West Region Emergency Medical Services & Trauma Care System Strategic Plan

July 1, 2019 – June 30, 2021

Submitted By: West Region EMS & Trauma Care Council
Approved By: EMS & Trauma Steering Committee: May 15, 2019
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Plan Introduction

The purpose of the 2019-21 West Region Emergency Medical Services (EMS) and Trauma Care System Strategic 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 EMS & Trauma Care (WREMS) Council is empowered by legislative authority (RCW 70.168.100-70.168.130) and Washington Administrative Code (WAC 246.976.960) to plan, develop, and administer the EMS and trauma care system in the five counties that make up the Region. It is composed of appointed volunteer representatives and funded primarily by the Washington State Department of Health (WA DOH).

The West Region is one of eight EMS and trauma care regions in Washington State. Each region is responsible for developing an in-depth strategic plan every two years with input from their respective local councils, county medical program directors, and stakeholders. These plans are the cornerstone in the maintenance, improvement, and sustainability of Washington state’s EMS and trauma care system. Based on plan guidance and a basic format template from the Washington State Department of Health (WA DOH), the regional plans focus on the work each council will accomplish. These plans align with the goals of the State of Washington EMS and trauma system strategic plan, yet are specific to the unique needs of each region. Goals, objectives, strategies, and measuring progress form the heart of the plans.

To provide the 1,316,620 citizens and additional visitors with 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
- Regional resources to support high quality trauma rehabilitation
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.

**West Region Council Structure**

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 9: WREMS Council Bylaws for a list of Council positions. The WREMS Council meets quarterly.

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 comprised of eight members, three of whom are officers to include chair, vice-chair and secretary/treasurer. The Executive Board and its officers are elected by a majority of the Council for a two-year term. No more than two of the officers may be from the same county. The Executive Board meets monthly and has fiduciary oversight of the Council’s regional plan, budget, finances, contracts, as well as administrative policies and procedures. The Executive Board is responsible for developing recommendations to the full Council with any action being subject to review and ratification by the full Council.
**West Region Subcommittees**

There are three standing committees which undertake the core work of the Council: Injury and Violence Prevention; Training, Education and Development; and the MPD, Planning and Standards Committees.

The Injury and Violence Prevention (IVP) Committee is dedicated to preventing the leading causes of injury and death in the West Region which are suicide, poisoning, falls, motor vehicle crashes, assault, suffocation, drowning and fire/burn, according to 2013-17 data from Dept of Health. Each year WREMS awards prevention grants. Grant projects must address one of the leading causes of injury and death in the region and use evidence based or promising strategies. The grant subcommittee uses a comprehensive selection process and criteria to evaluate a project’s supporting data, objectives, strategies and evaluation plan.

IVP meetings are held five times per year and engage participants from all West Region counties. Meetings provide education, opportunities for building partnerships, sharing best practices, and learning about resources and prevention programs in the region and at the state level. It is also an opportunity for grantees to share their work and outcomes with the region and prevention partners.

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. The committee meets on a monthly basis.

The MPD, Joint Standards and Planning Committee was revitalized during the 2017-19 plan period. The committee resumed the responsibilities of developing and updating regional patient care procedures, overseeing updates to the strategic plan on issues related to prehospital patient care delivery, and reviewing recommended changes to the minimum/maximum numbers and levels of trauma designated services and verified prehospital services. The committee convened five meetings during the plan period.

The WREMS Council works to collaboratively assist the independent regional quality improvement (QI) work of the region’s two Quality Improvement Forums (QIF). The Council administratively supports the Trauma QIF, and the Cardiac and Stroke QIF responsibilities to improve patient outcomes, identify areas for improvement, educate providers and build coordination between services. The Trauma QIF meets five times a year and the Cardiac and Stroke QIF meets quarterly.
Regional Profile: West Region Counties

The West Region is a major population, manufacturing, transportation, and shipping corridor as well as tourist center of the state. Its jurisdictional composition is a five-county area including Grays Harbor, Lewis, North Pacific, Pierce and Thurston Counties. The large urban and rural geography spreads population density centers out and increases the challenge for emergency medical service (EMS) response and treatment services in an area of over 7,765 square miles. The region serves 1,316,620 citizens and has seen increase of 19,290 residents since 2017.

Grays Harbor & North Pacific Counties

As a gateway to the Pacific Ocean and Olympic Peninsula Grays Harbor County, has a landscape which varies from coastline to rainforest. Total square mileage is 2,224; 1,902 is land and 322 is water. The WA Office of Financial Management lists the 2018 population as 73,610 with 28,320 in unincorporated Grays Harbor County and 45,290 in incorporated Grays Harbor County. The median age of the population is 43 and there is a median household income of $44,521. There are 28,579 households, and 18,493 families residing in the county; 21% of the population are seniors. The population density is 38.3 inhabitants per square mile, the largest city is Aberdeen with a population of 16,760; the county seat is Montesano.

Due to its coastal location, Grays Harbor County has tourism throughout the year and specialized EMS responses (such as ocean rescues) are common. Two Indian tribes have territories which border Grays Harbor County: the Confederated Tribes of the Chehalis Reservation & the Quinault Indian Nation. A vast portion north of the county is the Quinault Indian Nation’s territory and the Olympic National Forest.

Pacific County is divided into two separate regions for the purpose of EMS transport to healthcare locations: the northern half of Pacific is in the West Region and southern half of the county is in the Southwest Region; a portion of the natural line of division is the Grays River along State Route 4. The two North Pacific County EMS agencies work under the guidance of the Grays Harbor/North Pacific EMS Medical Program Director (MPD).

The WA Office of Financial Management lists the county’s 2018 population as 21,420 with 14,500 in unincorporated Pacific County and 6,920 in incorporated Pacific County. Population numbers for the northern portion of the county are approximately half that amount. The population density is 22 people per square mile. The median income is $38,387. Population centers in northern Pacific County include Raymond, South Bend, Tokeland, and the Shoalwater Bay Indian Tribe. Raymond is the largest city with a population of 2,885 and the county seat is South Bend.
**Lewis County**

Lewis County was created as Vancouver County on December 19, 1845, by the Provisional Government of Oregon, named for George Vancouver. In 1849, the county was changed to honor Meriwether Lewis. At the time, the county included all U.S. lands north of the Cowlitz River, including much of the Puget Sound region and British Columbia. Lewis County has a total square mileage of 2,436; 2,403 is land and 33 is water. The geography varies from the mountain views of Packwood to the east, to the agricultural landscapes of the west.

The WA Office of Financial Management lists the 2018 population as 78,380 with 46,660 in unincorporated Lewis County and 31,720 in incorporated Lewis County. The county seat is Chehalis, and its largest city is Centralia with a population of 17,060. Population density is 31.4 inhabitants per square mile. Median income for a household in the county is $43,874 and the median income for a family is $53,358. Lewis County is divided in half by the 1-5 corridor. Fire and EMS respond to emergencies frequently along the corridor. There are two hospitals serving the county: Arbor Health, Morton Hospital in Morton and Providence Centralia in Centralia.

**Pierce County**

Pierce County was formed out of Thurston County on December 22, 1852 and was named for US President Franklin Pierce. Pierce County’s total area is 1806 square miles, of which 1669.51 is land and 137 is water. It is notable for being home to Mount Rainier, the tallest mountain (14,410 feet) and a volcano in the Cascade Range. Its most recent recorded eruption was between 1820 and 1854. There is no imminent risk of eruption, but geologists expect that the volcano will erupt again. If this should happen, parts of Pierce County and the Puyallup Valley would be at risk from lahars, lava, or pyroclastic flows. The Mount Rainier Volcano Lahar Warning System was established in 1998 to assist in the evacuation of the Puyallup River valley in case of eruption, and sirens in that valley continue to be tested monthly. There are three rivers that run through the county, and six islands in the Pierce County portion of Puget Sound.

The WA Office of Financial Management lists the 2018 population as 872,220, with 409,020 in unincorporated Pierce County and 463,200 in incorporated Pierce County. This shows a growth rate of 5.27% in the past year. The population density is 522.44 per square mile. The number of employees is 392,703, with Joint Base Lewis-McChord contributing more than 42,000 military and civilian jobs to the local economy. The median property value is $271,300, the median household income is $64,434, the poverty rate is 12.1% - with an unemployment rate of 4.9%, and the median age is 36.1. Of the 633,001 adults in the county, 105,778 are senior citizens. The gender ratio is female 50.36% and male 49.64%. Pierce County has 86,815 veterans, with the largest age range being 35 to 54 years.
of age. 85.45% of the residents speak only English, while 14.55% speak other languages; the largest non-English language is Spanish, which is spoken by 5.85% of the population.

Access to healthcare is important. Some groups in the county are more likely to have health insurance coverage than others, 86.9% of age 18-29, 92.1% of age 18.64, and 97.5% ≥ 65 years of age. Long periods without insurance can negatively affect health. Uninsured people often have more trouble getting care, may be diagnosed at later disease stages, and get less therapeutic care. A person’s income plays an important role in their health. High premiums and co-pays can be a barrier to getting medical treatment and preventive care. Cultural and racial barriers also can stop people from seeking health care. The following health needs were selected as the focus of the next three-year implementation period by the healthcare systems in Pierce County: Access to Care, Obesity, Behavioral Health, Tobacco Use, Infant Mortality & Lack of Early and Adequate Prenatal Care, Childhood Immunizations, and Cultural Competency.

Thurston County

Thurston County was created out of Lewis County by the government of Oregon Territory on January 12, 1852. At that time, it covered much of the Puget Sound region and the Olympic Peninsula. On December 22, 1952, Pierce, King, Island, and Jefferson counties were split off from Thurston County. It is named after Samuel R. Thurston, the Oregon Territory’s first delegate to Congress.

The WA Office of Financial Management lists the 2018 population as 281,700 with 141,800 in unincorporated Thurston County and 139,900 in incorporated Thurston County. The population density is 349.4 inhabitants per square mile. The median income for a household in the county is $60,930 and the median income for a family is $71,833.

The county seat and largest city is Olympia, the state capital, with a population of 52,490. The county has a total area of 774 square miles; 722 is land and 52 is water. Major watersheds include Black River, Budd/Deschutes, Chehalis River, Eld Inlet, Henderson Inlet, Nisqually River, Skookumchuck River, Totten Inlet and West Capitol Forest.

Thurston County is the eighth most populated county among Washington State’s 39 counties.

Emergency Care System Resources

Trauma Verified Prehospital Resources

Identification of need and distribution of verified aid and ambulance services is determined by local county EMS councils in Grays Harbor/N. Pacific, Lewis, Pierce and Thurston Counties. Local councils also identify where those services operate within their county’s unique Trauma Response Areas.

