Central Region EMS and Trauma Care System Plan
July 1, 2019 – June 30, 2021

Submitted by
Central Region EMS and Trauma Care Council
March 1, 2019
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Introduction

The Central Region is located in King County, Washington. There are five (5) paramedic agencies, twenty-five (25) fire department based BLS agencies, four (4) private ambulance companies, eighteen (18) hospitals, and three (3) stand-alone emergency departments in Central Region. There is one (1) level I trauma center, four (4) level III trauma centers, three (3) level IV trauma centers and two (2) level V trauma centers. Categorized Cardiac and Stroke Centers are also distributed in the heavily populated areas along I-5, I-405, and I-90. Currently there are eleven (11) level 1 and four (4) level 2 cardiac centers; and four (4) level 1, six (6) level 2, and five (5) level 3 stroke centers in Central Region. The majority of the County’s 2.19 million residents live in urban and suburban communities located along the I-5 and I-405 corridors where emergency medical hospital services are located.

The Central Region EMS and Trauma Council is made up of members of the EMS and Trauma community in King County, including representatives from hospital emergency departments, public and private EMS agencies, rehabilitation facilities, Seattle-King County Public Health, and the Northwest Healthcare Response Network. The council has an Executive Board that is made up of seven (7) members elected by the council. The board is comprised of the following positions: chair, vice chair, secretary, treasurer, and three board members. All meetings are open public meetings, and members of the public are welcome and encouraged to attend. The council meets every other month, and the Executive Board meets monthly. Meetings are held in different formats, depending upon the needs of the region; some meetings are in person, others are held via conference call. The council also helps to coordinate quality assurance meetings, which are attended by representatives from trauma-designated hospitals and trauma-verified EMS agencies.

The Central Region has a mature and robust EMS system that began in 1969 when Leonard A. Cobb, M.D. and Chief Gordon Vickery, Seattle Fire Department, created Seattle’s paramedic program, Medic One. Beginning with the EMS and Trauma System Act of 1990, trauma system elements mandated by RCW 70.168 and WAC 246-976-960 were incorporated into the existing EMS system. Local fire district levies, the Medic One Foundation, and the King County Medic One/EMS levy support prehospital training, and quality improvement activities. This financial support and oversight allows the Central Region EMS and Trauma Care Council to focus on access to emergency department services and overall EMS system performance. The Central Region EMS and Trauma Care Council receives its funding from the state Department of Health. Central Region representatives participate in a number of ad hoc workgroups, local and state committees and organizations related to EMS and Trauma Care in the region. Within the council, workgroups are formed on an ad hoc basis to discuss specific EMS system and patient care issues and to develop strategies to address those issues. Project-specific ad hoc committees have been formed on an as-needed basis. Outside of the council, members actively participate in regional partnerships and on state Technical Advisory Committees (TAC).

The Central Region EMS and Trauma Care Council accomplished numerous goals in the 2017-2019 plan cycle. The strategic plan included some goals, objectives and strategies that are
required in each plan cycle, and others that were unique to the specific needs of Central Region. The region reviewed recommended minimum and maximum numbers of trauma-designated hospitals and trauma-verified EMS agencies. The region voted to keep the levels of trauma-designated hospitals the same, and to devote time and effort to census planning improvements. The region also voted to increase the minimum number of trauma-verified BLS agencies from 24 to 25, to allow an increase in trauma-verified interfacility transfers, and to allow the Port of Seattle’s BLS team to be trauma-verified. In the 2019 fiscal year, the region granted $21,486 to regional fire departments to provide training and equipment to their EMS teams, and an additional $21,486 to non-profit and public agencies for prevention work in the region. The training grants supported public and non-profit agencies in their purchase of training supplies and materials. The types of materials purchased with these grants were many and varied. Some examples of items purchased included new CPR manikins, including specialty manikins to assist with pregnant women and infants, updated electronics for training facilities, and materials to train the public in hemorrhage cessation. During the review process, the council was able to fully fund grant applications from rural and underserved areas, allowing for greater support of those departments who needed it. Likewise, prevention grants funded a number of projects in the region, and were chosen based upon their relevance to the top causes of injury in King County—falls, drug addiction and mental health diagnoses, and gun violence. In the 2019 fiscal year, funding went to projects providing falls prevention education for senior citizens, and school districts’ and fire departments’ Stop the Bleed programs. Central Region has a robust Psychiatric Patient Task Force, which has been very active in the goal of mitigating the impact of increasing census of psychiatric patients in emergency departments. The Psychiatric Patient Task Force is working on a number of projects in pursuit of this goal, including coordinating a data collection project for the region for better measurement of the impact on the EMS and trauma system. Finally, the region coordinated the production of an educational film about the trauma system that has been used in two movie theater-based educational campaigns, resulting in over 350,000 impressions.

Because of the uniquely robust EMS system that exists in Central Region, the region contains few underserved geographical areas. The council has reviewed response and transport times and found, consistently, that the number and level of trauma-verified prehospital and hospital agencies matches the demand within the county. That said, there are unique challenges in Central Region, due to its ever-growing population and its population diversity. EMS and Trauma Care Council is dedicated to addressing barriers to service, potential gaps in service and opportunities for improvement within the region. The region consistently balances the applications against where the highest need is in awarding grants. In the 2019-2021 plan cycle, the council has identified the following opportunities for improvement and project work: management of high patient census in emergency departments, coordination of EMS data collection systems, and ongoing efforts to improve the care for psychiatric patients in the region. As part of a state-wide initiative to coordinate EMS and Trauma regions’ work with emergency planning efforts, Central Region will continue to work with the Northwest Healthcare Response Network to coordinate EMS resources in emergency planning activities in the region. The council has also identified an opportunity to work more closely with the county’s Office of Emergency Management so that the region and the county can operate
with the highest levels of efficiency in the event of an emergency.

This 2019-2021 Central Region Strategic EMS & Trauma Care System Plan is made up of goals adapted from the State Strategic EMS & Trauma Care System Plan. The objectives and strategies are developed by the Regional Council and its stakeholders to meet needs of the region.

The Central Region EMS & Trauma Care Council has adopted the following mission and vision statements:

**Vision**
Central Region has an efficient, well-coordinated statewide EMS & Trauma System which reduces death, disability, human suffering and costs due to injury and medical emergencies.

**Mission**
The Central Region EMS and Trauma Care Council’s mission is to provide leadership and coordination of EMS community partners to reduce injury and to ensure provision of high-quality emergency medical and trauma care.

**GOAL 1 Maintain, assess and increase emergency care resources.**

**Need and Distribution of Services**

**Hospital Care:** There are four (4) level III trauma centers and three (3) level IV trauma centers in Central Region which are located in the heavily populated communities along the I-5 and I-405 corridors. There are two (2) level V trauma centers; one is located along highway 410 in the mostly rural city of Enumclaw, and the other is in the rural area of Snoqualmie, near the I-90 mountain pass. The State’s level one trauma center is located in Seattle and serves patients from Washington, Alaska, Montana and Idaho. Central Region will be reviewing trauma center performance measures for designation purposes during this plan cycle.

