algorithm

Receive dispatch

Respond as directed

Arrive at scene & Establish Incident Command (IC)

Scene Assessment and size-up

Determine if mass casualty conditions exist

Implement county MCI plan

Request additional resources as needed

The dispatch center shall coordinate notification and dispatch of required agencies and resources including notification of the appropriate Disaster Medical Control Center (DMCC). The appropriate local Public Health Department shall be notified in events where a public health threat exists.

Identify hazards and determine needs to control or eliminate them. Take immediate action to isolate and deny access (Site Access Control) or mitigate the hazards as necessary to prevent additional injuries. Consider possibility of terrorist attack (WMD, secondary device)

Initiate START

Reaffirm additional resources

Initiate ICS 201 and/or other similar NIMS compliant worksheets

Upon arrival at medical facilities, transfer care of patients to medical facility staff (medical facility should activate their respective MCI Plan as necessary).

Prepare transport vehicle to return to service
Patient Care Procedure #9

Cardiac Patient Destination

OBJECTIVES

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

PROCEDURES

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

IMPLEMENTATION

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

QUALITY ASSURANCE

West Region prehospital agencies participate in local and regional cardiac quality improvement. The West Region Cardiac Quality Improvement Forum, as established in October 2012, conducts quality improvement reviews to include all aspects of patient care from prevention, dispatch, pre-hospital, hospital and through rehabilitation.
Patient Care Procedure #10

Stroke Patient Destination

OBJECTIVES

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

PROCEDURES

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

IMPLEMENTATION

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

QUALITY ASSURANCE

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

Measure Vital Signs & Level Of Consciousness

- Glasgow Coma Scale < 13 or
- Systolic Blood Pressure < 90 mmHg
- Respiratory Rate < 10 or > 29 per minute or need for
  Ventilator support (> 20/min in infant aged < 1 year)

STEP 1

Assess Anatomy of Injury

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g., flail chest)
- Two or more proximal long bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

STEP 2

Assess Mechanism of Injury & Evidence of High-Energy Impact

- Falls
  - Adults: > 20 ft (1 story = 10 ft)
  - Children: ≥ 10 ft or 2-3 times height of child
- High-Risk auto crash
  - Ejection, including roof > 12 inches occupant site, >18 inches any site
  - Ejection (partial or complete) from automobile
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with a high-risk injury
- Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
- Motorcycle crash > 20 mph

STEP 3

Assess Special Patient or System Considerations

- Older Adults
  - Risk of injury or death after age 55 years
  - Risk of injury or death after age 65
  - Low impact mechanism (e.g., ground level) fall may result in severe injury
- Children
  - Should be triaged preferentially to pediatric capable trauma center
- Anticoagulants and bleeding disorders
  - Patients with head injury are at high risk for rapid deterioration
- Burns
  - Without other trauma mechanism, triage to burn facility
- Pregnancy > 20 weeks
- EMS provider judgment

STEP 4

When in Doubt, Transport to a Trauma Center!

Take patient to the system’s highest appropriate level Trauma Center within 30 minutes transport time (Air or Ground)

"System" is defined as the Regional or Local EMS and Trauma System.

Transport to closest appropriate trauma center within 30 minutes transport time (Air or Ground), which, depending upon the defined trauma system, need not be the highest level trauma center

Contact medical control and consider transport to a trauma center or a specific resource hospital

Transport according to local protocol & Regional PCP

DOH 530-143 July 2012   Washington State Department of Health Prehospital Trauma Triage Destination Procedures  Page 2
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.
Pierce County

Prehospital triage is based on the following 4 steps. Steps 1 and 2 require prehospital EMS personnel to notify medical control and activate the Trauma System. Activation of the Trauma System in Step 3 & 4 is determined by medical control.

**STEP 1 MEASURE VITAL SIGNS & LEVEL OF CONSCIOUSNESS**
- Glasgow Coma Scale < 14 or
- Systolic blood pressure < 90 mm Hg or
- Respiratory rate > 20 breaths/minute ( < 20 in infant < 1 year)

**STEP 2 ASSESS ANATOMY OF INJURY**
- All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
- Flat chest
- Two or more proximal long-bone fractures
- Crushed, depressed or mangled extremity
- Amputation proximal to wrist and ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

**STEP 3 ASSESS MECHANISM OF INJURY & EVIDENCE OF HIGH-ENERGY IMPACT**
- Falls
  - Adults: > 20 ft. (one story is equal to 10 ft.)
  - Children: > 10 ft. or 2-3 times the height of the child
- High-Risk Vehicle Crash
  - Intrusion: > 12 in. or occupant site > 18 in. In any site
  - Ejection (partial or complete) from vehicle
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with high risk of injury
- Bicycle, Pedestrian/Bicycle at Thrown, Run Over, or with Significant (> 20 mph) Impact
- Motorcycle Crash > 20 mph

**STEP 4 ASSESS SPECIAL PATIENT OR SYSTEM CONSIDERATIONS**
- Age
  - Older Adults: Risk of injury death increases after age 55 years
  - Children: Should be traged preferentially to pediatric-capable trauma centers
- Anticoagulation and Bleeding Disorders
- Burns
  - Without other trauma mechanism: Triage to burn facility
  - With trauma mechanism: Triage to trauma center
- Time Sensitive Extremity Injury
- End-Stage Renal Disease Requiring Dialysis
- Pregnancy > 20 Weeks
- EMS Provider Judgment

Transport patient per regional patient care procedures.
State of Washington
Prehospital Cardiac Triage Destination Procedure

Assess Applicability for Triage
- Post cardiac arrest with ROSC
- ≥ 21 years of age with symptoms lasting more than 10 minutes but less than 12 hours suspected to be caused by coronary artery disease:
  - Chest discomfort (pressure, crushing pain, tightness, heaviness, cramping, burning, aching sensation), usually in the center of the chest lasting more than a few minutes, or that goes away and comes back.
  - Pain or discomfort in 1 or both arms, neck, jaws, shoulders, or back.
  - Shortness of breath with or without chest discomfort.
  - Epigastric (stomach) discomfort, such as unexplained indigestion, belching, or pain.
  - Other symptoms may include sweating, nausea/vomiting, lightheadedness.