For a GIS map of West Region Trauma Response Areas please go to: https://fortress.wa.gov/doh/ems/index.html
There are currently 80 prehospital trauma verified aid and ambulance services within the West Region with a total of 2,956 EMS providers: 2,147 are paid and 809 are volunteers. See Appendix 4 for data on West Region providers and services by county. 2018 data supplied by the WA DOH indicates 27.4% of prehospital providers in the West Region are volunteers. DOH data further shows a 0.5% decrease in volunteer EMS providers in the West Region since 2017.

**Trauma Designated Facilities**

Fourteen designated trauma care services currently operate within the West Region. In Pierce County there are eight 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 CHI 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. CHI Franciscan St. Anthony Hospital in Gig Harbor, CHI Franciscan St. Clare Hospital in Lakewood, and MultiCare Allenmore Hospital in Tacoma are all Adult Level IV facilities.

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

**Emergency Cardiac & Stroke Resources**

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. See Appendix 2 for a list of categorized cardiac and stroke facilities in the West Region.
Accomplishments from the West Region 2017-19 Strategic Plan

- Funding to support prehospital training and prevention grants stayed level during the plan period.
- Prehospital training contracts awarded to local EMS councils for a total of $40,000 each year.
- Eight prevention grants awarded in FY18 & seven awarded in FY19 targeting the leading causes of injury and death in the region during each fiscal year. $20,000 was awarded each year.
- West Region EMS Conferences held in March 2018 & 2019, offered affordable, high quality prehospital training to all Washington state providers.
- MultiCare Good Samaritan was recognized with the 2018 American Heart Association’s Get With The Guidelines Gold Plus Quality Award for consistent compliance with quality measures.
- MultiCare Good Samaritan Hospital expanded its rehabilitation unit from 37 to 48 beds and added 66 new acute care beds.
- CHI Franciscan opened a 60-bed inpatient rehabilitation hospital in Tacoma in May 2018.
- Mary Bridge Adolescent Behavioral Health at Tacoma General increased beds in their 27-bed in-patient unit for teens ages 13-17.
- Wellfound Behavioral Health Hospital opened an adult 120-bed, not-for-profit psychiatric hospital on the MultiCare Allenmore Hospital campus in March 2019.
- A single phone line was created for all transfers to the Tacoma Level II Trauma Centers. The same number is also used for consults. The new system was rolled out January, 2018; feedback has been very positive.

Challenges and Priorities

Challenges
There are challenges with the rapidly changing healthcare environment, limited and declining resources, increasing demand, workforce shortages, barriers to quality assurance and improvement, unequal access, rapidly changing technology, drivers of public expectations, and sustainability of community collaboration. Additionally, cross-county and cross-jurisdiction communication between prehospital EMS agencies with the Disaster Medical Coordination Center (DMCC) network is an area of opportunity to improve.

Priorities
Our priorities reflect our vision and mission statements: quality care and quality improvement, cost efficiency, access for as many as possible to appropriate care, data driven decision making, education and outreach, improving integration and collaboration with all stakeholders, resource and workforce development, and regulatory adjustment to increase effectiveness and efficiency.
Goal 1 Introduction

Maintain, assess and increase emergency care resources.

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.

There are 14 designated trauma care services currently operating within the West Region as mentioned in the main introduction to this plan. See Appendix 1 for a list of Approved Minimum & Maximum Numbers of Designated Trauma Care Services.

The Region gained and lost a Level IV trauma service during the last planning cycle. MultiCare Allenmore Hospital in Tacoma was designated as a Level IV trauma service and Capital Medical Center in Olympia did not renew their Level IV designation status in 2018. During the 2017-19 plan cycle, Providence St. Peter Hospital did not re-designate as a Level II Adult Trauma Rehabilitation Center. CHI Franciscan St. Joseph Medical Center also closed their Adult Level II Rehabilitation unit and opened the free-standing CHI Franciscan Rehabilitation Hospital in May 2018. At this time the new hospital is not trauma designated. For more information on trauma rehabilitation in the West Region see Goal 6.

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. US HealthVest has received state approval to develop a 108-bed mental health facility in Thurston County called South Sound Behavioral Health (SSBH). Located in Lacey, the hospital will provide behavioral health and addiction treatment services to all ages. Services will include 24/7 assessments, inpatient, and intensive outpatient care. Olympia Behavioral Health LLC (OBH) received approval from WA DOH to build an 85-bed hospital also in Lacey. OBH is a joint venture between Providence St. Peter Hospital and Fairfax Behavior Health. Both SSBH and OBH have committed to care for involuntary patients. Both facilities are expected to open in 2019.

MultiCare Health System and CHI Franciscan Health jointly opened an adult 120-bed not-for-profit psychiatric hospital in Tacoma in March 2019. The new psychiatric hospital, Wellfound Behavioral Health Hospital, is built on the MultiCare Allenmore Hospital campus, located at 1901 Union Avenue in Tacoma.

The WREMS Council supports local EMS 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 county EMS 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 WA DOH for approval.

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 DOH’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):

(4) Regional EMS and trauma care councils may provide comments to the department regarding the verification application, including written statements on the following if applicable:

(a) Compliance with the department-approved minimum and maximum number of verified trauma services for the level of verification being sought by the applicant;
(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) Regional EMS/TC councils will solicit input from local EMS/TC councils where local councils exist.
See Appendix 5 for a list of approved minimum/maximum numbers of verified prehospital services in the West Region. There are 81 EMS trauma verified aid and ambulance services within the West Region.

Regarding pre-hospital care in Pierce County, while the trauma incidents continually rise, there has been a leveling in trauma incidents during this review period. Without a cardiac & stroke registry we can only rely on anecdotal speculation to say that cardiac & stroke incidents have increased. There has been an increase of 5.1% in the number of licensed EMS units in the county, which agencies shift to locations that better achieve response time targets, as well as meet aging fleet replacement cycles needs. Limited, if any, capacity increases to existing infrastructure (streets, roads, highways) relative to the increase in population will cause response times to increase. The Pierce County EMS Council strives to achieve a better than forty-five-minute ALS ambulance response time to our constituents in rural Pierce County. There is continued concern 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, there is concern about timely EMS care being received by residents, staff and visitors of Mt. Rainier National Park. There are populated areas of the national park that should not be considered ‘wilderness’, especially during peak visitation/camping months. While the PC EMS Council, as a county entity, does not have influence on State and Federal properties, we do recognize the need to speak for residents, staff and visitors in those areas. Regulations and restrictions established by the Centers for Medicare & Medicaid Services and WA State Health Care Authority continue to affect reimbursement rates negatively in that both public and private EMS agencies. With requests for transport increasing, agencies find it difficult to provide optimal staffing when they cannot seek reimbursement at all or receive minuscule reimbursement based on narrow parameters.

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.

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 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 by the MPD, Joint Standards and Planning Committee.
## GOAL 1
*Maintain, assess and increase emergency care resources.*

<table>
<thead>
<tr>
<th>Objective 1: <strong>By June 2020</strong>, 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 2020.</th>
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<tbody>
<tr>
<td><strong>Strategy 1. By September 2019</strong>, 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.</td>
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<tr>
<td><strong>Strategy 2. By May 2020</strong>, 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.</td>
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<tr>
<td><strong>Strategy 3. By June 2020</strong>, 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).</td>
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<th>Objective 2: <strong>By January 2021</strong>, 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.</th>
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<tr>
<td><strong>Strategy 1. By September 2020</strong>, 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 WA DOH to determine optimal prehospital system recommendations to the WREMS Council for approval.</td>
</tr>
<tr>
<td><strong>Strategy 2. By December 2020</strong>, 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.</td>
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<tr>
<td><strong>Strategy 3. By January 2021</strong>, the WREMS Council will make recommendations for the minimum and maximum numbers and levels of trauma verified prehospital services from each county to the WA DOH.</td>
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<th>Objective 3: <strong>Throughout the planning cycle</strong>, the WREMS Council will review &amp; document categorized cardiac and stroke facilities within the West Region.</th>
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<tr>
<td><strong>Strategy 1. Throughout the planning cycle</strong>, the WREMS Council will query participating cardiac and stroke categorized facilities through the West Region Cardiac &amp; Stroke Quality Improvement Forum for any changes to their categorization level.</td>
</tr>
</tbody>
</table>
| Objective 4: By June 2021, the WREMS Council will conduct needs assessments for trauma, EMS, cardiac & stroke. | **Strategy 1.** During the 2020 fiscal year, the WREMS Council will collaborate with WA DOH and the Regional Advisory Technical Assistance Committee (RAC TAC) in developing an effective tool to conduct system needs assessments for trauma, EMS, cardiac and stroke.  
**Strategy 2.** By November 2020, the WREMS Council, with the guidance of WA DOH and the RAC TAC, will conduct needs assessments for trauma, EMS, cardiac, stroke.  
**Strategy 3.** By June 2021, the WREMS Council will report the findings of the needs assessments for trauma, EMS, cardiac, stroke, to WA DOH and at the June 2021 WREMS Council meeting. |
| --- | --- |
| Objective 5: By June 2021, the WREMS Council will identify unserved and underserved areas within the West Region. | **Strategy 1.** By September 2020, the WREMS Council will begin to collaborate with the county EMS councils and WA DOH to develop an effective method to review the trauma response area maps and revise as needed.  
**Strategy 2.** By December 2020, the WREMS Council will document and distribute the newly developed method to review and revise the county trauma response area maps to the county EMS councils.  
**Strategy 3.** By June 2021, the WREMS Council will request each county EMS council complete their review and revision of their trauma response area maps. |
Goal 2 Introduction

Support emergency preparedness activities.

In 2001-2018 West Region EMS Council (WREMS) contracted with the Washington State Department of Health Office of Emergency Preparedness and Response (EPR) Program to receive federal funds from the Hospital Preparedness Program (HPP) to provide administrative support and perform planning tasks for the counties identified as “Region 3” (Grays Harbor, Lewis, Mason, Pacific, and Thurston). Council staff planned closely with Thurston County Public Health staff to implement the work of the Region 3 Healthcare Preparedness Coalition. In 2018 EPR moved to a new model for Healthcare Preparedness Coalitions, constructing a Western Washington Coalition through the Northwest Healthcare Response Network (NWHRN) and an Eastern Washington Coalition (Spokane Public Health). This new model has impacted preparedness activities and funding in the West Region.

The WREMS Council recognizes the need for collaboration with the local emergency management, local public health 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.

As we move to the future, the region’s priorities will be to focus on: 1) collaboration with emergency management partners to support all-hazards preparedness and response planning and, 2) collaboration with pre-hospital emergency medical agency partners, hospitals and DMCCs to support cross-county all-hazards preparedness and response.

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. Emergency preparedness updates are a standing agenda item at WREMS Council meetings.