Categorized Cardiac and Stroke Centers are also distributed in the heavily populated areas along I-5, I-405, and I-90. Currently there are eleven level 1 and four level 2 cardiac centers; and four level 1, six level 2, and five level 3 stroke centers in Central Region.

Designated and categorized hospital services are listed by name and level of service in the regional PCPs and EMS guidelines. Annually, the Regional Council will compare the Patient Care Procedures (PCPs) with the current list of designated/categorized hospitals services on file with the Office of Community Health Systems to make sure the services listed in the PCPs are up to date. This process will ensure that prehospital agencies can transport their patient to the appropriate level of care.
Prehospital Care:

King County uses a tiered prehospital response system to ensure 9-1-1 calls receive medical care by the most appropriate care provider. Calls to 9-1-1 are received and triaged by professional dispatchers at five dispatch centers located throughout King County. The dispatchers are trained to identify the most appropriate level of care needed. Dispatchers provide pre-arrival instructions for most medical emergencies, and guide the caller through life-saving steps, including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) instructions, until the Medic One/EMS provider arrives. Basic Life Support (BLS) personnel are dispatched first to an incident, providing rapid basic life support that includes advanced first aid and CPR/AED to stabilize the patient. Staffed by fire department Emergency Medical Technicians (EMTs), BLS units arrive at the scene in less than five minutes on average. There are more than 3100 EMTs employed by 34 public EMS agencies and 700 private ambulance EMTs providing EMS care in King County.

Advanced Life Support (ALS/paramedic) personnel provide emergency medical care for critical or life-threatening injuries and illness. ALS units are dispatched simultaneous with BLS for life-threatening medical emergencies.

RCW 70.168.100 authorizes EMS Regions to 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. The Regional Council also uses standardized methods provided by the Office of Community Health Systems and King County EMS Division prehospital data to determine the need and distribution of trauma verified prehospital services in King County. Need and distribution of prehospital services are reviewed during each Plan cycle.

<table>
<thead>
<tr>
<th>Objective 1: By November 2020 the Regional Council will use methods developed by the Washington State Department of Health Office of Community Health Services and other data to determine the recommended minimum and maximum numbers and levels of trauma designated services (including pediatric and rehabilitation services) and provide recommendations to the Washington State Department of Health, Office of Community Health Systems and the EMS &amp; Trauma Steering Committee.</th>
<th>Strategy 1: By July 2020 the Regional Council will review Central Region trauma data including population demographics to determine the recommended min/max number and levels of trauma designated facilities in Central Region (King County).</th>
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<tr>
<td>Strategy 2: By September 2020 the Regional Council will vote on the recommended number and levels of trauma designated services in Central Region (King County).</td>
<td>Strategy 3: By September 2020, the Regional Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding the number and levels of trauma designated services in Central Region (King County).</td>
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<td>Strategy 4: By November 2020, the Regional Council will submit designated services min/max number and level recommendations to the EMS &amp; Trauma Steering Committee as needed.</td>
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**Objective 2:** By May 2021 the Regional Council will use Washington State Department of Health, Office of Community Health Systems standardized methodology and King County EMS system data to determine the minimum and maximum numbers and levels of verified prehospital service in King County and provide recommendations to the Washington State Department of Health Office of Community Health Systems and the EMS & Trauma Steering Committee.

**Strategy 1** By November 2020, the Regional Council and EMS Stakeholders will review EMS data including response and transport times, service demands, and population to determine the minimum and maximum levels of verified prehospital services in Central Region (King County).

**Strategy 2:** By January 2020 the Regional Council will vote on the recommended minimum and maximum numbers of verified ALS and BLS aid and ambulance services in Central Region (King County). The Regional Council will review the current AID-ALS minimum level of one and either change the minimum to zero or strategize how to assess the minimum services not being met.

**Strategy 3:** By March 2021, the Regional Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding the minimum and maximum numbers of verified ALS and BLS aid and ambulance services in Central Region (King County).

**Strategy 4:** By May 2021, the Regional Council will submit verified services min/max and level recommendations to the EMS & Trauma Steering Committee as needed to be attached to the 2021-2023 Central Region EMS Council Plan.

**Objective 3:** By December 2019 annually, the Regional Council will review the categorization levels for cardiac and stroke facilities to ensure consistency with Patient Care Procedures.

**Strategy 1:** By September 2019 annually, the Regional Council will review the list of currently categorized cardiac & stroke care centers and update the Patient Care Procedures (PCPs) so that they accurately reflect current appropriate cardiac & stroke patient destinations.

**Strategy 2:** By November 2019 annually, the Regional Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding revisions to the Region’s PCPs so that they accurately reflect current appropriate cardiac and stroke patient destinations.

**Strategy 3:** By December 2019, annually, the Regional Council will submit revisions to the Region’s PCPs to the EMS & Trauma Steering Committee as needed so that they accurately reflect current appropriate cardiac & stroke patient destinations.
Objective 4: By December 2019 annually the Regional Council will provide an updated list of all prehospital agencies in the King County per DOH requirements.

Strategy 1: By November 2019 annually, Regional Council staff will review the prehospital agency report provided by DOH.

Strategy 2: By November 2019 annually, Regional Council staff will send each King County prehospital agency a copy of the prehospital agency report provided by DOH and request each agency to update their report and return their updated information to the Regional Council.

Strategy 3: By December 2019 annually, Regional Council staff will submit the updated prehospital agency report to DOH.

GOAL 2
Support emergency preparedness activities.

Based upon past experience, the Central Region EMS and Trauma Care Council has determined that an opportunity exists for the region to collaborate and coordinate with emergency preparedness groups in the area, to facilitate the smooth functioning of the EMS and Trauma System in the event of an emergency. The region already works with the local healthcare coalition, the Northwest Healthcare Response Network (NWHRN), to share information at regional council meetings, and will continue to expand the collaborative work in the 2019-2021 planning period.

Objective 1: Coordinate with and participate in emergency preparedness and response to all hazardous incidents, patient transport, and planning initiatives to the extent possible of existing resources.

Strategy 1: At each regional council meeting, representatives from NWHRN will have the opportunity to present information to the region about emergency preparedness work that is happening in the region.

Strategy 2: By September 2019, Regional Council staff will work to fill a council seat with a representative from King County’s Office of Emergency Management.

Strategy 3: Throughout the plan cycle, Regional Council staff will seek out opportunities for council members to actively participate in emergency preparedness activities in the region.

GOAL 3
Plan, implement, monitor and report outcomes of programs to reduce the incidence and impact of injuries, violence, and illness in the region.
The Central Region EMS Council uses DOH and King County EMS injury data to identify prevention needs and to develop activities to address those needs. During this Plan cycle, the Central Region EMS and Trauma Care Council will focus prevention activities on injury causes that are most prevalent in the region. In the 2017-2019 planning period, the top causes of injury included falls and suicide. In FY 2019, the council voted to provide $21,486 in prevention mini-grants, which funded projects that addressed major causes of injury and death in the region. In past years, the council has supported projects targeted at reduction in patient falls, suicide prevention, and hemorrhage control in the event of a mass casualty incident, among others.