NOTE: Women, diabetics, and geriatric patients might not have chest discomfort or pain. Instead they might have nausea/vomiting, back or jaw pain, fatigue/weakness, or generalized complaints.

Assess High Risk Criteria
In addition to symptoms in Box 1, pt. has 4 or more of the following:
- Age ≥ 55
- 3 or more CAD risk factors:
  - Family history
  - High blood pressure
  - High cholesterol
  - Diabetes
  - Current smoker
- Aspirin use in last 7 days
- ≥ 2 anginal events in last 24 hours, including current episode
- Known coronary disease
- ST deviation ≥ 0.5 (if available)
- Elevated cardiac markers (if available)

IF ALS has not been dispatched, upgrade if available.

YES

Assess Immediate Criteria
- Post cardiac arrest with return of spontaneous circulation
- Hypotension or pulmonary edema
- EKG positive for STEMI (if available)

NO

If EMS personnel still suspect an acute coronary event, contact medical control for destination. If not, transport per regional patient care procedures.

YES

Unstable patients (life-threatening arrhythmias, severe respiratory distress, shock) unresponsive to EMS treatment should be taken to the closest hospital.

Assess Transport Time and Determine Destination by Level of Prehospital Care*

BLS/ILS

Level I Cardiac Hospital win 30 minutes

YES

Go to Level I Cardiac Hospital and alert destination hospital en route ASAP

NO

Level II Cardiac Hospital 30 minutes closer than Level I?

YES

Go to closest Level II Cardiac Hospital and alert destination hospital en route ASAP

NO

ALS

Level I Cardiac Hospital win 60 minutes

YES

Go to Level I Cardiac Hospital and alert destination hospital en route ASAP

NO

Level II Cardiac Hospital 60 minutes closer than Level I?

YES

Level II Cardiac Hospital 60 minutes closer than Level I?

* 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.
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, 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.
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
- 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

| Time Last Known Well < 6 Hours (Provide stroke alert to destination hospital ASAP) | OR | Time Last Known Well is > 6 Hours (regardless of Stroke Severity Score, alert destination hospital) |
|--------------------------------|--------------------------------|

Stroke Severity Score 4 or more?  

| NO | YES |
|--------------------------------|

Transport to nearest Level I or II Stroke Center with endovascular capability provided transport time is no more than 15 minutes greater than to a nearer Level II or Level III Stroke Center.

Additional Destination Considerations:
- Any additional transport time should not take the patient outside of the IV-TPA time window.
- Assess availability of critical care air transport if it can help get the patient to a Stroke Center within the window of time for intervention.
- If unable to manage airway, consider rendezvous with ALS or intermediate stop at nearest facility capable of definitive airway management.
- If there are two or more Stroke Centers of the same level to choose from within the transport timeframe, patient preference, physician practice patterns, and local rotation agreements may be considered.

DOH 530-182 January 2017
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 Washington DOH Level 1, 2 or 3 stroke centers (see a list of categorized hospitals here).

Patients who present to EMS with a severe stroke are more likely to have blockage of a large vessel and can benefit from mechanical clot retrieval (thrombectomy). Thrombectomy must begin by 6 hours since last known well, and is a more complex intervention, available only 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:** Use the LKW time as opposed to when symptoms were first noticed. For patients who woke up in the morning with symptoms and were 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 before symptoms starting if a patient delays reporting symptoms or, for example, someone discovers a patient with symptoms but saw the person well 2 hours earlier.

**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 ≤ 6 hours but NOT “Severe” or Time since LKW > 6 hours (regardless of severity):** these patients should be taken directly to the nearest Level 1 or Level 2 stroke center provided it is no more than 15 extra minutes travel compared to a nearer Level 3 stroke center.

**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 completed 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.
West Region Emergency Medical Services
& Trauma Care System Strategic Plan

Appendix A
## Nonfatal Injury Hospitalizations

### Cause by Year 2004-2013

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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<tr>
<td>Total</td>
<td>8,499</td>
<td>8,024</td>
<td>9,134</td>
<td>9,868</td>
<td>9,238</td>
<td>9,169</td>
<td>9,128</td>
<td>9,136</td>
<td>9,136</td>
<td>9,067</td>
<td>96,895</td>
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</table>

### Rate per 100,000 Resident Population

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<th>2005</th>
<th>2006</th>
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<th>2008</th>
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<tbody>
<tr>
<td>Total</td>
<td>8,499</td>
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<td>9,169</td>
<td>9,128</td>
<td>9,136</td>
<td>9,136</td>
<td>9,067</td>
<td>96,895</td>
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## 2015 West Region Fatality Data
### All Ages

<table>
<thead>
<tr>
<th>Injury Type</th>
<th>Intent</th>
<th>Death Numbers</th>
<th>Population</th>
<th>Rate</th>
<th>Lower Rate</th>
<th>Upper Rate</th>
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</thead>
<tbody>
<tr>
<td>All Mechanisms</td>
<td>All Intent</td>
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<td>16</td>
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<td>Falls</td>
<td>All Intent</td>
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<td>All Intent</td>
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<td>Suffocation</td>
<td>All Intent</td>
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<td>MVT Occupant</td>
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<td>2.6</td>
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## 2015 West Region Suicide Fatality Data
### All Ages