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 continue to 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.
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<th><strong>GOAL 2</strong></th>
<th><strong>Support emergency preparedness activities.</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Objective 1: From July 2019-June 2021,</strong> the WREMS Council will collaborate with emergency management partners to support all-hazards preparedness and response.</td>
<td><strong>Strategy 1.</strong> Quarterly during the 2019-21 plan cycle, a representative from the West District of the Northwest Healthcare Response Network will be invited to prepare regular reports and updates for WREMS Council meetings.</td>
</tr>
<tr>
<td><strong>Strategy 2.</strong> Annually, by September 1, the WREMS Executive Board will determine dates to invite each West Region county’s Emergency Management Director to Council meetings to provide overviews of their county’s Comprehensive Emergency Management Plan.</td>
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<tr>
<td><strong>Strategy 3.</strong> Annually, by September 1, the WREMS Executive Board will determine dates to invite representatives from Providence St. Peter Hospital and MultiCare Good Samaritan Hospital to discuss the role of EMS in their DMCC plans.</td>
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<tr>
<td><strong>Strategy 4.</strong> Beginning in July 2019, the WREMS Council will invite a representative of the WA DOH Emergency Preparedness Division to discuss the role and expectation of WREMS in the response, care and transport of a patient with a highly infectious disease.</td>
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<tr>
<td><strong>Strategy 5.</strong> Beginning in July 2019, the WREMS Council will invite the Emergency Program Manager from each hospital (system) within the West Region to discuss their Emergency Preparedness plans.</td>
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<tr>
<td><strong>Strategy 6.</strong> Beginning in July 2019, the WREMS Council will participate in and support the implementation of a WA State EMS Emergency Preparedness Toolkit.</td>
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<tr>
<td><strong>Objective 2: From July 2019-June 2021,</strong> the WREMS Council will collaborate with pre-hospital emergency medical agency partners, hospitals and DMCCs to support cross-county all-hazards preparedness and response.</td>
<td><strong>Strategy 1.</strong> Beginning in July 2019, the MPD Joint Standards and Planning Committee will continue their update of the West Region’s Mass Casualty Incident (MCI) Patient Care Procedure (PCP) to include a new Prehospital MCI Algorithm based upon common elements of all WR county MCI plans.</td>
</tr>
<tr>
<td><strong>Strategy 2.</strong> Beginning in July 2019, the WREMS Council will participate in and support multi-discipline, multi-jurisdictional, and multi-county complex coordinated attack scenario training and exercise(s).</td>
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Goal 3 Introduction

Plan, implement, monitor and report outcomes of programs to reduce the incidence and impact of injuries, violence and illness in the region.

Per Washington State Department of Health (WA DOH) data, in 2016, 906 people died from preventable injuries in the West Region. The most common cause of death in the West Region in 2016 was suicide, followed by poisoning, falls, motor vehicle crashes, assault, suffocation, drowning, and fire/burn. Data tables may be found in Appendix 9C and on the West Region EMS website, https://www.wrems.com/prevention-home. Data is used to prioritize work, make decisions regarding injury prevention grant awards, and evaluate the efficacy of prevention programs. By supporting evidence based or promising prevention strategies and providing education and resources to regional stakeholders, the number of injuries and fatalities due to trauma can be reduced.

Regional Councils have strong support from WA DOH staff who share a wealth of expertise and resources. State meetings provide an opportunity to collaborate with other regional prevention leads and address prevention issues at the state level. WA DOH staff coordinate valuable training on current and 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 WA DOH and regional stakeholders, and serves as a point of contact for community members seeking resources. Injury prevention information on a wide variety of topics is sent out via email to a distribution list of approximately 170 prevention partners.

The West Region includes many rural areas with limited resources. Building and strengthening partnerships is vital; it helps rural areas increase capacity and reduces duplication of efforts.

West Region IVP meetings are held five times per year. Meetings include an educational component and an update report from WA DOH. The meetings provide an opportunity for building partnerships, sharing best practices, and learning about prevention programs that participants can take back and adopt in their own community. Prevention meetings also provide an opportunity for grantees to share their work and outcomes with the region and other prevention partners.

Each year WREMS awards prevention grants. Grant funds are used to develop or strengthen prevention programs in local communities and must address one of the leading causes of injury and death in the region. 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. The grants make it possible to develop successful prevention programs which can then be eligible for additional grant funds from other sources. Eight prevention grants were awarded each year in FY17 and FY18, and seven grants were awarded in FY19.

The annual West Region EMS Conference includes a Prevention Workshop. The workshop provides a half-day of education on current and emerging issues for EMS providers and prevention partners in the region and across the state. Approximately 42 people attended the 2019 West Region EMS Conference Prevention Workshop which was held 3/22/19 at the Ocean Shores Shilo Inn. The Workshop offered a Kids Don’t Float Train-the-Trainer course which is a highly successful open water safety program. The presentation included a pool demo of some of the training modules. The program can be effectively implemented in communities with limited resources. The 2019 Workshop also included hands on training in using social media for prevention public education, including education on legal considerations. The 2018 Prevention Workshop offered the Impact Teen Drivers Train-the-Trainer course to 36 participants. Attendees received evidence based tools and resources to bring the program to their own communities; the program can be implemented in communities with limited resources.

2016 WA DOH data shows falls is the third leading cause of unintentional death in the West Region. During FY19, WREMS IVP Coordinator assisted with creating, “Finding Our Balance: 2018 Washington State Action Plan for Older Adult Falls Prevention”. The plan was released in September, 2018.

**County Specific Assessment**

Many of the 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 death in 2016 were poisoning, suicide, motor vehicle crashes, falls, suffocation and drowning. Grays Harbor & North Pacific counties are rural with limited resources. Grays Harbor Public Health (GHPH) received a Community Prevention & Wellness Initiative grant to build local partnerships to reduce youth substance abuse in high risk communities. GHPH is also participating in the Prescription Drug Overdose Prevention for States program.

**Lewis County:** Top causes of death in 2016 were suicide, poisoning, motor vehicle crashes, falls, suffocation, and drowning. Lewis County is rural with limited resources. In FY18 Lewis County Public Health received a WREMS prevention grant to develop a Naloxone distribution program for law enforcement; 84 Naloxone kits were distributed, 36 of those were purchased with WREMS grant funds. Suicide prevention is a priority for the Lewis County Coroner’s office. According to WA DOH data, there were 13 suicides in Lewis County in 2016. Per Lewis County Coroner’s Office data, there were 28 suicides in 2017
and 14 in 2018. A barrier to establishing an effective prevention program is that there is no clear pattern, and thus, no clear means to address the problem.

2016 US Fire Administration data showed Lewis County had the highest rate of fire related deaths per capita in the state; 5.2 per 100,000. During FY17 – 19, WREMS prevention grants were awarded to three Lewis County fire districts. The fire districts partnered with neighboring fire districts to provide fire prevention education and safety devices to families who otherwise would not have access to them. There were no fire related deaths in 2018.

**Pierce County:** Top causes of death in 2016 were suicide, poison, falls, motor vehicle crashes, assault, and suffocation. The Pierce County Falls Prevention Coalition is actively involved in falls prevention year round. MultiCare Mary Bridge Children’s Hospital (MBCH) has a strong pediatric injury prevention & education program. The Pierce County infant mortality rate of 5.3 is above the state average of 4.3. In FY19, NW Infant Survival & SIDS Alliance, and MultiCare Center for Healthy Living, were awarded WREMS Prevention grants to provide education and resources for safe sleep to low income families.

**Thurston County:** Top causes of death in 2016 were falls, suicide, motor vehicle crashes, poisoning, suffocation, and drowning. Safe Kids Thurston County has several robust child injury prevention programs; special emphasis is placed on serving low income families. Lewis Mason Thurston Area Agency on Aging (LMT AAA) serves as a resource for senior fall prevention. During FY19, WREMS IVP Coordinator partnered with the LMT AAA to reinvigorate the Lewis Mason Thurston Fall Prevention Coalition.
**GOAL 3**
*Plan, implement, monitor and report outcomes of programs to reduce the incidence and impact of injuries, violence and illness in the region.*

**Objective 1:** Annually during the 2019-21 plan cycle, the WREMS Council will research the most recent injury and mortality data available to identify the leading causes of traumatic injury and death in the West Region and support evidence-based or promising strategies and programs.

**Strategy 1. Annually, by August,** the Injury and Violence Prevention (IVP) Coordinator will review the most current injury and mortality data from WA 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.

**Strategy 2. Annually, by September,** the IVP Grant Workgroup will identify evidence-based or promising injury prevention programs and activities and provide funding to regional injury prevention partners as funding is available.

**Strategy 3. Throughout the grant year,** funding recipients will report on the progress of their programs to the WREMS Council.

**Strategy 4. Annually, by June 30,** grant recipients will submit documentation on interventions and outcomes.

**Strategy 5. Throughout the grant year,** the WREMS Council will provide bi-monthly progress reports to WA DOH.

**Objective 2:** During the 2019-21 plan cycle, WREMS IVP Coordinator will share suicide prevention resources and education with West Region stakeholders.

**Strategy 1. By February, 2020,** IVP Coordinator will research and identify suicide prevention resources, including training and organizations that provide resources & support for those who are at risk.

**Strategy 2. Throughout the 2019-21 plan cycle,** IVP Coordinator will share suicide prevention resources and information with regional stakeholders.

**Strategy 3. During the 2019-21 plan cycle,** IVP Coordinator will participate in WA State Suicide Prevention Workgroup meetings.

**Strategy 4. Annually, by June 30,** IVP Coordinator will offer education and share resources for suicide prevention at a WREMS Prevention meeting.

**Strategy 5. Annually, by June 30,** WREMS Prevention grants will be offered for projects that address the leading causes of death and injury, including suicide.
<table>
<thead>
<tr>
<th><strong>Objective 3:</strong> During the 2019-21 plan cycle, WREMS IVP Coordinator will document interventions &amp; outcomes and report to the EMS &amp; Trauma Steering Committee.</th>
<th><strong>Strategy 1.</strong> Annually, by June 30, the WREMS Council will report on interventions &amp; outcomes to the EMS &amp; Trauma Steering Committee.</th>
</tr>
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</table>
| **Objective 4:** During the 2019-21 plan cycle, the WREMS IVP Coordinator will utilize resources from WA DOH and the WA Poison Center which address the opioid crisis and share with regional stakeholders. | **Strategy 1.** Throughout the 2019-21 Plan Cycle, IVP Coordinator will utilize WA 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.  
**Strategy 2.** Throughout the 2019-21 Plan Cycle, IVP Coordinator will share information and resources from WA DOH and WA Poison Center with regional stakeholders regarding opioid misuse, efforts to address the opioid crisis, and evidence based and promising strategies. |
| **Objective 5:** During the 2019-21 plan cycle, WREMS IVP Coordinator will reach out to state and regional partners to explore emerging concepts for Mobile Integrated Health Care (MIH)/Community Paramedicine programs in the state and region. | **Strategy 1.** By October, 2019, IVP Coordinator will reach out to state and regional partners to identify emerging concepts for MIH/Community Paramedicine programs in the state and region.  
**Strategy 2.** By January, 2020, IVP Coordinator will seek guidance from the WREMS Board/Council regarding MIH/Community Paramedicine in WREMS Prevention work. |
| **Objective 6:** During the 2019-21 plan cycle, the WREMS Council will collaborate to educate the public, partners and policy makers on the Emergency Care System. | **Strategy 1.** Throughout the plan cycle, the WREMS Council will make current Emergency Care system information available to stakeholders on the WREMS website and by email. |
Goal 4 Introduction

Assess weakness and strengths of quality improvement programs in the 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. Each QI Forum has a plan which calls for confidential quarterly meetings, a membership of both hospitals and EMS agencies, and the sharing of case reviews and data. See Appendix 9 for the West Region QI Forums’ plans.