The Central Region collaborates with other EMS partners to develop and promote public health and public education messages for publication on the Regional Council website and through various media outlets. The council will continue to research and plan public education projects, in part through the continued distribution of the short educational film produced by the council in 2016.

### Objective 1: By March 2021, the Regional Council will identify prevention needs and support evidence based and/or promising practices as resources are available.

| Strategy 1 | by November 2020, the Regional Council will review injury/illness data and identify injury and illness prevention needs in King County. |
| Strategy 2 | By January 2021, the Regional Council will develop activities to address one or more of the injury and/or illness prevention needs which were identified at the November 2020 Regional Council meeting. |
| Strategy 3 | By January 2021, the Regional Council will review outcomes data from council-supported prevention programs. |
| Strategy 4 | By March 2021, the Regional Council will add the identified injury prevention activities to the 2021-2023 Regional Plan. |

### Objective 2: By May 2020 annually, the Regional Council will collaborate with EMS stakeholders to educate the public and our partners on the Emergency Care System.

| Strategy 1 | By September 2019, and throughout the plan cycle, the Regional Council and other EMS stakeholders will identify public education topics or issues to address. |
| Strategy 2 | By May 2020, and throughout the plan cycle, the Regional EMS Council and/or EMS partners will develop and release a pre-packaged public information message. |

### GOAL 4
Assess weaknesses and strengths of quality improvement programs in the region.
The Central Region EMS and Trauma Care Council has an active Quality Improvement (QI) group that meets three times per year. The QI group reviews case studies and specific incidents for education and improvement of emergency medical care in the region. During the 2019 fiscal year, EMS providers in the county identified a need for EMS agencies to develop a comprehensive data-sharing program. As such, the Central Region EMS and Trauma Care Council will coordinate with the Washington State Department of Health and Seattle-King County Public Health to expand knowledge of and access to comprehensive data sharing amongst public and private EMS agencies in the region, with the end goal of improving data gathering for quality assurance.

**Objective 1:** By July 2019, and throughout the plan cycle, the Regional Council will coordinate with the DOH and Seattle-King County Public Health to expand knowledge of and access to comprehensive data sharing amongst public and private EMS agencies in the region, with the end goal of improving data gathering for quality assurance.

**Strategy 1:** In July 2019, The Regional Council will discuss strategies to expand knowledge and use of comprehensive data sharing programs among EMS agencies in King County.

**Strategy 2:** By September 2019, The Regional Council will develop action plans to expand knowledge and use of comprehensive data sharing programs among EMS agencies in King County.

**Strategy 3:** By December 2019, the Regional Council will implement action plans to expand knowledge and use of comprehensive data sharing programs among EMS agencies in King County.

**Strategy 4:** By January 2020 and throughout the plan cycle the Regional Council will evaluate the impact of the action plans previously developed.

**GOAL 5**

Promote regional system sustainability.

RCW 70.168 and WAC 246-976 identify the membership, and responsibilities of the regional and local EMS & trauma care councils. The Central Region EMS and Trauma Care Council membership includes local government, prehospital agencies, hospitals, the Medical Program Director, medical directors, rehabilitation facilities, and consumers. The Central Regional EMS and Trauma Care Council provides a forum for open discussion of EMS system and patient care issues and for sharing of information among EMS system partners. Workgroups are formed on an ad hoc basis to discuss specific EMS system and patient care issues and to develop strategies to address those issues.

Representatives from the Central Region participate on local and state planning committees, task forces, and workgroups so that EMS system issues, guidelines, plans, and information can be shared among local and state EMS partners.
In Central Region emergency medical technicians receive more than 140 hours of basic training and hospital experience with additional training in defibrillation. All paramedics in King County are graduates of the University of Washington Paramedic Training Program regardless of previous training. Paramedic candidates receive 2,500 hours of rigorous training, including classroom instruction, clinical rotations at Seattle Children’s, University of Washington Medical Center and Harborview Medical Center, as well as extensive field training supervised by experienced senior paramedics. Dispatch, BLS and some ALS continuing education is provided by the King County EMS Online program which is funded through the King County Medic One/EMS levy. Paramedics receive 30 hours of continuing medical education classes each year along with surgical airway management laboratories and advanced cardiac life support and pediatric advanced life support classes. Funding for paramedic continuing education is funded through the Medic One Foundation and through the Medic One/EMS Levy. During each Plan cycle, the Central Region EMS Council surveys prehospital agencies to determine education and training needs not met through EMS online and other trainings that are funded through the EMS levy. In FY 2019, the Regional Council appropriated $21,486 to fund training needs requested through the 2019 training needs survey. Throughout the July 1, 2019-June 30, 2021 plan cycle, the Central Region EMS Council will appropriate funding for additional training based on need and financial resources.

Regional Patient Care Procedures (PCPs) have been developed to provide specific directions for how the trauma system functions within the Central Region. PCPs are developed by the King County Medical Program Director in collaboration with local medical directors and the Central Region Council to ensure consistency with the Regional Patient Care Procedures.

Local fire district levies, the Medic One Foundation, and the King County Medic One/EMS levy support prehospital training, and quality improvement activities. This financial support and oversight allows the Central Region EMS and Trauma Care Council to focus on access to emergency department services and overall EMS system performance. During this Plan cycle:

- The Central Region EMS & Trauma Care Council will continue to monitor hospital compliance with the Central Region No Diversion Policy and the regional WaTrac reporting policy.
- The Psychiatric Patient Care Task Force will continue to monitor psychiatric patient care access and work toward finding a long term solution to providing adequate psychiatric patient care in King County.
- The council will develop action plans to address increasing patient census in hospital emergency departments.

### Objective 1
By July 2019 and throughout the plan cycle, Central Region hospitals will continue to support a no diversion policy.

### Strategy 1
By July 2019 and throughout the Plan cycle, Regional Council staff will monitor hospital diversion as reported by WaTrac and provide bi-monthly reports to hospitals.