<table>
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<tr>
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<th>Death Numbers</th>
<th>Population</th>
<th>Rate</th>
<th>Lower Rate</th>
<th>Upper Rate</th>
</tr>
</thead>
<tbody>
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<td>All Mechanisms</td>
<td>224</td>
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<td>Firearm</td>
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<td>6.6</td>
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<tr>
<td>Suffocation</td>
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<td>4.3</td>
<td>3.3</td>
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<tr>
<td>Poisoning</td>
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<tr>
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<td>.3</td>
<td>1.2</td>
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<td>Cut/Pierce</td>
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<td>.2</td>
<td>1</td>
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<tr>
<td>Falls</td>
<td>6</td>
<td>1,268,515</td>
<td>.5</td>
<td>.2</td>
<td>1</td>
</tr>
</tbody>
</table>
West Region Emergency Medical Services
& Trauma Care System Strategic Plan

Appendix B
ARTICLE 1 - NAME
The name of the council shall be the West Region Emergency Medical Services and Trauma Care Council, Inc., hereafter referred to as the Council. The Council shall be composed of no less than three (3) and no more than five (5) counties.

ARTICLE 2 - PURPOSE
The Council:

2.1 Shall be an advisory and coordinating council for the planning and implementation of comprehensive, integrated regional emergency medical services and trauma care.

2.2 Shall be advisory to the State Department of Health in implementation of the State of Washington Emergency Medical Services & Trauma System Strategic Plan.

2.3 Shall identify specific activities necessary to meet statewide standards, identified in statute and WAC, and patient care outcomes in the region and develop a plan of implementation for regional compliance.

2.4 Shall assess and analyze regional emergency medical services and trauma care needs and identify personnel, agencies, facilities, equipment, training, and education to meet regional and local needs.

2.5 Shall recommend to the Department of Health on distribution of regional funds based on those needs and priorities identified in Article 2.4.

2.6 Shall establish and review agreements with regional providers necessary to meet state standards and establish agreements with providers outside the region to facilitate patient transfer.

2.7 Shall establish the number and level of facilities to be designated that are consistent with state standards and based upon availability of resources and the distribution of trauma within the region.

2.8 Shall review and evaluate the emergency medical services and trauma care system as it develops and review grievances within the system as they arise.

2.9 Shall identify the need for and recommend distribution and level of care of prehospital services to assure adequate availability and avoid inefficient duplication and lack of coordination of prehospital services within the region.

2.10 Shall adopt a budget subject to the availability of funds from the State Department of Health and any other sources.

2.11 The authority, duties and responsibilities of the Council are defined by:

WAC 246-976-960 Regional Emergency Medical Services and Trauma Care Councils.

(1) In addition to meeting the requirements of chapter 70.168 RCW and elsewhere in this chapter, regional EMS/TC councils must:

(a) Identify and analyze system trends to evaluate the EMS/TC system and its
component subsystems, using trauma registry data provided by the department;

(b) Develop and submit to the department regional EMS/TC plans to:

(i) Identify the need for and recommend distribution and level of care (basic, intermediate or advanced life support) for verified aid and ambulance services for each response area. The recommendations will be based on criteria established by the department relating to agency response times, geography, topography, and population density;

(ii) Identify EMS/TC services and resources currently available within the region;

(iii) Describe how the roles and responsibilities of the MPD are coordinated with those of the regional EMS/TC council and the regional plan;

(iv) Describe and recommend improvements in medical control communications and EMS/TC dispatch, with at least the elements of the state communication plan described in RCW 70.168.060 (1) (h);

(v) Include a schedule for implementation.

(2) In developing or modifying its plan, the regional council must seek and consider recommendations of:

(a) Local EMS/TC councils;

(b) EMS/TC systems established by ordinance, resolution, interlocal agreement or contract by counties, cities, or other governmental bodies.

(3) In developing or modifying its plan, the regional council must use regional and state analyses provided by the department based on trauma registry data and other appropriate sources;

(4) Approved regional plans may include standards, including response times for verified services, which exceed the requirements of this chapter.

(5) An EMS/TC provider who disagrees with the regional plan may bring its concerns to the steering committee before the department approves the plan.

(6) The regional council must adopt regional patient care procedures as part of the regional plans. In addition to meeting the requirements of RCW 18.73.030 (14) and 70.168.015 (23):

(a) For all emergency patients, regional patient care procedures must identify:

(i) Guidelines for rendezvous with agencies offering higher levels of service if appropriate and available, in accordance with the regional plan.

(ii) The type of facility to receive the patient, as described in regional plan destination and disposition guidelines.

(iii) Procedures to handle types and volumes of trauma that may exceed regional capabilities, taking into consideration resources available in other regions and adjacent states.

(b) For major trauma patients, regional patient care procedures must identify procedures to activate the trauma system.