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. Both the Cardiac and Stroke QI utilize “Get with the Guidelines” developed by the American Heart Association/American Stroke Association. The Cardiac QI also 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. The Council will continue to work with the WA DOH to identify and implement strategies to increase prehospital reporting and participation in prehospital data sources.

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.
### GOAL 4
Assess weakness and strengths of quality improvement programs in the region.

<table>
<thead>
<tr>
<th>Objective 1: During the 2019-21 plan cycle, the WREMS Council will review regional emergency care system performance.</th>
<th>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.</th>
</tr>
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<tbody>
<tr>
<td>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.</td>
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<td>Strategy 3. During the 2019-21 plan cycle, the West Region local councils will be requested to report quarterly ‘lessons learned’ from prehospital case reviews back to the Council as a contract deliverable for their prehospital training funds.</td>
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<tr>
<td>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.</td>
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<tr>
<th>Objective 2: During the 2019-21 plan cycle, the West Region EMS Quality Improvement Forums facility. (QIF) will review Trauma, Cardiac and Stroke data.</th>
<th>Strategy 1. Throughout the plan cycle, the WREMS Council will continue to assist the West Region Trauma, Cardiac and Stroke QIFs in meeting preparation.</th>
</tr>
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<tr>
<td>Strategy 2. Annually by June 30, 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.</td>
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<tr>
<th>Objective 3: Throughout the plan cycle, the West Region Cardiac Quality Improvement Forum (QIF) will explore barriers to STEMI activation from all hospital admit sources, to include EMS transports and facility transfers.</th>
<th>Strategy 1. From July 2019 to June 2021, the West Region Cardiac QIF will determine the percentage of prehospital STEMI notifications identified correctly in the prehospital setting and that appropriately notified the receiving hospital.</th>
</tr>
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<tr>
<td>Strategy 2. From July 2019 to June 2021, the West Region Cardiac QIF will determine the percentage of patients that go directly to catheterization lab as a result of a field activation and those that go to the emergency department as a result of a successful STEMI activation.</td>
<td></td>
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<tr>
<td>Strategy 3. From July 2019 to June 2021, the West Region Cardiac QIF will identify, and address, barriers to direct-to-catheterization lab patients that come from a prehospital STEMI activation. This strategy will also address the Get With The Guidelines goals of 90 minutes</td>
<td></td>
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<tr>
<td>Objective 4: During the 2019-21 plan cycle, the West Region Stroke QIF will reduce the time to treatment for acute stroke by 5% from baseline.</td>
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<tr>
<td><strong>Strategy 1. From July 2019 to June 2021</strong>, the West Region Stroke QIF will collect and analyze data for median ‘Last Known Well’ to hospital arrival times and median door to treatment times for acute stroke.</td>
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<tr>
<td><strong>Strategy 2. From July 2020 to June 2021</strong>, the West Region Stroke QIF will identify barriers to reducing the time to treatment for acute stroke.</td>
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<tr>
<td><strong>Strategy 3. From July 2020 to June 2021</strong>, the West Region Stroke QIF will implement initiatives to reduce the time to treatment for acute stroke.</td>
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<tr>
<td><strong>Strategy 4. Throughout the planning cycle</strong>, the West Region Stroke QIF will share progress and results with the West Region Council and the Emergency Cardiac &amp; Stroke Technical Advisory Committee.</td>
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<tr>
<td><strong>Strategy 5. When released by WA DOH</strong>, the WREMS Council will plan to implement the updated Prehospital Stroke Triage Destination Procedure.</td>
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<tr>
<th>Objective 5: During the 2019-21 plan cycle, the WREMS Council will identify and implement strategies to increase prehospital services reporting to and participation in prehospital data sources.</th>
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<tr>
<td><strong>Strategy 1. During the planning cycle</strong>, the WREMS Council will request the county EMS councils participate in conducting a SWOT analysis on WEMSIS reporting in their respective counties.</td>
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<tr>
<td><strong>Strategy 2. During the planning cycle</strong>, the WREMS Council and county EMS councils will develop written recommendations to help increase prehospital data submission to the WEMSIS.</td>
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<tr>
<td><strong>Strategy 3. By June 2020</strong>, the WREMS Council will submit the recommendations to the WEMSIS Workgroup and WA DOH.</td>
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<tr>
<td><strong>Strategy 4. By September 2020</strong>, the WREMS Council will request WEMSIS Data Extraction Training be provided to demonstrate to EMS agencies the WEMSIS data mining opportunities.</td>
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<tr>
<th>Objective 6: By June 2020, the WREMS Council will conduct a SWOT analysis of regional and local EMS and trauma quality improvement programs.</th>
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<tr>
<td><strong>Strategy 1: By September 2019</strong>, the WREMS Council will request the county EMS councils participate in compiling lists of QI programs within their respective counties.</td>
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<tr>
<td><strong>Strategy 2. By December 2019</strong>, the WREMS Council will assist each county EMS council in conducting a county SWOT analysis of their QI programs.</td>
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<tr>
<td>Strategy 3. <strong>By January 2020,</strong> the WREMS Council will request the West Region Quality Improvement Forums conduct a regional SWOT analysis based upon information provided by the local county EMS councils and the regional EMS council.</td>
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<tr>
<td><strong>Objective 7:</strong> <strong>By June 2021,</strong> the WREMS Council will assess the state of quality improvement programs in the region.</td>
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<tr>
<td><strong>Strategy 1. By June 2020,</strong> the WREMS Council will create a summary report from the results of the SWOT analysis conducted in G4O6.</td>
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<tr>
<td><strong>Strategy 2. By January 2021,</strong> the WREMS Council will analyze the results of the summary report to assess the state of QI programs and develop preliminary recommendations to enhance overall EMS and trauma system quality improvement.</td>
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<tr>
<td><strong>Strategy 3. By April 2021,</strong> the WREMS Council will provide the QI assessment outcome to county EMS councils, regional QIF committees, regional council members, and WA DOH.</td>
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Goal 5 Introduction

**Promote regional system sustainability.**

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 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 WA 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 sponsors an 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 34 years. Despite facing rising costs, diminishing funds, and the advent of statewide online training; the Council seriously evaluated the sustainability of the conference and heard very clearly from the conference attendees and stakeholders that they felt this was an exemplary and highly beneficial training opportunity.

The WREMS Council recognizes enhanced education for credentialed Senior EMS Instructors (SEIs) and EMS Evaluators (ESE) 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 and ESEs.

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**  
*Promote regional system sustainability.*

| Objective 1: During the 2019-21 plan cycle, the WREMS Council will work to identify cost saving practices. | Strategy 1. **By June of each plan year**, the WREMS Council Executive Board will develop a draft budget which takes into consideration cost efficiencies.  
Strategy 2. **Anually, 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. |
|---|---|
| Objective 2: **Annually, by June,** the WREMS Council will utilize a process to identify needs and allocate available funding to support Prehospital training. | Strategy 1. **Annually, at the WREMS Council’s Budget Meeting**, Council members will review needs and approve educational funding levels for each local EMS council.  
Strategy 2. **Annually, 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.**  
Strategy 3. **Annually, by September,** the WREMS Council staff will initiate contracts with local EMS councils to distribute funds for coordination and delivery of OTEP and CME EMS training.  
Strategy 4: **Annually, by June**, the WREMS Council will facilitate SEI training and development by scheduling at least one SEI workshop a year.  
Strategy 5. **Annually, by June,** 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. |
| Objective 3: During the 2019-21 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. | Strategy 1. **Annually, at the beginning of the plan year,** the WREMS Council will provide WA DOH with a regional budget.  
Strategy 2. **Annually, in November,** the WREMS Council will provide the Washington State Auditor’s Office with the previous year’s financial information and required schedules. |
| Objective 4: **Beginning in July 2019,** the West Region EMS Council will implement the 2019-21 Regional EMS and Trauma System Strategic Plan. | Strategy 1. **Beginning in July 2019,** the WREMS Council’s staff will begin collaborating with stakeholders to accomplish the WA DOH reporting process on implementing the 2019-21 Strategic Plan.  
Strategy 2. **By August 2019,** the WREMS Council will distribute the 2019-21 Plan to the local councils and county MPDs and post it on the Council website. |
Strategy 3. Beginning August 2019, the WREMS Council will provide bi-monthly progress reports to the WA DOH.

Strategy 4. Beginning September 2019, and throughout the plan cycle, WREMS Council staff will provide bi-monthly progress reports to the West Region EMS Executive Board.

Objective 5: During the 2019-2021 plan cycle the West Region EMS Council will facilitate the exchange of information throughout the emergency care system.

Strategy 1. Beginning in July 2019, and throughout the plan cycle, WREMS Executive Board and staff will manage Council membership to ensure adequate representation.

Strategy 2. Beginning in July 2019, and throughout the plan cycle, meeting facilities, agendas and minutes will be provided to regional EMS stakeholders in advance of each meeting through email.

Strategy 3. Beginning in July 2019, and throughout the plan cycle, WREMS Council members will participate in EMS stakeholder meetings including: EMS & Trauma Steering Committee (EMSTC) and various Technical Advisory Committees (TACs) then share information with the West Region EMS Council at regularly scheduled meetings.

Strategy 4. Throughout the plan cycle, WREMS Council will bring EMS system and patient care issues forward to the WA DOH, as necessary.

Objective 6: By March 2021, the West Region EMS Council will complete a review and update of the Regional EMS & Trauma Care System Strategic Plan to define the system direction and work in the West Region for 2021-23.

Strategy 1. By September 2020, the WREMS Council will obtain and begin review of directives from the WA DOH for the 2021-23 system plan components.

Strategy 2. From November 2020-March 2021, 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 2021, the designated planners will present a completed draft of the 2021-23 West Region Strategic Plan to the WREMS Council, and subsequently to the WA DOH.

Objective 7: By September 2020, 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 2019, the West Region MPDs will begin to review the WA DOH template and guidelines for statewide standardization of PCPs.