### Strategy 2
By July 2019 and throughout the Plan cycle, Regional Council staff will monitor hospital ED
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<th><strong>Objective 2:</strong> By July 2019 and throughout the plan cycle, the Regional Council will monitor psychiatric patient access to appropriate care in Central Region.</th>
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<td><strong>Strategy 1:</strong> By July 2019 and throughout the plan cycle, Regional Council staff will schedule quarterly Psychiatric Patient Task Force (PPTF) meetings.</td>
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<td><strong>Strategy 2:</strong> By July 2019, and throughout the Plan cycle, the PPTF will discuss issues which affect psychiatric patient care in the region.</td>
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<td><strong>Strategy 3:</strong> By July 2019 and throughout the Plan cycle, the PPTF will discuss best practices for addressing psychiatric patient care issues that have been identified.</td>
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<td><strong>Strategy 4:</strong> By July 2019 and throughout the Plan cycle the PPTF will develop action plans to address psychiatric patient care issues which have been identified.</td>
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<td><strong>Strategy 5:</strong> By July 2019 and throughout the Plan cycle the Regional Council will evaluate the impact of the action plans on psychiatric patient care in the region.</td>
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<th><strong>Objective 3:</strong> By September 2019, and throughout the plan cycle, the Regional Council will develop action plans to address increasing patient census in hospital emergency departments.</th>
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<tr>
<td><strong>Strategy 1:</strong> By September 2019, The Regional Council will discuss strategies to improve high patient census in King County.</td>
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<td><strong>Strategy 2:</strong> By November 2019, The Regional Council will develop action plans, if applicable, to improve the effects of high patient census in King County.</td>
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<tr>
<td><strong>Strategy 3:</strong> By January 2020, the Regional Council will implement action plans, if applicable, to improve the effects of high patient census in King County.</td>
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<td><strong>Strategy 4:</strong> Throughout the remainder of the plan cycle, the council will evaluate the impact of the action plans previously developed.</td>
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<th><strong>Objective 4:</strong> During the Plan cycle the Regional Council will facilitate the exchange of information throughout the emergency care system.</th>
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<td><strong>Strategy 1:</strong> By July 2019 and throughout the Plan cycle, the Regional Council will provide meeting rooms for the Regional Council and workgroups.</td>
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<td><strong>Strategy 2:</strong> By July 2019 and throughout the Plan cycle, Regional Council members will participate in EMS stakeholder meetings including: King County EMS Advisory Council, Medical Directors Committee, Northwest Healthcare Response Network, EMS &amp; Trauma Steering Committee, and associated Technical</td>
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<td>Objective 5: During the Plan cycle, the Regional Council will work with the Washington State Department of Health Office of Community Health Systems and the State Auditor’s Office to ensure the Regional Council business structure and practices remain compliant with RCW.</td>
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<td><strong>Strategy 1:</strong> By August 2019 annually, the Regional Council will develop an annual budget and submit the annual budget to the Washington State Department of Health Office of Community Health Systems.</td>
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<td><strong>Strategy 2:</strong> By October 2019 annually, the Regional Council will submit the previous year’s financial information and related schedules to the Washington State Auditor’s Office.</td>
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<td><strong>Strategy 3:</strong> By January 2020 annually, the Regional Council will review semi-annual budget vs. actual revenues &amp; expenditures and submit a report to the Washington State Department of Health Office of Community Health Systems.</td>
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<td><strong>Strategy 4:</strong> By June 2020 annually, the Regional Council will review the end of year annual budget vs. actual revenues &amp; expenditures and submit a report to the Washington State Department of Health Office of Community Health Systems.</td>
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<td><strong>Strategy 5:</strong> By July 2020 annually, the Regional Council Board will review the Regional Council financial policies and Board/Staff roles and responsibilities.</td>
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<th>Objective 6: At Regional Council meetings, the Regional Council will identify patient care issues and develop strategies to address the patient care issues.</th>
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<td><strong>Strategy 1:</strong> By July 2019 and throughout the Plan cycle, the Regional Council will discuss issues which affect patient care in the region.</td>
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<td><strong>Strategy 2:</strong> By July 2019 and throughout the Plan cycle, the Regional Council will discuss best practices for addressing patient care issues that have been identified.</td>
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<tr>
<td><strong>Strategy 3:</strong> By July 2019 and throughout the Plan cycle the Regional Council will develop action plans to address patient care issues which have been identified.</td>
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<td>Objective 7: By May 2021, the Regional Council will develop a FY 2021-2023 strategic plan.</td>
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<tr>
<th>Objective 8: By October 2019 annually, the Regional Council will allocate available funding to support prehospital training needs.</th>
<th><strong>Strategy 1:</strong> By May 2019 annually, the Regional Council will develop a budget for prehospital training support.</th>
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<td><strong>Strategy 2:</strong> By July 2019 annually, the Regional Council will survey EMS agencies in King County to determine training needs.</td>
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<td><strong>Strategy 3:</strong> By September 2019 annually, the Regional Council will review the survey results and prioritize training needs.</td>
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<td><strong>Strategy 4:</strong> By October 2019 annually, the Regional Council will allocate available funding for prioritized training needs.</td>
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<th>Objective 9: By May 2020 annually, the Regional Council will provide any new or revised Patient Care Procedures to the Washington State Department of Health Office of Community Health Systems and the EMS &amp; Trauma Steering Committee for review and approval.</th>
<th><strong>Strategy 1:</strong> By January 2020 annually, the Regional Council, MPD and other EMS stakeholders will review Central Region Patient Care Procedures and make revisions as necessary.</th>
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<td><strong>Strategy 2:</strong> By March 2020 annually, the Regional Council will submit any revised Patient Care Procedures to the Washington State Department of Health Office of Community Health Systems for review and approval.</td>
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<td><strong>Strategy 3:</strong> By May 2020 annually, the Regional Council will submit any revised Patient Care Procedures to the EMS &amp; Trauma Steering Committee as needed.</td>
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| Objective 10: By September 2019, annually, the Regional Council will review the Key Performance Indicators | **Strategy 1:** By July 2019, annually, Regional Council staff will coordinate with the MPD to review Key Performance Indicators and assess prehospital performance as necessary. |
developed by the Prehospital TAC and assess prehospital performance as necessary.

**Strategy 2:** By September 2019, annually, any recommendations for performance improvements will be communicated to the appropriate prehospital agencies.

**Strategy 3:** By September 2019, annually, any recommendations for performance improvements that affect all prehospital members of the Regional Council will be communicated and addressed at a Regional Council meeting.

### Appendices:

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

<table>
<thead>
<tr>
<th>Level</th>
<th>State Approved</th>
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<tbody>
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<td></td>
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**Appendix 2: Current Stroke and Cardiac Categorized Facilities in Central Region**

<table>
<thead>
<tr>
<th>Level</th>
<th>Number of Facilities</th>
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<tbody>
<tr>
<td>Cardiac: Level I</td>
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<td>Cardiac: Level 2</td>
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<tr>
<td>Stroke: Level 1</td>
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</tr>
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<td>Stroke: Level 2</td>
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<tr>
<td>Stroke: Level 3</td>
<td>5</td>
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</tbody>
</table>

*Numbers are current as of date submitted. For real-time numbers, please see: [Cardiac and…](#)
### Stroke Categorized Facilities

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

<table>
<thead>
<tr>
<th>Level</th>
<th>State Approved</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>I</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>II</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>III</td>
<td>0</td>
<td>1</td>
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</table>

**Appendices 4 and 5: Approved Min/Max numbers of Verified Trauma Services by Level and Type by County**

<table>
<thead>
<tr>
<th>County (Name)</th>
<th>Verified Service Type</th>
<th>State Approved - Minimum number</th>
<th>State Approved - Maximum number</th>
<th>Current Status (# Verified for each Service Type)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aid – BLS</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Aid – ILS</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Aid – ALS</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Amb – BLS</td>
<td>1</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Amb – ILS</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Amb - ALS</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

*Numbers current as of date submitted. For real-time numbers, please see: [Trauma Designated Services List](#)*
## Appendix 6: Trauma Response Areas by County