(7) Matching grants made under the provisions of chapter 70.168 RCW may include funding to:

(a) Develop, implement, and evaluate prevention programs; or

(b) To accomplish other purposes as approved by the department.
ARTICLE 3 - COMPOSITION AND MEMBERSHIP

3.1 The Council shall be comprised of (per RCW 70.168.120) a balance of hospital and prehospital trauma care and emergency medical services providers, local elected officials, consumers, local law enforcement representatives, and local government agencies involved in the delivery of emergency medical services and trauma care as follows:

<table>
<thead>
<tr>
<th>Council Position</th>
<th>Total # of Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: Grays Harbor (1), Lewis (1), Pierce (2), Thurston (1)</td>
<td>5</td>
</tr>
<tr>
<td>Prehospital: Grays Harbor (1), Lewis (1), Pierce (2), Thurston (2)</td>
<td>6</td>
</tr>
<tr>
<td>Private Ambulance</td>
<td>1</td>
</tr>
<tr>
<td>Physicians: Emergency (1) &amp; Surgeon (1)</td>
<td>2</td>
</tr>
<tr>
<td>Emergency Room Nurse</td>
<td>2*</td>
</tr>
<tr>
<td>Prevention Specialist</td>
<td>1</td>
</tr>
<tr>
<td>Trauma Program Manager</td>
<td>1</td>
</tr>
<tr>
<td>Cardiac and/or Stroke Coordinator</td>
<td>1</td>
</tr>
<tr>
<td>Local Elected Official: At-Large</td>
<td>1</td>
</tr>
<tr>
<td>Consumer</td>
<td>2*</td>
</tr>
<tr>
<td>Law Enforcement: At-Large</td>
<td>1</td>
</tr>
<tr>
<td>Local Government Agency (County Specific)</td>
<td>4**</td>
</tr>
<tr>
<td>Local EMS/TC Council</td>
<td>4**</td>
</tr>
<tr>
<td>Military Prehospital/Hospital</td>
<td>1</td>
</tr>
<tr>
<td>North Pacific County</td>
<td>1</td>
</tr>
<tr>
<td>Fire Chief</td>
<td>4**</td>
</tr>
<tr>
<td>EMS Educating Agency</td>
<td>2*</td>
</tr>
<tr>
<td>County Medical Program Director</td>
<td>4**</td>
</tr>
<tr>
<td>Rehabilitation Specialist</td>
<td>1</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>1</td>
</tr>
<tr>
<td>Local County Public Health Official</td>
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<tr>
<td>Emergency Management</td>
<td>1</td>
</tr>
<tr>
<td>Dispatch</td>
<td>1</td>
</tr>
<tr>
<td>Mason County (non-voting member)</td>
<td>1</td>
</tr>
</tbody>
</table>

Total Number of Council Positions: 49

*No two being from the same county.

**One from each county. Grays Harbor and N. Pacific are counted as one county.
3.2 Representatives will be recommended by each local EMS/TC council for appointment by the Department of Health. The term of membership shall not be limited, except by local EMS/TC councils or the Department of Health.

3.3 For each membership position, local EMS/TC councils may recommend one alternate for appointment by the Department of Health. The alternate shall have all the rights, privileges, and protections of the member during his/her absence (whether excused or unexcused). Votes cast by an alternate in the member’s absence shall have the same import as if cast by the primary member. If the member is present, the alternate abstains from voting.

3.4 An absence is excused when a member/alternate notifies the Council chair, or designee, in advance of his/her inability to attend such meeting stating such reason for non-attendance. An alternate member is automatically excused when the member is in attendance.

3.5 If a member/alternate misses three consecutive regularly scheduled Council meetings, where the designated position has not been represented, and the member/alternate has not been excused by the Council for these absences, the Council may recommend to the local EMS/TC council to terminate that individual’s membership, with documentation to support the request. Upon a member’s termination by the Department, the alternate may take the member’s place and a new alternate shall be appointed, if necessary. The Council shall call for recommendations for a replacement from the local EMS/TC council and/or other organization appropriate to the position. The replacement shall be for the unexpired term of the original alternate.

ARTICLE 4 - OFFICERS

4.1 The officers shall be chair, vice-chair, and secretary/treasurer, elected by a majority of the Council for a two-year term, with no more than two officers being from the same county.

4.2 Nominations for elections of officers shall be in May with elections in June. Newly elected officers shall begin duties in July. The nominating committee shall be composed of the non-officer positions on the Executive Board.

4.3 The chair shall preside at all regular and special meetings of the Council.

4.4 In the absence of the chair, the vice-chair, then the secretary/treasurer shall perform the duties of the chair.

4.5 The secretary/treasurer shall maintain accurate records of all Council meetings and be responsible for general correspondence of the Council. The secretary/treasurer shall keep charge of funds of the Council and shall report at regular meetings on the status of the funds.

4.6 Any vacancies in the above officers shall be filled by appointment by the chair, subject to Council approval. A vacancy in the chair's office shall be filled by a majority vote of the Council for the unexpired term of the office.

ARTICLE 5 - EXECUTIVE BOARD

5.1 The Executive Board shall consist of no more than eight (8) members. The three officers shall serve on the Executive Board as representatives of their respective counties. The remaining five positions shall represent each of the four counties with the fifth position
being from the county without an officer on the Executive Board. These representatives-at-large shall be selected by each county’s delegation on the Council.

5.2 Meetings of the Executive Board shall be called by the chair or at the request of a majority of the voting membership as needed, to conduct routine or Council directed business between meetings or to develop recommendations to the full Council. Any action by the Executive Board shall be subject to review and ratification by the full Council at the next meeting.

5.3 A quorum must be present at an Executive Board meeting in order to conduct business. A quorum of the Executive Board shall consist of 50% or greater of appointed Executive Board members.

ARTICLE 6 - MEETINGS

6.1 Regular meetings of the full Council are held quarterly. Location shall be included in meeting announcement at least thirty (30) days prior to meeting date.

6.2 Regular Executive Board meetings are held monthly. Location shall be included in meeting announcement at least fifteen (15) days prior to meeting date.