Strategy 2. Beginning July 2019, the West Region MPDs will review and update the Regional PCPs and COPs using input from appropriate stakeholders. 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.
<table>
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<tr>
<th>Objective 8: By June 2021, the West Region Council will explore opportunities for sustainable practices for rural EMS systems.</th>
<th><strong>Strategy 1. Beginning September 2019,</strong> the West Region Council and regional MPDs will review the draft of “Rural and Frontier Emergency Medical Services: Three Year National Tactical Plan,” a project supported by the Health Resource &amp; Services Administration (HRSA). The Council will review additional tools, as provided by the WA DOH.</th>
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<td><strong>Strategy 2. By November 2020,</strong> the West Region Council and regional MPDs will identify and define core issues affecting sustainability in the West Region’s rural EMS systems.</td>
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<td><strong>Strategy 3. By March 2021,</strong> the West Region Council will strategize on implementing portions of the draft Rural and Frontier EMS Tactical Plan and any additional core issues identified that are relevant for the West Region’s rural EMS systems.</td>
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<tr>
<td><strong>Strategy 3. When appropriate,</strong> the WREMS Council will review recommendations from the Executive Board and solicit DOH approval for any updated PCPs and COPs.</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.*

Developments in trauma rehabilitation have occurred during the 2017-19 plan. There is currently one trauma-designated rehabilitation center within the West Region. MultiCare Good Samaritan Hospital in Puyallup is a Level I Trauma Rehabilitation Service and is recognized as one of the best rehabilitation centers in the nation. Good Samaritan Hospital’s expansion of its rehabilitation unit from 37 to 48 beds is projected to be completed in 2019. During the 2017-19 plan cycle, Providence St. Peter Hospital did not re-designate as a Level II Adult Trauma Rehabilitation Center.

CHI Franciscan St. Joseph Medical Center closed their inpatient trauma rehabilitation unit to open the free-standing CHI Franciscan Rehabilitation Hospital in Tacoma in May 2018. The 60-bed inpatient acute rehabilitation hospital offers care tailored to individuals recovering from stroke, brain injury, neurological conditions, spinal cord injury, amputation and orthopedic injury.

Even with these additional beds, the WREMS Council is concerned about the lack of access to local rehabilitation facility resources in the more rural areas of Lewis, N. Pacific and Grays Harbor counties.

**Trauma Rehabilitation Issues in the 2019-21 West Region Plan**

The work outlined for the 2019-21 cycle continues to look at outpatient rehabilitation care availability in the West Region. It is vital that trauma rehabilitation patients be referred to outpatient rehabilitation care in their own communities; however, many rural areas do not have access to these services. During the 2017-19 cycle the WREMS Council invited Rehab Without Walls (RWW) to present at the September 2018 WREMS Council meeting. RWW provides customized neuro-based rehabilitation and resources within the patient’s own home and community. RWW agreed to collaborate with EMS representatives and to participate on the Rehab TAC.

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 rehabilitation care will receive it. Data further shows patients who receive rehabilitation care are almost 9 times more likely to be discharged home or to an Adult Family Home. Those that do not receive proper rehabilitation care are often discharged to a skilled nursing facility where they experience a higher mortality rate.
**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.*

| Objective 1: During the 2019-21 plan cycle, the West Region EMS Council will integrate trauma rehabilitation information/issues into Regional Council meetings. | Strategy 1. **Quarterly during the 2019-21 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.  
**Strategy 2. By June 2020,** an ad hoc workgroup of the WREMS Council will work with the Rehab Without Walls agency to identify pathways for rural communities to access therapy. |
|---|---|
| **Objective 2: By September 2019,** the WREMS Council will establish a trauma rehabilitation committee. | **Strategy 1. By April 2020,** the West Region Trauma Rehabilitation Committee will meet to explore strategies to address the need for rehabilitation outpatient clinic services in underserved communities within the West Region.  
**Strategy 2. By June 2020,** the West Region Trauma Rehabilitation Committee will report their strategies to the WREMS Council. |
Appendix 1

Approved Minimum/Maximum Numbers of Designated Trauma Care Services (General Acute Trauma Services)
### Approved Minimum/Maximum of Designated Trauma Care Services

(General Acute Trauma Services)

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Numbers are current as of June 17, 2019

**Hyperlink to list of resources.**

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West Region Emergency Medical Services
& Trauma Care System Strategic Plan

Appendix 2

Washington State Emergency Care Categorized
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Numbers are current as of June 17, 2019

**Hyperlink to list on DOH website.**
Appendix 3

Approved Minimum/Maximum Numbers of Designated Rehabilitation Trauma Care Services
### Approved Minimum/Maximum of Designated Rehabilitation Trauma Care Services

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Numbers are current as of June 17, 2019

**Hyperlink to list of resources.**

(*There are no restrictions on the number of Level III Rehab Services.*)
West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 4

EMS Resources, Prehospital Verified Services, Prehospital Non-Verified Services
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Numbers are current as of June 17, 2019
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Numbers are current as of June 17, 2019

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</table>

Numbers are current as of June 17, 2019
Appendix 5

Approved Minimum/Maximum Numbers of Verified Prehospital Trauma Services by Level and Type by County
<table>
<thead>
<tr>
<th>County</th>
<th>Verified Service Type</th>
<th>Care Level</th>
<th>State Approved Minimum #</th>
<th>State Approved Maximum #</th>
<th>Current Status (total # verified for each service type)</th>
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<tbody>
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<td>BLS</td>
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### North Pacific

<table>
<thead>
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<th>County</th>
<th>Verified Service Type</th>
<th>Care Level</th>
<th>State Approved Minimum #</th>
<th>State Approved Maximum #</th>
<th>Current Status (total # verified for each service type)</th>
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<tbody>
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<td>AIDV</td>
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<td></td>
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<td></td>
<td></td>
<td>ALS</td>
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<td>AMBV</td>
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### Pierce

<table>
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<th>Verified Service Type</th>
<th>Care Level</th>
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<th>State Approved Maximum #</th>
<th>Current Status (total # verified for each service type)</th>
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<tr>
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<td>BLS ΦΩ</td>
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<td>5</td>
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<td>ALS Φ</td>
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<tr>
<td></td>
<td>AMBV</td>
<td>BLS ΦΩ</td>
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<td>11</td>
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<td></td>
<td>ILS</td>
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<td></td>
<td>ALS Ω</td>
<td>1</td>
<td>16</td>
<td>14</td>
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</tbody>
</table>

Φ Any current BLS agency may submit an application to upgrade to ALS.
Ω 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 & 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>Care Level</th>
<th>State Approved Minimum #</th>
<th>State Approved Maximum #</th>
<th>Current Status (total # verified for each service type)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AIDV</td>
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</tr>
<tr>
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Numbers are current as of June 17, 2019
Appendix 6

Trauma Response Areas (TRAs) by County
## Trauma Response Area by County

<table>
<thead>
<tr>
<th>County</th>
<th>Trauma Response Area Number</th>
<th>Name of Agency Responding in Trauma Response Area</th>
<th>Description of Trauma Response Area’s Geographic Boundaries</th>
<th>Number of Verified Services in the response area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grays Harbor</td>
<td>#1</td>
<td>GHFD #1, Elma FD, McCleary FD, GHFD #5</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>0 AIDV-ILS, 2 AIDV-BLS, 0 AIDV-ALS, 0 AMBV-ILS, 0 AMBV-BLS, 1 AMBV-ALS</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td>#2</td>
<td>GHFD #2, Montesano FD</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>0 AIDV-ILS, 0 AIDV-BLS, 0 AIDV-ALS, 0 AMBV-ILS, 0 AMBV-BLS, 2 AMBV-ALS</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td>#3</td>
<td>Aberdeen FD, Hoquiam FD, Cosmopolis FD, GHFD #6, GHFD #10, GHFD #15, GHFD #17</td>
<td>Encompasses the geographic boundaries of Aberdeen FD, Hoquiam FD, Cosmopolis 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>0 AIDV-ILS, 5 AIDV-BLS, 0 AIDV-ALS, 0 AMBV-ILS, 0 AMBV-BLS, 2 AMBV-ALS</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td>#4</td>
<td>South Beach Regional Fire Authority</td>
<td>Encompasses the geographic boundaries of Westport, Ocosta, Grayland, North Cove, and Tokeland in Pacific County 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>0 AIDV-ILS, 0 AIDV-BLS, 0 AIDV-ALS, 0 AMBV-ILS, 0 AMBV-BLS, 1 AMBV-ALS</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td>#5</td>
<td>Ocean Shores FD, GHFD #4, GHFD #7, GHFD #8, GHFD #16</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>0 AIDV-ILS, 0 AIDV-BLS, 0 AIDV-ALS, 1 AMBV-ILS</td>
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</table>
### Trauma Response Area by County

<table>
<thead>
<tr>
<th>County</th>
<th>Trauma Response Area Number</th>
<th>Name of Agency Responding in Trauma Response Area</th>
<th>Description of Trauma Response Area’s Geographic Boundaries</th>
<th>Number of Verified Services in the response area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoquiam</td>
<td>#9</td>
<td>Quinault Nation Amb GHFD #4 GHFD #8 GHFD #10 GHFD #17 Hoquiam FD</td>
<td>and wilderness areas of the zone were used to determine responses to these areas.</td>
<td>3 AMBV-BLS 2 AMBV-ALS</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td>#6</td>
<td>Quinault Nation Amb GHFD #2 GHFD #4 GHFD #8 GHFD #10 GHFD #17</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>0 AIDV-ILS 2 AIDV-BLS 0 AIDV-ALS 1 AMBV-ILS 2 AMBV-BLS 2 AMBV-ALS</td>
</tr>
</tbody>
</table>

### Trauma Response Area by County

<table>
<thead>
<tr>
<th>County</th>
<th>Trauma Response Area Number</th>
<th>Name of Agency Responding in Trauma Response Area</th>
<th>Description of Trauma Response Area’s Geographic Boundaries</th>
<th>Number of Verified Services in the response area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lewis</td>
<td>#1</td>
<td>Riverside FA AMR</td>
<td>Within the current boundaries of the City of Chehalis and urban growth area</td>
<td>0 AIDV-ILS 0 AIDV-BLS 0 AIDV-ALS 0 AMBV-ILS 0 AMBV-BLS 2 AMBV-ALS</td>
</tr>
<tr>
<td>Lewis</td>
<td>#2</td>
<td>Lewis Co FD #6 AMR Chehalis FD</td>
<td>Within the current boundaries of the City of Chehalis and urban growth area</td>
<td>0 AIDV-ILS 0 AIDV-BLS 0 AIDV-ALS 0 AMBV-ILS 1 AMBV-BLS 2 AMBV-ALS</td>
</tr>
<tr>
<td>Lewis</td>
<td>#3</td>
<td>Riverside FA AMR Lewis Co FD #5 Lewis Co FD #6</td>
<td>Area 3 is located in the NW corner of Lewis County bordering Thurston County to the North, Grays Harbor County and Pacific County to</td>
<td>0 AIDV-ILS 1 AIDV-BLS 0 AIDV-ALS 0 AMBV-ILS 1 AMBV-BLS</td>
</tr>
<tr>
<td>County</td>
<td>Trauma Response Area Number</td>
<td>Name of Agency Responding in Trauma Response Area</td>
<td>Description of Trauma Response Area’s Geographic Boundaries</td>
<td>Number of Verified Services in the response area</td>
</tr>
<tr>
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</tr>
<tr>
<td>Lewis</td>
<td>#4</td>
<td>Pe Ell Volunteer FD &amp; Ambulance Auxiliary Lewis Co FD #13</td>
<td>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.</td>
<td>4 AMBV-ALS</td>
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### Trauma Response Area by County