<table>
<thead>
<tr>
<th>County (name)</th>
<th>Trauma Response Area Number</th>
<th>Description of Trauma Response Area’s Geographic Boundaries</th>
<th>Type and # of Verified Services in each Response Areas <em>use key</em></th>
</tr>
</thead>
</table>
| King          | Primary Zone 1             | From NW border of Seattle; north to Snohomish County border; east along Snohomish County border to NE corner of FD 45; south along the eastern borders of FD 45 and Eastside Fire & Rescue and FD 27 FD 27 and continuing along the eastern border of Eastside Fire & Rescue, FD 27 borders to the NE border of Maple Valley Fire & Life Safety; west to NW border of Renton FD, north along east side of Lake Washington, including Mercer Island to the Northeast border of Seattle and west to NW border of Seattle.                                                                                                                                       | A-1  
D-10  
F-3                                                                   |
| King          | NE Zone 1                  | Boundaries of FD 50                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | D-1                                                                   |
| King          | E Zone 1                   | Boundaries of FD 51                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | D-1                                                                   |
| King          | Zone 3                    | South border of Seattle and south end of Lake Washington along north border of Renton and Maple Valley, east: along Kittitas County Border; south along Pierce County border; west along Puget Sound including Vashon Island.                                                                                                                                                                                                                                                                                                                                                                                | A-3  
D-11  
F-2                                                                   |
| King          | Zone 5                    | City of Seattle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | A-1  
D-1  
F-1                                                                   |
| King          | Zone SW                   | North from SE border of Zone 3 along eastern borders of Zone 3 and Primary Zone 1 to the intersection of Primary Zone 1 and I-90; east along I-90 to intersection of 1-90 and E Zone 1; around the southern border of E Zone 1 to Kittitas County border; south along Kittitas County border to Pierce County border; west along Pierce County border to SE corner of Zone 3.                                                                                                                                                                                                                                                                           | No designated service                                              |
King Zone NW | From intersection of I-90 and Primary Zone 1; North along the eastern border of Primary Zone 1 to Snohomish County Border; east along Snohomish County border to NW border of NE Zone 1; south along western border of NE Zone 1 to SW corner of NE Zone 1; east along southern border of NE Zone 1 to Kittitas County border; south along Kittitas County border to intersection of E Zone 1 and Kittitas border; west and south around E Zone 1 to intersection of I-90 and E Zone 1, along I-90 to intersection of I-90 and Primary Zone 1. | No designated service

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

Central Region Trauma Response Area Map:

Appendix 7: Link to Approved EMS Training Programs

BLS Training, King County EMS: https://www.kingcounty.gov/depts/health/emergency-medical-services/training.aspx

Paramedic Training:
https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EMSPrivateEducation/ParamedicPrograms

Appendix 9: Regional Council Member Composition

**Prehospital:**
- Airlift Northwest, American Medical Response, Bellevue Fire Department Medic One, Falack Northwest, King County Medic One, King County Medical Director, Seattle Fire Department Medic One, Redmond Medic One, Tri-Med Ambulance, Northwest Ambulance

**Hospital:**
- Auburn Regional Medical Center, Children’s Hospital, Evergreen Health, Kaiser Permanente, Harborview Medical Center, Highline Medical Center, Overlake Medical Center, Snoqualmie Valley Hospital, St. Elizabeth Medical Center, St. Francis Medical Center, Swedish-Ballard, Swedish-Cherry Hill, Swedish-First Hill, Swedish-Issaquah, University of Washington Medical Center, Northwest Hospital, Valley Medical Center, Virginia Mason Medical Center

**Other Representatives:**
- Rehabilitation, local elected official, consumer, Seattle-King County Public Health, Emergency Nurses’ Association, Northwest Healthcare Response Network.
Appendix 8:
CENTRAL REGION PATIENT CARE PROCEDURES

Submitted : 3-2019
Central Region Emergency Medical Services and Trauma Care Council
INTRODUCTION

WAC 246-976-960, Regional Emergency Medical Services and Trauma Care Systems, established the requirement for regions to adopt patient care procedures and specifically identified elements that must be included. The Central Region has developed and adopted patient care procedures consistent with this requirement.

WAC 246-976-960 also requires regions to adopt county operating procedures specific to county needs. Because the Central Region is made up of one county, the patient care procedures serve as county operating procedures as well. From this point on, only the term “patient care procedures” will be used.

Patient care procedures (PCPs) in Washington State are numbered per a guideline issued by the state Department of Health. Not all regions adopt all procedures. As such, Central Region’s patient care procedures are not numbered in sequential order, and some PCP numbers are not present, as they have not been utilized in the region.
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</tr>
<tr>
<td>PCP 5.3</td>
<td>Paramedic Training and Changes in Service Levels</td>
</tr>
</tbody>
</table>
PCP 1: PREHOSPITAL RESPONSE TO AN EMERGENCY SCENE

Dispatch

Dispatch centers are accessed through the enhanced 911 system. Regional dispatch centers dispatch EMS units in accordance with King County Criteria Based Dispatch Guidelines. Seattle dispatchers use Seattle Fire Department Dispatch Guidelines. Dispatchers provide bystander emergency medical instructions while EMS units are in route to the scene.

The Central Region EMS Trauma Committee requires that emergency dispatching protocols be based on medical criteria. All EMS dispatching guidelines and protocols must be approved by the Program Medical Director of King County EMS in consultation with the Medical Program Directors of the paramedic programs within the County.

Basic Life Support

Basic Life Support response is provided by city and county fire department units staffed by EMTs or private ambulance services staffed by EMTs. The nearest unit to an emergency scene will be dispatched following established dispatch guidelines.

BLS Code Red Response and Transport

Note: Primary responding EMS personnel refers to fire department EMT personnel or paramedics response originating as part of the 911 EMS system. Emergency response refers to travel with light and sirens. The following procedures are intended to maximize patient safety and minimize risk to life and limb. Common sense and good judgment must be used at all times.

1) The response mode from primary BLS response (fire department EMT personnel) shall be based on information made available to the EMS dispatchers and the decision for mode of travel made according to dispatch guidelines.

2) The default mode for travel to the scene for non-primary BLS responders shall be by non-emergency response unless a specific response for code-red (emergency response) is made by primary responding EMS personnel at the scene or specific protocols or contracts defining response modes exist between fire departments or private agencies and private ambulance companies.
3) The default mode for BLS transport from scene to hospital shall be by non-emergency response unless a specific response for code-red transport is made by primary responding EMS personnel at the scene.

4) If a patient undergoing BLS transport to hospital deteriorates, the BLS personnel should contact the EMS dispatcher and ask for paramedic assistance, unless documentary evidence exists to travel code-red to hospital (such as travel to hospital can occur faster than waiting for paramedic assistance).

**Advanced Life Support**

The paramedic unit nearest the emergency scene is simultaneously dispatched consistent with dispatch guidelines. Paramedic units provide advanced life support transport.

**Wilderness**

Wilderness response is directed by the King County Sheriff Search and Rescue Coordinator. EMS units may be dispatched to a staging area depending on the nature and location of the incident. Transportation of trauma patients from wilderness areas is primarily accomplished by helicopter. The Level I trauma center should be the primary destination of these patients.
PCP 5: TRIAGE OF TRAUMA PATIENTS

These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which trauma center will receive the patient.