6.3 Standing committee meetings will be held at least quarterly and as scheduled by the committee chair. An annual calendar of meeting dates will be published by July 1 for the committees described in 7.1.

6.4 The year for terms of officers shall be the fiscal year from July 1 - June 30.

6.5 A quorum of the Council shall consist of a majority of the members present that are appointed by the Department of Health.

6.6 Meetings shall be called by the chair or at the request of a majority of the voting membership with at least ten (10) days advance notice.

6.7 Meetings shall be open to the public and held in accordance with Chapter 42.30 RCW, the Open Public Meetings Act.

ARTICLE 7 - COMMITTEES

7.1 Three standing committees shall be established as follows: Prevention, Education, Joint Standards & Planning.

7.2 Additional committees may be appointed by the chair as needed, with the approval of Council members. The chair shall be an ex-officio member of all committees.

7.3 Committee chairs may be elected by committee members or appointed by the Council chair. Chair or designee shall, at a minimum, give oral reports to the full Council.

7.4 Independent committees may receive administrative support, with the approval of Council members. At least one (1) Council member must be a member of the independent committee and shall, at the minimum, give written quarterly reports on committee activities, which may be supplemented with oral reports to the full Council. Independent committee includes:

- West Region Quality Improvement Forum

7.5 The officers may appoint such agents or assistants as they find necessary with the advice and consent of the full Council.
ARTICLE 8 - AMENDMENTS

8.1 These by-laws may be repealed or amended upon recommendation of a majority of the appointed members of the Council in a formal vote.

8.2 Council members shall be notified in writing at least ten (10) days prior to the meeting at which the vote is to be taken.

ARTICLE 9 - RULES OF PROCEDURE

Robert's Rules of Order (latest revision) shall be the rules of procedure of the Council except as amended herein.
Appendix C
WEST REGION
QUALITY IMPROVEMENT PLANS

Administrative Support Provided by

West Region Emergency Medical Services & Trauma Care Council, Inc.
Proudly Serving Grays Harbor, Lewis, N. Pacific, Pierce and Thurston Counties
5911 Black Lake Blvd SW, Olympia, WA 98512
360-705-9019 • www.wrems.com
I. West Region QI – Trauma
4th Revision: 3/21/13

Mission Statement

Continuously strive to optimize Trauma/EMS patient care and outcome through the continuum of care.
Mission Statement
Continuously strive to optimize Trauma/EMS patient care and outcome through the continuum of care.

GOAL: EVALUATE & IMPROVE PATIENT CARE THROUGH THE USE OF COMPREHENSIVE, DATA-DRIVEN QUALITY IMPROVEMENT PROCESSES.

1. Collect Accurate, Timely Data
   Accurate, timely data is an essential prerequisite to effective quality improvement.
   1.a. Patient Care Analysis
       QI reviews should include all aspects of patient care from prevention, pre-hospital, hospital and through rehabilitation.

2. Analyze Patterns and Trends of Regional Trauma and EMS
   Compare similarities and differences between West Region and other regional, state and national models.
   2.a. Assess Patient Flow Patterns
       A special concern of West Region is trauma patient flow patterns as well as inter-facility transfers and methods of transport. Ongoing monitoring will be required to provide data for consideration of additional (or fewer) designated trauma centers or when categorized cardiac/stroke facilities are available.
   2.b. Compare Similar Hospital/Agency Outcomes
       Case review requires objective comparisons with similar institutions within the region, state or nationally. In addition, a benchmark is used when available to which comparisons can be made.
   2.c. Analyze Individual Cases of Trauma and EMS
       Highlighting the trends and patterns with individual case review. This will provide a specific focus for improvements and changes, as well as affording the opportunity to discuss individual cases.

3. Action Plan/Loop Closure
   3.a. Washington State Department of Health
       Provide communication on patterns and trends of regional trauma, EMS & Cardiac/Stroke care through the West Region QIF or appropriate agency.
   3.b. Opportunities for Improvement
       Recommend opportunities for improvement to the training or prevention committee of the West Region Council to disseminate among West Region agencies/facilities.
   3.c. Loop Closure
       Cases sent to the QIF for review and recommendation require follow-up with action taken at the next meeting. Based upon information learned, key teaching points from each forum may be disseminated.
PRINCIPLES

- **Trauma Center Leadership**
  As described in WAC 246-976-910 (2) and RCW 70.168.090 (2): Levels II, and III trauma care facilities shall establish and participate in regional EMS/TC systems quality improvement programs. West Region QIF encourages full participation from all West Region hospitals.

- **System Analysis**
  This is intended to be a process for continuous quality improvement of the regional system of trauma care throughout the age continuum. It is not intended to duplicate or supplant quality improvement programs of prehospital agencies, individual hospitals or rehabilitation units involved in regional trauma care. The state Trauma Registry will provide accurate data to assess regional performance as well as individual provider/agency performance.

- **Confidential Case Review & Education**
  Effective identification, analysis and correction of problems require objective review by qualified, appropriate members of trauma care programs, protected by a process which ensures confidentiality. The approach used by the QIF will be standard case review profiling and issue for education and/or process improvement.
PROCESS

TRAUMA QIF MEMBERSHIP
The West Region QIF membership includes the following voting & non-voting members and is consistent with WAC 246-976-910(3) & (4)

Voting Members:
Trauma Medical Director from each designated trauma and trauma rehabilitation center
Trauma Program Managers from each designated trauma and trauma rehabilitation center
Medical Program Director (MPD) from each county - total 4
Emergency Department Representative from each designated trauma center (director or designee)
EMS representative (field provider preferred) - 3 from each county
CQI Representative – 1 prehospital and 1 hospital from each county
Regional EMS Council Chair
Regional Injury Prevention Representative: 1 pediatric and 1 adult
Regional Aero Medical Provider
*Any of the above members may be replaced by an official designee from the represented facility or agency.