<table>
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<th>County</th>
<th>Trauma Response Area Number</th>
<th>Name of Agency Responding in Trauma Response Area</th>
<th>Description of Trauma Response Area’s Geographic Boundaries</th>
<th>Number of Verified Services in the response area</th>
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</thead>
<tbody>
<tr>
<td>Lewis Co</td>
<td>#17</td>
<td>Lewis Co FD #17</td>
<td>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.</td>
<td>0 AIDV-ALS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 AMBV-ILS</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>1 AMBV-BLS</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>0 AMBV-ALS</td>
</tr>
<tr>
<td>North Pacific</td>
<td>#1</td>
<td>Raymond FD South Beach RFA</td>
<td>City of Raymond, City of South Bend, Pacific Co 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 Co in and around the community of Brooklyn in the northeast corner of Pacific Co.</td>
<td>0 AIDV-ILS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0 AIDV-BLS</td>
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<td></td>
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<td>0 AIDV-ALS</td>
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<td></td>
<td>0 AMBV-BLS</td>
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<td>2 AMBV-ALS</td>
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<table>
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<tr>
<th>County</th>
<th>Trauma Response Area Number</th>
<th>Name of Agency Responding in Trauma Response Area</th>
<th>Description of Trauma Response Area's Geographic Boundaries</th>
<th>Number of Verified Services in the response area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pierce</td>
<td>#1</td>
<td>Ruston FD&lt;br&gt;Steilacoom PS&lt;br&gt;PCFD #13&lt;br&gt;PCFD #14&lt;br&gt;PCFD #27&lt;br&gt;McNeil Isl FD&lt;br&gt;PCFD #3&lt;br&gt;PCFD #5&lt;br&gt;PCFD #16&lt;br&gt;PCFD #22&lt;br&gt;Central Pierce F&amp;R&lt;br&gt;Tacoma FD&lt;br&gt;AMR&lt;br&gt;Falck NW&lt;br&gt;Rural Metro</td>
<td><strong>Area #1 (North)</strong>&lt;br&gt;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.</td>
<td>0 AIDV-ILS&lt;br&gt;2 AIDV-BLS&lt;br&gt;0 AIDV-ALS&lt;br&gt;0 AMBV-ILS&lt;br&gt;4 AMBV-BLS&lt;br&gt;9 AMBV-ALS</td>
</tr>
<tr>
<td>Pierce</td>
<td>#2</td>
<td>Steilacoom PS&lt;br&gt;JBLM FD&lt;br&gt;Dupont FD&lt;br&gt;PCFD #3&lt;br&gt;PCFD #17&lt;br&gt;PCFD #21&lt;br&gt;Central Pierce F&amp;R&lt;br&gt;AMR&lt;br&gt;Falck NW&lt;br&gt;MAMC&lt;br&gt;Rural Metro</td>
<td><strong>Area #2 (South)</strong>&lt;br&gt;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</td>
<td>0 AIDV-ILS&lt;br&gt;1 AIDV-BLS&lt;br&gt;0 AIDV-ALS&lt;br&gt;0 AMBV-ILS&lt;br&gt;1 AMBV-BLS&lt;br&gt;10 AMBV-ALS</td>
</tr>
<tr>
<td>County</td>
<td>Trauma Response Area Number</td>
<td>Name of Agency Responding in Trauma Response Area</td>
<td>Description of Trauma Response Area's Geographic Boundaries</td>
<td>Number of Verified Services in the response area</td>
</tr>
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<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Pierce</td>
<td>#3</td>
<td>PCFD #26, Carbonado FD, PCFD #14, PCFD #23, PCFD #17, PCFD #18, PCFD #21, PCFD #22, Buckley FD, Central Pierce F&amp;R AMR, Falck NW, Rural Metro</td>
<td><strong>Area #3 (East)</strong>&lt;br&gt;Area #3 is bordered by Thurston County in SW at a point where an imaginary line running south along 8th 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 1st Ave E west through Auburn, then along County Line west to 384th 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 8th Ave E, then south along an imaginary line to Thurston county border at Nisqually River.</td>
<td>0 AIDV-ILS, 3 AIDV-BLS, 0 AIDV-ALS, 0 AMBV-ILS, 2 AMBV-BLS, 9 AMBV-ALS</td>
</tr>
<tr>
<td>County</td>
<td>Trauma Response Area Number</td>
<td>Name of Agency Responding in Trauma Response Area</td>
<td>Description of Trauma Response Area’s Geographic Boundaries</td>
<td>Number of Verified Services in the response area</td>
</tr>
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<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Thurston</td>
<td>#1</td>
<td>City of Olympia FD Lacey FD #3 Tumwater FD AMR</td>
<td>City of Olympia jurisdictional boundaries</td>
<td>0 AIDV-ILS 0 AIDV-BLS 0 AIDV-ALS 0 AMBV-ILS 1 AMBV-BLS 3 AMBV-ALS</td>
</tr>
<tr>
<td>Thurston</td>
<td>#2</td>
<td>City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance</td>
<td>City of Tumwater jurisdictional boundaries &amp; FD# 15 jurisdictional boundaries</td>
<td>0 AIDV-ILS 0 AIDV-BLS 0 AIDV-ALS 0 AMBV-ILS 1 AMBV-BLS 3 AMBV-ALS</td>
</tr>
<tr>
<td>Thurston</td>
<td>#3</td>
<td>City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance</td>
<td>City of Lacey jurisdictional boundaries &amp; FD# 3 jurisdictional boundaries</td>
<td>0 AIDV-ILS 0 AIDV-BLS 0 AIDV-ALS 0 AMBV-ILS 1 AMBV-BLS 3 AMBV-ALS</td>
</tr>
<tr>
<td>Thurston</td>
<td>#4</td>
<td>SE Thurston FA City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance</td>
<td>SETRFA City of Yelm jurisdictional boundaries &amp; FD# 2 jurisdictional boundaries &amp; City of Rainer jurisdictional boundaries &amp; FD# 4 jurisdictional boundaries</td>
<td>0 AIDV-ILS 1 AIDV-BLS 0 AIDV-ALS 0 AMBV-ILS 1 AMBV-BLS 3 AMBV-ALS</td>
</tr>
<tr>
<td>Thurston</td>
<td>#5</td>
<td>SE Thurston FA City of Olympia FD Lacey FD #3 Tumwater FD Olympic Ambulance</td>
<td>SETRFA City of Yelm jurisdictional boundaries &amp; FD# 2 jurisdictional boundaries &amp; City of Rainer jurisdictional boundaries &amp; FD# 4 jurisdictional boundaries</td>
<td>0 AIDV-ILS 1 AIDV-BLS 0 AIDV-ALS 0 AMBV-ILS 1 AMBV-BLS 3 AMBV-ALS</td>
</tr>
<tr>
<td>County</td>
<td>Trauma Response Area Number</td>
<td>Name of Agency Responding in Trauma Response Area</td>
<td>Description of Trauma Response Area’s Geographic Boundaries</td>
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</tr>
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Numbers are current as of March 1, 2019
West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 7

Approved EMS Education and Training Programs
### WEST REGION TRAINING PROGRAMS APPROVED BY WASHINGTON STATE DEPARTMENT OF HEALTH

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<thead>
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<th>Credential #</th>
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<td>Olympia</td>
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West Region Emergency Medical Services & Trauma Care System Strategic Plan

Appendix 8

Patient Care Procedures (PCPs)
Who To Contact

**Grays Harbor and N. Pacific Counties**
Medical Program Director  Julie Buck, MD (360) 533 6038
Grays Harbor County EMS Council  Sharryl Bell (360) 532 2067

**Lewis County**
Medical Program Director  Peter McCahill, MD
Lewis County EMS Council  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  Anna Lee Drewry (360) 704 2783

**WA Department of Health**
Office of Community Health Systems, EMS
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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WEST REGION PATIENT CARE PROCEDURES

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<td>Alternate Destination Transport</td>
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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) verified prehospital services that transports trauma patients must:

(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 this WAC, see 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

Trauma Patient Destination- Trauma Triage/Transport (reviewed 3/6/19)

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. Each county has looked at its medical, environmental and physical resources and developed training and/or protocols to determine trauma patient destination.

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 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 control or trauma receiving facilities will keep accurate recorded communications 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.
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)

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

STEP 2
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
- Paraesthesia

YES

Assess Mechanism of Injury & Evidence of High-Energy Impact

STEP 3
- Falls
  - Adults: > 20 ft (1 story = 10 ft)
  - Children: ≥0 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

YES

Assess Special Patient or System Considerations

STEP 4
- 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

When in Doubt, Transport to a Trauma Center!

DOH 530-143 August 2012 - Washington State Department of Health Prehospital Trauma Triage (Destination) Procedure
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.
B. PIERCE COUNTY
PREHOSPITAL TRAUMA TRIAGE (DESTINATION) PROCEDURES

STEP 1  Measure Vital Signs & Level of Consciousness
- Glasgow Coma Scale ≤13 or
- Systolic blood pressure <90 mmHg or
- Respiratory rate <10 or >29 breaths/minute (<20 or ≥29 breaths/minutes in infant aged <1 year), or need for ventilatory support

**YES**
Take patient to the nearest Level I or Level II trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures.

**NO**
If prehospital personnel are unable to effectively manage airway, consider rendezvous with ALS, or intermediate stop at nearest facility capable of immediate definitive airway management.

STEP 2  Assess Anatomy of Injury
- All penetrating injuries to head, or neck, or torso, or extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long-bone fractures
- Crushed, or degloved, or mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

**YES**
Take patient to Harborview Medical Center

**NO**

STEP 3  Assess Mechanism of Injury & Evidence of High-Energy Impact
- Falls
  - Adults and Children ≥15 years: >20 feet (one story is equal to 10 feet)
  - Children <15 years: >10 feet or 2-3 times the height of the child
- High-Risk Vehicle Crash
  - Intrusion, including roof: >12 inches occupant site or >18 inches any site
  - Ejection (partial or complete) from vehicle
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with high risk of injury
- Vehicle v. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
- Motorcycle crash >20 mph

**YES**
Take patient to the nearest 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.

**NO**

STEP 4  Assess Special Patient or System Considerations
- Older Adults
  - Risk of injury death increases 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 centers
- Anticoagulation and Bleeding Disorders
  - Patients with head injury are at high risk for rapid deterioration
- Burns
  - Without other trauma mechanism: Triage to burn facility
  - With trauma mechanism: Triage to trauma center
- Pregnancy >20 Weeks
- EMS Provider Judgment

**YES**
Contact medical control or receiving facility and consider transport to a trauma center or a specific resource hospital.