1. For patients meeting the inclusion criteria of the State of Washington Prehospital Trauma Triage (Destination) Procedure, prehospital providers will contact online medical control of the closest trauma center or Harborview Medical Center (Reference: Designated Trauma Centers in King County/Paramedic Response Area). Medical Control or Harborview Medical Center will determine patient destination consistent with the State of Washington Prehospital Trauma Triage (Destination) Procedure.

2. The primary destination of pediatric patients meeting the inclusion criteria of the State of Washington Prehospital Trauma Triage (Destination) Procedure is the Level I trauma center.

3. Unstable trauma patients should be managed consistent with the State of Washington Prehospital Trauma Triage (Destination) Procedure. Unstable trauma patients are those needing a patent airway or who may benefit from the initiation of fluid resuscitation. EMS providers who are unable to secure an airway or establish an intravenous line should consider these factors in the following order:
   a. time to arrival of responding medic unit
   b. time to rendezvous with responding medic unit
   c. time to nearest trauma center
   d. time to arrival of Airlift
   e. time to nearest hospital with 24 hr emergency room
   f. unusual events such as earthquakes and other natural disasters

4. Patient destination decisions will be monitored by the Regional Quality Assurance Committee.

The goal in treating the unstable trauma patient is to provide potential life saving intervention and transportation to the highest-level trauma center able to provide definitive treatment. Ideally these interventions will be performed in a manner that does not unduly delay transport of a patient to the appropriate level of trauma center. This may require EMS providers to stop at a local hospital to stabilize and then transfer the patient to the trauma center.

Consistent with inter-facility transfer agreements, trauma patients stabilized at non-designated hospitals should be transferred to a trauma center as soon as possible. Patients stabilized at Level III or IV trauma centers and meeting the criteria for triage to the Level I trauma center should be transferred as necessary. The State’s Level I trauma center is:

Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104
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.
WASHINGTON STATE TRAUMA TRIAGE DESTINATION PROCEDURES

STEP 1
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)

No

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

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

YES

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

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
  - Intrusion, 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

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

YES

STEP 3
Assess Special Patient or System Considerations
- Older Adults
  - Risk of injury or death after age 55 years
  - Systolic BP < 110 may represent shock after age 65
  - Low impact mechanisms (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

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

YES

NO

Transport according to local protocol & Regional PCP

When in Doubt, Transport to a Trauma Center!
PCP 5.1: TRAUMA CARE FACILITIES

Central Region Trauma Care Facilities are as follows:

Level I Trauma Center (Pediatric and Adult)
Harborview Medical Center

Level III Trauma Centers
Multicare Auburn Medical Center
Evergreen Health Medical Center
Overlake Hospital Medical Center
Valley Medical Center

Level IV Trauma Centers
Highline Community Hospital
Northwest Hospital
St. Francis Hospital

Level V Trauma Center
St. Elizabeth Hospital
Snoqualmie Valley Hospital
PCP 5.5: QUALITY IMPROVEMENT:

The Central Region Prehospital Committee at the next regularly scheduled meeting will review this PCP upon receipt of suggested modifications from a local provider, the Central Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document.
PCP 9: INTERFACILITY TRANSFERS

Private ALS and BLS agencies provide interfacility patient transfers at the direction of the hospital initiating the transfer. All interfacility patient transfers shall be consistent with the transfer procedures in WAC 246-976-890.

Level III, Level IV, and Level V trauma centers will transfer patients to the State Level I trauma center when appropriate. The State’s Level I trauma center is:

Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104
**PCP 10.1: MULTIPLE CASUALTY INCIDENTS (TYPES AND EXPECTED VOLUME OF TRAUMA)**

The Central Region has adequate resources to meet normal trauma patient volumes. The Quality Assurance Committee monitors mechanism of injury and patient volumes.

Large Multiple Casualty Incidents may require the triage of patients to non-designated King County hospitals or to trauma centers in adjacent counties.
I. STANDARD: During a mass casualty incident (MCI) with severely burned adult and pediatric patients,
   1. All verified ambulance and verified aid services shall respond to an MCI per the King County Fire Chief’s MCI Plan
   2. All licensed ambulance and licensed aid services shall assist during an MCI per King County Fire Chief’s MCI Plan when activated by incident command through dispatch in support of the King County Fire Chief’s MCI Plan and/or in support of verified EMS services
   3. All EMS certified personnel shall assist during an MCI per King County Fire Chief’s MCI Plans when requested by incident command through dispatch in support of the King County Fire Chief’s MCI Plan and/or in support of verified EMS services
   4. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
   5. All EMS agencies working during an MCI event shall operate within the Incident Command System as identified in local protocol and MCI plan.

II. PURPOSE:
   1. To develop and communicate the information of regional trauma plan section VII prior to an MCI.
   2. To implement King County Fire Chief’s MCI Plan during an MCI.
   3. To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region.
   4. To provide safe mass transportation with pre-identified medical staff, equipment, and supplies per mass transport vehicle.

III. PROCEDURES:
   1. Incident Command shall follow the King County Fire Chief’s MCI Plan and will notify Disaster Medical Control Center (DMCC) when an MCI condition exists, including factors identifying severe burn injuries and number of adult/pediatric patients.
   2. Medical program directors agree that protocols being used by responding agencies shall continue to be used throughout transport of patients regardless of county, state or country.
   3. EMS personnel may use the “Prehospital Mass Casualty Incident (MCI) general Algorithm during the MCI incident.
      A. The “SAMPLE ONLY” algorithm is intended as a boilerplate or skeleton outline only. It is not intended as a state directed requirement.
      B. the DRAFT-SAMPLE Algorithm is attached below.
Prehospital Mass Causality Incident (MCI) General Algorithm

1. Receive dispatch
2. Respond as directed
3. Arrive at scene
4. Determine mass causality conditions exist
5. Establish Incident Command (IC)
6. Scene assessment and size-up

**CBRNE**

1) Notify the DMCC and IC of CBRNE situation
2) Standby for HazMat/LE to clear scene
3) Don PPE if needed
4) Establish hot, warm, and cold zones
5) Begin Initial Triage of Patients
6) Notify medical control and IC of patients conditions
7) Decontaminate patients as needed
8) Begin initial treatment
9) Follow PCPs and MCI Plans
10) Request additional resources that may include activating MAA
11) Initiate patient transport to medical centers as directed by medical control and/or the DMCC
12) Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)

**NON-CBRNE**

Notify medical control and/or the DMCC and local Emergency Management Office

1) Ensure scene is safe
2) Begin Initial Triage and Treatment of Critically Injured Patients
3) Establish a staging area
4) Follow EMS patient care procedures (PCPs) and MCI Plans
5) Request additional resources that may include activating MAA
6) Initiate patient transport to medical centers as directed by medical control and/or the DMCC
7) Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)

Prepare transport vehicle to return to service
PCP 5.1: ACTIVATION OF TRAUMA TEAM

Trauma team activation is accomplished at the time of contact with Medical Control. Online medical control at the receiving trauma center will activate the trauma team upon notification of the transporting agency or dispatcher. All designated trauma centers will activate their trauma team per WAC 246-976-870.
PCP 5.2: CARDIAC CARE

State of Washington
Prehospital Cardiac Triage Destination Procedure

Assess Applicability for Triage

- Post cardiac arrest with ROSC OR
- ≥ 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, light headedness.