Non-voting Members:
State Department of Health Staff
Appropriate medical specialists as needed and determined by QIF voting members
Non-designated facility representatives
EMS Coordinator/Director from each county
Regional Council staff member

Quorum: A quorum shall consist of a minimum of 10 voting members at the beginning of the meeting and will continue as long as 6 or more voting members remain.

- Confidentiality
  Actions of the QIF are confidential as provided in WAC 246-976-910 (6) (a) and protected by RCW 43.70.510 and chapters 18.71, 18.73, and 70.168. See Attachment A. A written plan for confidentiality is required. See Attachment B. Notification in writing of the confidentiality of each meeting is required. Information identifying individual patients cannot be publicly disclosed without patient consent.

- Regional QA meetings
  - Frequency: 5 meetings per year
  - Chairperson and 2 Vice Chairs: 3 year position elected by the majority of voting members (preferred structure: Chair = MD)
  - 3 hours in length

- Components to meeting:
  - Review of regional data and trends
  - Performance Improvement (PI) Project Presentation or Mortality Review
  - Focused case(s) review with directed discussion
  - Next QIF meeting goals and targets
    - Yearly process/injury focus will be identified at the last QIF meeting of the year.

- Summary Conclusions and Reporting
  The Chairperson is responsible for providing summary conclusions of discussions. Provisions must be provided for feedback to the Department of Health and the West Region EMS & Trauma Care Council on identified EMS and trauma care issues and concerns.
DETAILS

Component 1: Review of regional data and trends

- The state Department of Health Trauma Registry shall provide a focused report on issues/filters as requested.

Component 2: Performance Improvement Project Presentation

Presentation will include following points:
- Problem identification
- Process changes
- Implementation process
- Evaluation
  - Lessons learned

Component 3: Mortality Review

Component 4: Focused cases reviews:

Designated agencies present injury or process specific case reviews as assigned by the committee. Cases will be not exceed 60 minutes and include:
- Continuum of care from dispatch through rehabilitation
- Major players involved be present or available for questions and discussion
- Audio-visual aids
- Topics from case for discussions
- Lessons learned

Component 5: Identification of next quarter’s meeting goals and targets
ATTACHMENT A

WEST REGION QUALITY IMPROVEMENT FORUM

QI FORUM MEMBERS AND GUESTS
CONFIDENTIALITY AGREEMENT
in accordance with RCW 70.168.090(3) and (4)

The undersigned attendees of the QI Forum meeting held (date), agree to hold in strict confidence all information, data, documentation, and discussions resulting from this meeting, and subsequently documented in meeting minutes. No information will be disclosed to parties outside this QI Forum, except as agreed to by the attendees for the purposes of follow-up, resolution or systems design changes. Failure to observe this agreement will result in dismissal from the Forum and possible personal liability.

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ATTACHMENT B

West Region Quality Improvement Plan
Confidentiality and Exemption from Discoverability
Policy and Procedures
Revised 3/21/13

Policy
It is the intention of the West Region Quality Improvement Forum (QIF) to use the information gathered to support clinical research and improve patient care through measuring and improving systems performance. It is necessary that providers have protection from discoverability and possible liability to reach that end.

Pledge of Confidentiality
All attendees of the QIF will sign a pledge of confidentiality which will also act as a record of attendance. At each meeting the pledge of confidentiality will be read into the minutes. (See Att A).

Documentation
Patient records will be identified by the unique Trauma Registry identifier. Patient information cannot be publicly disclosed without written permission of the patient or guardian. All QIF handouts shall be labeled “Confidential QI Document/Privilege Information/Not Authorized for Distribution.” All confidential documents will be collected at the end of the meeting, and all copies will be destroyed following the meeting. One permanent copy will be kept in a locked cabinet.

Minutes
Minutes from QIF meetings will be prepared by the West Region EMS staff. Minutes will be reviewed and approved by the members. One copy of the minutes will be kept for the purpose of record by the West Region EMS, and its staff will be responsible for collecting and destroying all documents following the meeting. Retention schedule for minutes will be 4 years. The one permanent copy will be kept in a locked cabinet. Any case specific information presented during QIF meetings will be held in strict confidence among those attending the meeting. All identifying references to specific cases will be omitted from meeting minutes.

Reports
A report will be generated to summarize significant findings of the materials reviewed in the QIF meeting. The summary report will be modified to scrub information that might identify individuals or agencies involved in the QI review. Names, dates, times and situations may be modified to prevent loss of confidentiality while communicating intent of the finding(s). The QIF will approve the summary report (redacted meeting minutes) before it is released external to the QIF.

Educational Learning Points
Key learning points will be generated from a review of QI Forum reports and case presentations. To close the loop between quality improvement and training, this information will be distributed to EMS and hospital providers to assist with education and training. All information will be carefully scrubbed to eliminate individual or agency identifiers.