**NO**
Transfer according to local protocol

When in Doubt, Transport to a Trauma Center!
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 nearest, 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 nearest, 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 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. Transport to the nearest 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.

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 (PCPs) and Local County Operating Procedures (COPs) provide additional detail about the appropriate hospital destination. PCPs and COPs 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.
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.
**Patient Care Procedure #4 (continued)**

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 *(reviewed 3/6/19)*

**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: https://www.doh.wa.gov/Portals/1/Documents/Pubs/530142.pdf
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
5. Pierce County Burn Plan http://www.piercecountywa.org/ems
7. WMD Emergency Medical Services Training (EMS) face-to-face at http://cdp.dhs.gov/coursesems.html
8. FEMA’s NIMS training link: 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

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Receive dispatch</td>
</tr>
<tr>
<td>2</td>
<td>Respond as directed</td>
</tr>
<tr>
<td>3</td>
<td>Arrive at scene &amp; Establish Incident Command (IC)</td>
</tr>
<tr>
<td>4</td>
<td>Scene Assessment and size-up</td>
</tr>
<tr>
<td>5</td>
<td>Determine if mass casualty conditions exist</td>
</tr>
<tr>
<td>6</td>
<td>Implement county MCI plan</td>
</tr>
<tr>
<td>7</td>
<td>Request additional resources as needed</td>
</tr>
</tbody>
</table>

The dispatch center shall coordinate notification and dispatch of appropriate agencies and resources to the scene. Notification of the Disaster Medical Control Center (DMCC) will be according to county protocol. 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.

For the most current State of Washington Prehospital Cardiac Triage Destination Procedure go to:
https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf
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 Immediate Criteria
☐ Post cardiac arrest with return of spontaneous circulation
☐ Hypotension or pulmonary edema
☐ EKG positive for STEMI (if available)

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.

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 w/in 30 minutes

ALS
  - Level I Cardiac Hospital w/in 60 minutes

Level I Cardiac Hospital 30 minutes closer than Level I?
  - Yes: Go to Level I Cardiac Hospital and alert destination hospital en route ASAP
  - No: Go to closest Level II Cardiac Hospital and alert destination hospital on route ASAP

Level II Cardiac Hospital 60 minutes closer than Level I?
  - Yes: Go to Level II Cardiac Hospital and alert destination hospital on 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.

DOH 346-050 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 (UAINSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure?
A. Assess applicability for triage – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the “Assess Immediate Criteria” box. NOTE: Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.
B. Assess immediate criteria – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to “Assess Transport Time and Determine Destination” box. If the patient does not meet immediate criteria, or you can’t do an ECG, go to the “Assess High Risk Criteria” box.
C. Assess high risk criteria – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:
  - 3 or more CAD (coronary artery disease) risk factors:
    - Age ≥ 55: epidemiological data for WA show that incidence of heart attack increases at this age
    - Family history: father or brother with heart disease before 55, or mother or sister before 65
    - High blood pressure: ≥140/90, or patient/family report, or patient on blood pressure medication
    - High cholesterol: patient/family report or patient on cholesterol medication
    - Diabetes: patient/family report
    - Current smoker: patient/family report.
  - Aspirin use in last 7 days: any aspirin use in last 7 days.
  - ≥2 anginal events in last 24 hours: 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
  - Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery.
  - ST deviation ≥ 0.5 mm (if available): ST depression ≥ 0.5 mm is significant; transient ST elevation ≥ 0.5 mm for < 20 minutes is treated as ST-segment depression and is high risk; ST elevation > 1 mm for more than 20 minutes places these patients in the STEMI treatment category.
  - Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.
D. Determine destination – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For BLS, this is generally within 30 minutes transport time, and for ALS, generally 60 minutes transport time. See below for further guidance. Regional patient care procedures and county operating procedures may provide additional guidance.
E. Inform the hospital en route so staff can activate the cath lab and call in staff if necessary.

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

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

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

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

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

For the most current State of Washington Prehospital Stroke Triage Destination Procedure go to: https://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf
**State of Washington**

**Prehospital Stroke Triage Destination Procedure**

**STEP 1: Assess Likelihood of Stroke**
- Numbness or weakness of the face, arm, or leg, especially on one side of the body
- Confusion, trouble speaking, or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance, or coordination
- Severe headache with no known cause

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

**STEP 2: Perform F.A.S.T. Assessment** *(positive if any of Face/Arms/Speech abnormal)*
- **Face:** Unilateral facial droop
- **Arms:** Unilateral arm drift or weakness
- **Speech:** Abnormal or slurred
- **Time:** Best estimate of Time Last Known Well = __________________________

*If FAST negative, transport per regional/county operating procedures*

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

<table>
<thead>
<tr>
<th>Facial Droop:</th>
<th>Absent 0</th>
<th>Present 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arm Drift:</td>
<td>Absent 0</td>
<td>Drifts 1</td>
</tr>
<tr>
<td>Grip Strength:</td>
<td>Normal 0</td>
<td>Weak 1</td>
</tr>
</tbody>
</table>

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

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DOH 530-182 February 2019
STEP 4: Determine Destination: Time Last Known Well + Stroke Severity Score

**Time Last Known Well ≤ 6 Hours** (Provide stroke alert to destination hospital ASAP)

- 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.

**Time Last Known Well > 24 hours** (regardless of Stroke Severity Score, alert destination hospital)

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

- 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 30-60 min greater than to a nearer Level II or Level III Stroke Center. Regional care procedures and county operating procedures may provide additional guidance.

**Time Last Known Well 6-24 hours** (Provide stroke alert to destination hospital ASAP)

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.
The purpose of the Prehospital Stroke Triage and Destination Procedure is to identify stroke patients in the field and take them to the most appropriate hospital, which might not be the nearest hospital. Stroke treatment is time-critical – the sooner patients are treated, the better their chances of survival and recovering function.

For strokes caused by a blocked blood vessel in the brain (ischemic, the majority of strokes), clot-busting medication (tPA) must be administered within 4.5 hours from the time the patient was last known well, a treatment that can be given at WA DOH Level 1, 2 or 3 stroke centers (for a list of categorized hospitals, please click here).

If a patient presents to EMS with a severe stroke, they are more likely to have blockage of a large vessel and can benefit from mechanical clot retrieval (thrombectomy). Thrombectomy must begin by 24 hours since last known well, and is a more complex intervention, only available in Level I and a small number of Level II stroke centers.

There are 3 key elements to determine the appropriate destination hospital:

- **FAST stroke screen** to identify a patient with a high probability of stroke.
- **Stroke Severity Score** to determine if a patient meets criteria for “severe” stroke.
- **Time since Last Known Well (LKW)** which helps determine eligibility for tPA and thrombectomy.

**STEPS to determine destination:**

**Do a FAST Stroke Screen Assessment:** (Facial droop, Arm drift, Speech changes, Time since LKW) is a simple way to tell if someone might be having a stroke. If FAST is negative, stroke is less likely, and standard destination procedures apply. If FAST is positive (face or arms or speech is abnormal), it’s likely the patient is having a stroke and the EMS provider moves on to assessing stroke severity.

**Assess Stroke Severity Score:** 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 $\geq 4$ is interpreted as “severe.”

**Determine time since LKW:** It is important to use the LKW time as opposed to when symptoms were first noticed. If a patient woke up in the morning with symptoms and was well when they went to bed, time LKW is the time they went to bed. If stroke symptoms occur when the patient is awake, LKW could be the same time the symptoms started if the patient or a bystander noticed the onset. LKW time could also be prior to symptoms starting if a patient delays reporting symptoms or, for example, someone discovers a patient with symptoms but saw them well 2 hours prior.

**Determine Destination:**

- **Time since LKW $\leq$ 6 hours and “Severe” (score $\geq 4$):** This group benefits from preferential transport to a thrombectomy stroke center. The patient should be taken directly to the
nearest thrombectomy stroke center provided it is no more than 15 extra minutes travel compared to the nearest stroke center.

- **Time since LKW is > 24 hours (regardless of severity score):** These patients should be taken to nearest Level I or II stroke center provided it is no more than 15 minutes greater than to a nearer Level III stroke center.
- **Time since LKW 6-24 hours but NOT “Severe”:** These patients should be taken directly to the nearest Level I or Level II stroke center provided it is no more than 15 extra minutes travel compared to a nearer Level 3 stroke center.
- **Time since LKW 6-24 hours AND “Severe”**: Transport to nearest Level I or II Stroke Center with endovascular capability provided transport time is no more than 30-60 min greater than to a nearer Level II or Level III Stroke Center. Regional care procedures and county operating procedures may provide additional guidance.

**Notification:** Immediately notify the destination hospital of incoming stroke. If the patient is within 6 hours LKW, call a stroke alert according to county operating procedures or locally determined protocol.

**Document:** key medical history, medication list and next of kin phone contacts; time on scene; FAST assessment and results (or reason why not); blood glucose level; LKW time (including unknown); and whether the hospital was notified from the field and if it was a stroke alert.
D. PIERCE COUNTY
PREHOSPITAL STROKE TRIAGE (DESTINATION) PROCEDURES

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 county operating procedures

STEP 2: Perform B.E. F.A.S.T. Assessment (positive if any are abnormal)
- Balance: Sudden trouble with balance or coordination
- Eyes: Sudden blurred or double vision or loss of vision in one or both eyes
- Face: Unilateral facial droop
- Arms: Unilateral arm drift or weakness
- Speech: Abnormal or slurred
- Time: Best estimate of Time Last Known Well = _______

If B.E. F.A.S.T. negative transport per county operating procedures

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

Facial Droop: Absent 0  Present 1
Arm Drift: Absent 0 Drifts 1 Falls Rapidly 2
Grip Strength: Normal 0 Weak 1 No Grip 2
Total Stroke Severity Score = _____ (max. 5 points)

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

Time Last Known Well is < 6 hours
(Provide stroke alert to destination hospital ASAP)

Time Last Known Well is >24 hours
(regardless of Stroke Severity Score, alert destination hospital)

Time Last Known Well is 6-24 hours
(Provide stroke alert to destination hospital ASAP)

NO

Stroke Severity Score 4 or more?

YES

NO

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

Transport to nearest Level I or II Stroke Center with endovascular capability provided transport time is no more than 30-60 minutes greater than to a nearer Level II or Level III Stroke Center.

DOH 530-182 February 2019- PC April 2019
PIERCE COUNTY

PREHOSPITAL STROKE TRIAGE (DESTINATION) PROCEDURES

The purpose of the Prehospital Stroke Triage and Destination Procedure is to identify stroke patients in the field and take them to the most appropriate hospital, which might not be the nearest hospital. Stroke treatment is time-critical – the sooner patients are treated, the better their chances of survival and recovering function.