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

Assess Immediate Criteria

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

If ALS has not been dispatched, upgrade if available.

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

<table>
<thead>
<tr>
<th>BLS/ILS</th>
<th>ALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I Cardiac Hospital win 30 minutes</td>
<td>Level I Cardiac Hospital win 60 minutes</td>
</tr>
</tbody>
</table>

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

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

* Slight modifications to the transport times may be made in county operating procedures. See page 2.

Consider ALS and air transport for all transports greater than 30 minutes.

If there are two or more Level I facilities to choose from within the transport timeframe, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in determining destination.

This also applies if there are two or more Level II facilities to choose from.

April 2011
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 (UANSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure?
A. Assess applicability for triage – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the "Assess Immediate Criteria" box. NOTE: Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.
B. Assess immediate criteria – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to "Assess Transport Time and Determine Destination" box. If the patient does not meet immediate criteria, or you can’t do an ECG, go to the "Assess High Risk Criteria" box.
C. Assess high risk criteria – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:

☐ 3 or more CAD (coronary artery disease) risk factors:
  • Age ≥ 55; epidemiological data for WA show that incidence of heart attack increases at this age
  • Family history: father or brother with heart disease before 55, or mother or sister before 65
  • High blood pressure: ≥140/90, or patient/ family report, or patient on blood pressure medication
  • High cholesterol: patient/family report or patient on cholesterol medication
  • Diabetes: patient/family report
  • Current smoker: patient/family report.

☐ Aspirin use in last 7 days. Any aspirin use in last 7 days.
☐ ≥2 anginal events in last 24 hours. 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
☐ Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery
☐ ST deviation ≥ 0.5 mm (if available); ST depression ≥ 0.5 mm is significant; transient ST elevation ≥ 0.5 mm for < 20 minutes is treated as ST-segment depression and is high risk; ST elevation >1 mm for more than 20 minutes places these patients in the STEMI treatment category.
☐ Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.
D. Determine destination – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For ALS, 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 I 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.
Cardiac Patient Triage and Destination

These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which Cardiac Center will receive the patient.

1. Prehospital providers will contact established medical control. Medical Control will determine patient destination consistent with Washington State Cardiac Patient Care Triage Destination Procedure.

2. Patients shall be managed consistent with the State of Washington Prehospital Cardiac Triage Destination Procedure.

3. Patient destination decisions and patient outcome will be monitored by the Regional Quality Assurance Committee

Current Approved Cardiac Care Centers

Level I
Multicare Auburn Regional Medical Center
Evergreen Hospital Medical Center
Harborview Medical Center
Highline Medical Center
Northwest Hospital Medical Center
Overlake Hospital Medical Center
St. Francis Hospital
Swedish Cherry Hill
University of Washington Medical Center
Valley Medical Center
Virginia Mason Medical Center
Swedish- Issaquah

Level II
Swedish First Hill
Snoqualmie Valley Medical Center
St. Elizabeth Hospital
Swedish Ballard
PCP 5.3: STROKE CARE

State of Washington
Prehospital Stroke Triage Destination Procedure

Assess Applicability for Triage

Report from patient or bystander of one or more sudden:
- 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

NO Transport per regional patient care procedures and county operating procedures where they exist

YES Perform F.A.S.T. Assessment

- Face: unilateral facial droop?
- Arms: unilateral drift or weakness?
- Speech: abnormal or slurred?
- Time last normal (determine time patient last known normal)
  Yes to any one sign (Face, Arms, Speech) = YES
  No to all three signs = NO

NO Transport per regional patient care procedures and county operating procedures where they exist

YES Determine Destination

- Transport the patient to the nearest Level I, II, or III Stroke Center.
- If the nearest center is a Level III, and there’s a Level I or II available with no more than 15 minutes increase in transport time, go to the nearest Level I or II Stroke Center.

See side box for additional destination considerations

Limit scene time and alert destination hospital ASAP

Additional Destination Considerations:

- Any additional transport time should not take the patient outside of the IV thrombolysis window of 3.5 hours from the last seen normal.
- For patients last seen normal plus transport time ≥ 3.5 hours to ≤ 6 hours, consider transport to a Level I Stroke Center or a Level II Stroke Center with intra-arterial interventional capability.
- 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, insurance, physician practice patterns, and local rotation agreements may be considered.
Prehospital Stroke Triage Destination Procedure

**Purpose**
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. Like trauma, stroke treatment is time-critical – the sooner patients are treated, the better their chances of survival and recovering function. For strokes caused by a blood clot in the brain (ischemic), clot-busting medication must be administered within 4.5 hours from the time they first have symptoms. For most bleeding strokes (hemorrhagic), time is also critical. Currently, there are no accurate tools to distinguish between an ischemic and hemorrhagic stroke in the field so there is no difference in prehospital triage.

This triage tool, along with protocol guidelines and other state policies, are the framework for the Washington State Emergency Cardiac and Stroke System. Regional patient care procedures (PCPs) and especially county operating procedures (COPs) define exactly how the system will work in each community based on its unique EMS resources and stroke centers. The formula for success will look slightly different in each community. Use this tool to develop PCPs and COPs that get the right patient to the right treatment in time, using local resources effectively and efficiently.

**Stroke Assessment – F.A.S.T.**
The F.A.S.T. assessment tool (also known as the Cincinnati Prehospital Stroke Scale + Time) is a simple but pretty accurate way to tell if someone might be having a stroke. It’s easy to remember: Facial droop, Arm drift, Speech, + Time. If face, arms, or speech is abnormal, it’s likely the patient is having a stroke. Immediately transport the patient to a stroke center. Regional patient care procedures and county operating procedures may provide additional guidance. Alert the hospital on the way. Transport should not be delayed for IV or EKG monitoring.

<table>
<thead>
<tr>
<th>TEST</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial droop:</td>
<td>Ask the patient to show his or her teeth or</td>
<td>Both sides of the face move equally.</td>
</tr>
<tr>
<td></td>
<td>smile.</td>
<td>One side of the face does not move as well</td>
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<tr>
<td></td>
<td></td>
<td>as the other.</td>
</tr>
<tr>
<td>Arm drift:</td>
<td>Ask the patient to close his or her eyes</td>
<td>Both arms move the same or both arms do not</td>
</tr>
<tr>
<td></td>
<td>and extend both arms straight out for 10</td>
<td>move at all.</td>
</tr>
<tr>
<td></td>
<td>seconds. The palms should be up, thumbs</td>
<td>One arm drifts down, or one arm does not</td>
</tr>
<tr>
<td></td>
<td>pointing out.</td>
<td>move at all.</td>
</tr>
<tr>
<td>Speech:</td>
<td>Ask the patient to repeat a simple phrase</td>
<td>The patient says it correctly, with no slurring</td>
</tr>
<tr>
<td></td>
<td>such as “Firefighters are my</td>
<td>The patient slurs, says the wrong words, or</td>
</tr>
<tr>
<td></td>
<td>friends.”</td>
<td>is unable to speak.</td>
</tr>
<tr>
<td>Time:</td>
<td>Ask the patient, family or bystanders the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>last time the patient was seen normal.</td>
<td></td>
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<tr>
<td></td>
<td>Encourage family to go to the hospital to</td>
<td></td>
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<tr>
<td></td>
<td>provide medical history, or obtain contact</td>
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<tr>
<td></td>
<td>information for a person who can provide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>medical history.</td>
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</tr>
</tbody>
</table>

**Stroke Warning Signs**
- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden, severe headache with no known cause

DOH 346-049 October 2012
Stroke Patient Triage and Destination

These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which Stroke Center will receive the patient.