Access to Information
All members of the QIF, and those who have been invited to attend by members of the forum, have access to view or discuss patient, provider, and systems information when the patient and the provider’s identifying information has been obscured. It is the obligation of the attendees to keep all information confidential and to protect it against unauthorized intrusion, corruption, and damage.
West Region Quality Improvement Plan

TEMPLATE FOR CASE REVIEWS

December, 2002

I. WRQIF Case Review
   • Name of presenter
   • Name of agencies represented
   • Date

II. Topic
   • Question or issue to be addressed with this case review

III. Scene/Background Information

IV. EMS Findings/Interventions
   • Description of Pt
   • Vital Signs
   • Interventions

V. ED Interventions/Findings
   • Vital Signs
   • Interventions
   • Findings
   • Injury List
   • Consults
   • Pt Disposition

VI. Hospital Course
   • Length of Stay
   • Surgeries
   • Other Injuries/Procedures Done
   • Cost

VII. Rehab (if appropriate)

VIII. Outcome
   • Discharge Status
   • Current Update on Pt Outcome
II. West Region QI – Cardiac & Stroke QI
   Approved 10/15/12

**Mission Statement**

Continuously strive to optimize Cardiac and Stroke patient care and outcome through the continuum of care.
Mission Statement
Continuously strive to optimize Cardiac and Stroke patient care and outcome through the continuum of care.

GOAL: EVALUATE & IMPROVE CARDIAC & STROKE PATIENT CARE THROUGH THE USE OF COMPREHENSIVE, DATA-DRIVEN QUALITY IMPROVEMENT PROCESSES.

1. Collect Accurate, Timely Data
   Accurate, timely data is an essential prerequisite to effective quality improvement.
   
   1.a. Patient Care Analysis
   QI reviews should include all aspects of patient care from prevention, dispatch, pre-hospital, hospital and through rehabilitation

2. Analyze Patterns and Trends of Regional Cardiac/Stroke Care
   Compare similarities and differences between West Region and other regional, state and national models.
   
   2.a. Assess Patient Flow Patterns
   A special concern of West Region is cardiac and stroke patient flow patterns as well as inter-facility transfers and methods of transport. Ongoing monitoring will be required to provide data to assure access to WA State categorized cardiac and stroke centers in accordance to the state triage tools for cardiac and stroke.

   2.b. Compare Similar Hospital/Agency Outcomes
   Case review requires objective comparisons with similar institutions within the region, state or nationally. In addition, benchmarking is used when available to which comparisons can be made.

   2.c. Analyze Individual Cases of Cardiac and Stroke Care
   Analysis can be provided by highlighting the trends and patterns with examples from individual case review. This will provide a specific focus for education, improvements and changes, as well as affording the opportunity to discuss individual cases.

3. Action Plan/Loop Closure
   
   3.a. Washington State Department of Health
   Provide communication on patterns and trends of regional Cardiac/Stroke care through the West Region Quality Improvement Forum (QIF) or appropriate agency.

   3.b. Opportunities for Improvement
   Recommend opportunities for improvement to the training or prevention committee of the West Region Council to disseminate among West Region agencies/facilities.

   3.c. Loop Closure
   Cases sent to the Quality Improvement Forum (QIF) for review and recommendation require follow-up with action taken at the next meeting. Based upon information learned, key teaching points from each forum may be disseminated.
PRINCIPLES

- **Cardiac and Stroke Center  Leadership and Participation**
  According to Washington State Department of Health Participation Criteria for Level 1 Cardiac and Level 1 Stroke Categorization provide community/regional resources for guidance and recommendations through leadership. All Levels of Cardiac and Stroke centers have committed to participate in regional quality improvement activities through the categorization process. West Region QIF encourages full participation from all West Region hospitals.

- **System Analysis**
  This is intended to be a process for continuous quality improvement of the regional system of cardiac and stroke care throughout the age continuum. It is not intended to duplicate or supplant quality improvement programs of prehospital agencies, individual hospitals or rehabilitation units involved in cardiac and stroke care. By use of Clinical Outcomes Assessment Program (COAP) and Outcomes Science Get With The Guidelines (GWTG) for Stroke or the additional data collection tool there will be accurate data provided to assess regional performance as well as individual provider/agency performance.

- **Confidential Case Review & Education**
  Effective identification, analysis and correction of problems require objective review by qualified, appropriate members of cardiac and stroke care programs, protected by a process which ensures confidentiality. The approach used by the QIF will be standard case review profiling and issue for education and/or process improvement.

PROCESS

CARDIAC AND STROKE QIF MEMBERSHIP
The West Region Cardiac & Stroke QIF membership includes the following voting & non-voting members:

**Voting Members:**
- Cardiac and Stroke Medical Directors from each categorized cardiac and stroke hospital
- Cardiologist
- Neurologist
- Emergency Medicine Physician
- Emergency Department RN
- Cardiac and Stroke Coordinators from each categorized cardiac and stroke hospital
- Medical Program Director (MPD) from each county - total 4
- Emergency Department Representative from each categorized cardiac and stroke hospital (director or designee)
- EMS representative (field provider preferred) - 3 from each county
- CQI Representative – 1 prehospital and 1 hospital from each county
- Regional EMS Council Chair
- Prevention Representative: 1 cardiac and 1 stroke
- Regional Aero Medical Provider
- Representatives from County Cardiac and Stroke QI
  *Any of the above members may be replaced by an official designee from the represented facility or agency.*

**Non-voting Members:**
- State Department of Health Staff
- Appropriate medical specialists as needed and determined by QIF voting members
- American Heart/Stroke Association representative
- Non-designated facility representatives
- EMS Coordinator/Director from each county
- Regional Council staff member
Quorum: A quorum shall consist of a minimum of 10 voting members at the beginning of the meeting and will continue as long as 6 or more voting members remain.

- Confidentiality
  The Emergency Cardiac and Stroke (ECS) law amended RCW 70.168.090(2) to allow existing regional EMS and trauma quality assurance (QA) programs to evaluate cardiac and stroke care delivery in addition to trauma care delivery. See Attachment A. A written plan for confidentiality is required. See Attachment B. Notification in writing of the confidentiality of each meeting is required. Information identifying individual patients cannot be publicly disclosed without patient consent.