For strokes caused by a blocked blood vessel in the brain (ischemic, the majority of strokes), clot-busting medication (tPA) must be administered within 4.5 hours from the time the patient was last known well, a treatment that can be given at WA DOH Level 1, 2 or 3 stroke centers (for a list of categorized hospitals, please click here).

If a patient presents to EMS with a severe stroke, they are more likely to have blockage of a large vessel and can benefit from mechanical clot retrieval (thrombectomy). Thrombectomy must begin by 24 hours since last known well, and is a more complex intervention, only available in Level I and a small number of Level II stroke centers.

There are 3 key elements to determine the appropriate destination hospital:

- **BE 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:**

1) **Do a BE FAST Stroke Screen Assessment:** (Balance, Eyes, Facial droop, Arm drift, Speech changes, Time since LKW) is a simple way to tell if someone might be having a stroke. If BE FAST is negative, stroke is less likely, and standard destination procedures apply. If BE FAST is positive (balance or vision or 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.

2) **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.

3) **Add up the points:** A score ≥ 4 is interpreted as “severe.”

4) **Determine time since LKW:** It is important to use the LKW time as opposed to when symptoms were first noticed. If a patient woke up in the morning with symptoms and was well when they went to bed, time LKW is the time they went to bed. If stroke symptoms occur when the patient is awake, LKW could be the same time the symptoms started if the patient or a bystander noticed the onset. LKW time could also be prior to symptoms starting if a patient delays reporting symptoms or, for example, someone discovers a patient with symptoms but saw them well 2 hours prior. Report by actual clock hour, not by ‘30 prior to arrival’, etc.

5) **Determine Destination:**
   - **Time since LKW ≤ 6 hours and “Severe” (score ≥ 4):** 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.
   - **Time since LKW > 24 hours (regardless of severity score):** Transport to the nearest Level I or Level II stroke center provided it is no more than 15 extra minutes travel than to a nearer Level III stroke center.
   - **Time since LKW 6 – 24 hours AND “Severe”**: Transport to the nearest Level I or Level II stroke center with endovascular capability provided transport time is no more than 30-60 extra minutes travel to a nearer Level II or Level III stroke center.
   - **Time since LKW 6 – 24 hours but NOT “Severe”:** Transport to the nearest Level I or Level II stroke center provided it is no more than 15 extra minutes travel compared to a nearer Level III stroke center.

6) **Notification:** Immediately notify the destination hospital of incoming stroke.

7) **Document:** key medical history, medication list and next of kin phone contacts; time on scene; BE 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.

DOH 530-182 February 2019- PC June 2019

2019-21 West Region Strategic Plan
Patient Care Procedure #11

Mental Health/Chemical Dependency Alternate Destination Transport Procedure
(reviewed 3/6/19)

STANDARD

In the state of Washington, Emergency Medical Services (EMS) licensed ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170.

OBJECTIVES

In the West Region, licensed EMS ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170, if approved by their county Medical Program Director (MPD).

PROCEDURES

1. Participation
   a. Prehospital EMS agency participation is voluntary unless directed by the county MPD.
   b. Receiving mental health and/or chemical dependency facility participation is voluntary.

2. Participating agencies and facilities will adhere to the WA State Department of Health Guideline for Implementation of SHB 1721.

3. Facilities that participate will work with the county MPD and EMS agencies to establish criteria that all participating facilities and EMS agencies will follow for accepting patients.

4. Prior to implementing and during ongoing operation of transport to alternate receiving facilities the following must be in place with DOH approval:
   a. County operating procedure;
   b. MPD patient care protocol
   c. MPD specialized training for EMS providers participating in transport programs in accordance with RCW 70.168.170.

IMPLEMENTATION

As of December 6, 2017 the MPD and the local EMS and Trauma Care Council must develop a county operating procedure (COP)s. The COP must be consistent with the WA State Department of Health Guideline for Implementation of SHB 1721 and this PCP.

QUALITY ASSURANCE

The local EMS Council and MPD must establish a quality assurance process to monitor programs.
West Region Emergency Medical Services
& Trauma Care System Strategic Plan

Appendix 9

A. West Region Quality Improvement Forum Plans: Trauma & Cardiac/Stroke
B. West Region EMS & Trauma Care Council Bylaws
C. 10 Leading Causes of Injury Deaths by Age Group, West Region 2013-2017
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
    o 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
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.

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

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
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
    - Lessons learned

• **Component 3: Focused cases reviews:**
  Designated agencies present cardiac and stroke 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 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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2019-21 West Region Strategic Plan
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.

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
WEST REGION EMERGENCY MEDICAL SERVICES AND TRAUMA CARE COUNCIL

BYLAWS

REVISED: 6/22/15

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),</td>
<td></td>
</tr>
<tr>
<td>Thurston (1)</td>
<td>5</td>
</tr>
<tr>
<td>Prehospital: Grays Harbor (1), Lewis (1), Pierce (2),</td>
<td></td>
</tr>
<tr>
<td>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>
<td>1</td>
</tr>
</tbody>
</table>
Emergency Management...............................................1
Dispatch.................................................................1
Mason County (non-voting member)..............................1
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.
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.
# 10 Leading Causes of Injury Deaths by Age Group, West EMS & Trauma Region 2013-2017

Listed by: Death Counts and Death Rates per 100,000 people (rates in parentheses)

<table>
<thead>
<tr>
<th>Rank</th>
<th>&lt;1 yr</th>
<th>1-4 yr</th>
<th>5-9 yr</th>
<th>10-14 yr</th>
<th>15-24 yr</th>
<th>25-34 yr</th>
<th>35-44 yr</th>
<th>45-54 yr</th>
<th>55-64 yr</th>
<th>65+ yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unintentional Suffocation 24 (29.20)</td>
<td>Unintentional Fire/Burn 6**</td>
<td>Unintentional Drowning 3**</td>
<td>Self-Inflicted Firearm 6**</td>
<td>Unintentional MV Traffic 96 (11.72)</td>
<td>Unintentional Poisoning 174 (20.65)</td>
<td>Unintentional Poisoning 215 (24.82)</td>
<td>Unintentional Poisoning 201 (23.55)</td>
<td>Unintentional Falls 718 (76.64)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Assault Unspecified 5**</td>
<td>Assault Unspecified 5**</td>
<td>Unintentional MV Traffic 2**</td>
<td>Self-Inflicted Firearm 64 (7.81)</td>
<td>Self-Inflicted Firearm 98 (11.56)</td>
<td>Self-Inflicted Firearm 96 (11.94)</td>
<td>Self-Inflicted Firearm 54 (9.70)</td>
<td>Self-Inflicted Firearm 128 (13.66)</td>
<td>Self-Inflicted Firearm 58 (10.92)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Unintentional MV Traffic 2**</td>
<td>Unintentional Other Pedestrian 3**</td>
<td>Unintentional Poisoning 2**</td>
<td>Self-Inflicted Suffocation 5**</td>
<td>Unintentional Poisoning 60 (7.32)</td>
<td>Unintentional MV Traffic 90 (10.62)</td>
<td>Unintentional MV Traffic 84 (9.70)</td>
<td>Unintentional MV Traffic 102 (10.74)</td>
<td>Unintentional Suffocation 110 (11.74)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Assault Other Specified 2**</td>
<td>Unintentional MV Traffic 2**</td>
<td>Unintentional Drowning 2**</td>
<td>Self-Inflicted Suffocation 57 (6.96)</td>
<td>Unintentional Suffocation 77 (9.08)</td>
<td>Self-Inflicted Suffocation 52 (6.47)</td>
<td>Self-Inflicted Poisoning 66 (7.62)</td>
<td>Unintentional Falls 61 (7.15)</td>
<td>Unintentional MV Traffic 60 (6.40)</td>
<td></td>
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<tr>
<td>5</td>
<td>Unintentional Other Transportation 2**</td>
<td>Assault Firearm 36 (4.39)</td>
<td>Assault Firearm 41 (4.84)</td>
<td>Self-Inflicted Poisoning 42 (4.85)</td>
<td>Self-Inflicted Poisoning 51 (5.87)</td>
<td>Self-Inflicted Poisoning 60 (5.55)</td>
<td>Unintentional Unspecified 5**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Other/Undetermined Fire/Burn 2**</td>
<td>Unintentional Drowning 10**</td>
<td>Self-Inflicted Poisoning 31 (3.66)</td>
<td>Assault Firearm 22 (2.74)</td>
<td>Assault Firearm 33 (3.81)</td>
<td>Self-Inflicted Suffocation 40 (4.69)</td>
<td>Self-Inflicted Poisoning 52 (5.55)</td>
<td>Unintentional Poisoning 44 (4.70)</td>
<td>Unintentional Poisoning 57 (4.70)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Self-Inflicted Poisoning 7**</td>
<td>Unintentional Drowning 15 (1.77)*</td>
<td>Unintentional Drowning 16 (1.99)</td>
<td>Assault Firearm 1 (2.66)</td>
<td>Unintentional Drowning 21 (2.46)</td>
<td>Unintentional Poisoning 44 (4.70)</td>
<td>Unintentional Poisoning 57 (4.70)</td>
<td>Unintentional Poisoning 60 (6.40)</td>
<td>Unintentional Poisoning 60 (5.55)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Self-Inflicted Falls 7**</td>
<td>Unintentional Suffocation 9**</td>
<td>Unintentional Falls 10**</td>
<td>Unintentional Suffocation 15 (1.73)*</td>
<td>Unintentional Suffocation 17 (1.99)</td>
<td>Unintentional Poisoning 44 (4.70)</td>
<td>Unintentional Poisoning 57 (4.70)</td>
<td>Unintentional Poisoning 60 (6.40)</td>
<td>Unintentional Poisoning 60 (5.55)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Unintentional Falls 6**</td>
<td>Other/Undetermined Firearm 9**</td>
<td>Unintentional Other Transported 14 (1.62)*</td>
<td>Unintentional Other Specified 11**</td>
<td>Unintentional Natural Environment 17 (1.81)</td>
<td>Unintentional Poisoning 44 (4.70)</td>
<td>Unintentional Poisoning 57 (4.70)</td>
<td>Unintentional Poisoning 60 (6.40)</td>
<td>Unintentional Poisoning 60 (5.55)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>k</td>
<td>Unintentional Other Transportation 6**</td>
<td>Other/Undetermined Poisoning 8**</td>
<td>Other/Undetermined Poisoning 12 (1.39)*</td>
<td>Unintentional Drowning 16 (1.71)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total injury related deaths: 36 22 12 28 385 594 582 668 689 1382

Rate per 100,000: 43.8 6.6 2.9* 6.8 47 70.1 72.4 77.1 80.7 147.5

95% CI: 30.7, 60.6 4.2, 10.1 1.5, 5 4.6, 9.9 42.4, 51.9 64.6, 76.7 66.7, 78.5 71.4, 83.2 74.8, 87 139.8, 155.5

*The Relative Standard Error is between 25-30%, the estimate is not reliable.
** The Relative Standard Error is greater than 30%, the estimate is suppressed.