EMTs shall transport patient to the closest appropriate level Stroke Center consistent with the Washington State Stroke Patient Care Triage Destination Procedure and with regard to the patient or family preference."

1. For all patients with suspected stroke, EMS personnel will contact the closest Level 1 or II or III stroke center and describe the situation. The hospital will advise EMS of appropriate patient destination consistent with the Washington State Patient Care Triage Destination Procedure.

2. For unstable stroke patients, EMTs shall request Paramedic assistance

3. Paramedics shall contact established medical control. Medical Control will determine patient destination consistent with Washington State Stroke Patient Care Triage Destination Procedure.

4. Patients should be managed consistent with the King County ALS Protocols and State of Washington Prehospital Stroke Triage Destination Procedure.

5. Patients should be managed consistent with the King County ALS Protocols and State of Washington Prehospital Stroke Triage Destination Procedure.

6. Patient destination decisions and patient outcome will be monitored by the Regional Quality Assurance Committee

Current Approved Stroke Centers

Level 1
- Harborview Medical Center
- Northwest Hospital Medical Center
- Swedish Cherry Hill
- Virginia Mason Medical Center

Level II
- Multicare Auburn Regional Medical Center
- Evergreen Hospital Medical Center
- Highline Medical Center
- Overlake Hospital Medical Center
- Swedish First Hill
- Valley Medical Center
Level III
Snoqualmie Valley Hospital
St. Elizabeth Hospital
St. Francis Hospital
Swedish – Ballard
University of Washington Medical Center
PCP 1: MEDICAL AND MINOR TRAUMA PATIENTS TRANSPORTATION GUIDELINES

I. Prehospital care providers respect the right of the patient to choose a hospital destination and will make reasonable efforts to assure that choice is observed. Alternately and under ADAPT guidelines, fire department-based BLS providers may transport or suggest transport of patients to non-hospital settings such as stand alone emergency rooms and clinics. Reference Appendix II – ADAPT Guidelines

Factors including patient's choices may be:

1. Personal Preference
2. Personal physician's affiliation
3. HMO or preferred provider

Modifying factors which may influence the prehospital provider’s response:

1. Patient unable to communicate choice
2. Unstable patient who would benefit from transportation to nearest hospital or to hospital providing specialized services.
3. Transport to patient’s choice of hospital would put medic unit or aid car out of service for extended period and alternative transport is not appropriate or available.

II. Prehospital providers should transport unstable patients, i.e. compromised airway, post arrest, shock from non-traumatic causes, etc. to the nearest hospital able to accept the patient.

II. Emergency patients requiring specialized care such as hyperbaric treatment, neonatal ICU, or high-risk OB care should be transported to the nearest hospital able to provide such care.

IV. When in doubt, prehospital care providers should contact online medical control.
Ambulance diversion is defined as an active statement by a hospital, whether verbal or via WaTrac ED Status, that patients arriving by ambulance will not be accepted. King County hospitals have unanimously adopted a No Diversion Policy for all medical and surgical patients effective May 31, 2011.

Hospitals may close their emergency departments only in an internal emergency such as facility damage or lockdown. There may be circumstances where an advisory to prehospital agencies will allow ambulance services to make transport destination decisions in the best interest of their patient; for example when a hospital reports “CT down” or “specialty care unavailable.” Prehospital service may use this information to make an appropriate transport decision. The decision on where to transport a patient will remain at the discretion of the prehospital provider unless directed to a specific facility by medical control.
PCP 5.3: ADAPT CLINIC AND URGENT CARE CLINIC TRANSPORTATION POLICY

Selected patients may be transported to a clinic, urgent care clinic, free standing emergency department, or hospital based emergency department via BLS transport if the patient meets the criteria listed below. These policies apply to non-primary (private) BLS ambulance when EMS personnel request private BLS ambulance to transport the patient.

1) The fire department based (primary) EMT provider considers a taxi to be an appropriate and safe method of transportation for the particular clinical problem.
2) Paramedic care is NOT required
3) Patient is ambulatory
4) Patient has a non-urgent condition (clinically stable) including
   a) Low index of suspicion for:
      a. Cardiac problem
      b. Stroke
      c. Abdominal aortic aneurysm
      d. GI bleed problems
   b) Low index of suspicion for major mechanism of injury
5) Patient must not have
   a) Need for a backboard
   b) Uncontrolled bleeding
   c) Uncontrolled pain
   d) Need for oxygen (except patient self-administered oxygen)
6) Patient should be masked if there are respiratory symptoms

For guidance regarding transport decisions EMTs may consult with paramedics or with emergency department personnel at the medical control hospital. The EMT must notify the destination facility of the clinical problem and the facility must agree to accept the patient.

ADAPT Taxi Voucher Transportation Policy

Selected patients may be transported to a clinic, urgent care clinic, free standing emergency department, or hospital based emergency department via taxi if the following conditions listed above are met and the fire department-based EMT considers a taxi to be an appropriate and safe method of transportation for the particular clinical problem.
PCP 5.3: PARAMEDIC TRAINING AND CHANGES IN SERVICE LEVELS

In order to maintain the highest quality care for prehospital emergencies it shall be required that:

1. The standard level response of ALS service shall be two paramedics. Exceptions may be authorized by the King County MPD for outlying districts and when split crews are required to respond to mass casualties.
2. King County paramedics shall be trained through and satisfy the educational requirements of the Paramedic Training program at the University of Washington/Harborview Medical Center.
3. Requests to expand or reduce service to a trauma response area, to change the level of EMS service provided, and new applications for EMS agencies seeking trauma verification must be reviewed and receive a recommendation by the Regional EMS Council in accordance with WAC 246-976-395(4).
Sources

- EMS Agency Resource Listing, Washington State Department of Health:
  \[20181107\text{EMS }-\text{Agency Resource Listing.xls}\]

- United States Census Bureau:
  [https://www.census.gov/quickfacts/kingcountywashington](https://www.census.gov/quickfacts/kingcountywashington)

- Washington State Emergency Cardiac and Stroke System Hospitals- King County:
  [https://www.doh.wa.gov/Portals/1/Documents/Pubs/689138.pdf](https://www.doh.wa.gov/Portals/1/Documents/Pubs/689138.pdf)