- Regional Cardiac and Stroke QIF meetings
  - Frequency: 4 meetings per year
  - Chairperson and 1 Vice Chair: 3 year position elected by the majority of voting members
    (preferred structure: Chair = MD)
  - Length
    - 1.5 hours cardiac
    - 1.5 hours stroke

- Components to meeting:
  Review of regional data and trends
  Performance Improvement (PI) Project Presentation
  Focused case(s) review with teaching points and directed discussion
  Next QIF meeting goals and targets
  Yearly process/injury focus will be identified at the last QIF meeting of the year.
  Selection of goals and objectives for Cardiac/Stroke meetings will be identified annually.

- Summary Conclusions and Reporting
  The Chairperson is responsible for providing summary conclusions of discussions. Provisions must be provided for feedback to the Department of Health and the West Region EMS & Trauma Care Council on identified cardiac and stroke care issues and concerns.
DETAILS

Component 1: Review of regional data and trends

COAP and Outcomes Science GWTG for Stroke or the additional data collection tools will be used for data and trend reporting.

Component 2: Performance Improvement Project Presentation

Presentation will include following points:
  • Problem identification
  • Process changes
  • Implementation process
  • Tools or resources
  • Evaluation
    o Lessons learned

Component 3: Focused cases reviews:

Designated agencies present cardiac and stroke case reviews as assigned by the committee. Cases will not exceed 60 minutes and include:
  • Continuum of care from dispatch through rehabilitation
  • Major players involved be present or available for questions and discussion
  • Audio-visual aids
  • Topics from case for discussions
  • Lessons learned

Component 4: Identification of next quarter’s meeting goals and targets
ATTACHMENT A

WEST REGION CARDIAC & STROKE QUALITY IMPROVEMENT FORUM

QI FORUM MEMBERS AND GUESTS
CONFIDENTIALITY AGREEMENT
in accordance with RCW 70.168.090(3) and (4)

The undersigned attendees of the QI Forum meeting held (date), agree to hold in strict confidence all information, data, documentation, and discussions resulting from this meeting, and subsequently documented in meeting minutes. No information will be disclosed to parties outside this QI Forum, except as agreed to by the attendees for the purposes of follow-up, resolution or systems design changes. Failure to observe this agreement will result in dismissal from the Forum and possible personal liability.

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ATTACHMENT B

West Region Quality Improvement Plan
Confidentiality and Exemption from Discoverability
Policy and Procedures
October 2012

Policy
It is the intention of the West Region Quality Improvement Forum (QIF) to use the information gathered to support clinical research and improve patient care through improved systems performance. It is necessary that providers have protection from discoverability and possible liability to reach that end.

Pledge of Confidentiality
All attendees of the QIF will sign a pledge of confidentiality which will also act as a record of attendance. At each meeting the pledge of confidentiality will be read into the minutes. (See Att A).

Documentation
Patient records will be identified by the unique identifier. Patient information cannot be publicly disclosed without written permission of the patient or guardian. All QIF handouts shall be labeled “Confidential QI Document/Privilege Information/Not Authorized for Distribution.” All confidential documents will be collected at the end of the meeting, and all copies will be destroyed following the meeting. One permanent copy will be kept in a locked cabinet.

Minutes
Minutes from QIF meetings will be prepared by the West Region EMS staff. Minutes will be reviewed and approved by the members. One copy of the minutes will be kept for the purpose of record by the West Region EMS, and its staff will be responsible for collecting and destroying all documents following the meeting. Retention schedule for minutes will be 4 years. The one permanent copy will be kept in a locked cabinet. Any case specific information presented during QIF meetings will be held in strict confidence among those attending the meeting. All identifying references to specific cases will be omitted from meeting minutes.

Reports
A report will be generated to summarize significant findings of the materials reviewed in the QIF meeting. The summary report will be modified to scrub information that might identify individuals or agencies involved in the QI review. Names, dates, times and situations may be modified to prevent loss of confidentiality while communicating intent of the finding(s). The QIF will approve the summary report (redacted meeting minutes) before it is released external to the QIF.

Educational Learning Points
Key learning points will be generated from a review of QI Forum reports and case presentations. To close the loop between quality improvement and training, this information will be distributed to field and in-hospital EMS providers to assist with education and training. All information will be carefully scrubbed to eliminate individual or agency identifiers.

Access to Information
All members of the QIF, and those who have been invited to attend by members of the forum, have access to view or discuss patient, provider, and systems information when the patient and the provider’s identifying information has been obscured. It is the obligation of the attendees to keep all information confidential and to protect it against unauthorized intrusion, corruption, and damage.
I. WRQIF Case Review
   • Name of presenter
   • Name of agencies represented
   • Date

II. Topic
   • Question or issue to be addressed with this case review

III. Scene/Background Information

IV. EMS Findings/Interventions
   • Description of Pt
   • Vital Signs
   • Symptoms
   • Last known well time
   • Onset of symptom time
   • Interventions/Treatment
   • EKG tracings

V. ED Interventions/Findings
   • Vital Signs
   • Interventions
   • Findings
   • 12 lead EKG
   • Imaging
   • Consults
   • Door to thrombolytic treatment and intervention time

VI. Cath Lab/ Neuro Interventional lab/ OR
   • Balloon time
   • Timing of neuro interventions or surgery performed
   • Imaging or diagrams of procedures

VI. Hospital Course
   • Length of Stay
   • Surgeries or Procedures Done
   • Cost

VII. Rehab (if appropriate)

VIII. Outcome
   • Discharge Status
   • Current Update on Pt Outcome