NORTH CENTRAL REGION EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

S T R A T E G I C P L A N

July 1, 2015 – June 30, 2017

Submitted by the North Central Region EMS and Trauma Care Council
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INTRODUCTION

The North Central Region is comprised of Chelan, Douglas, Grant and Okanogan Counties of Washington State. The region covers 12,692 square miles with a population of approximately 248,600 residents. The region is primarily rural in nature with the Greater Wenatchee and Moses Lake areas being the largest population demographic. There are 49 licensed (L) and verified (V) aid and ambulance response agencies within North Central Region; 33 of which are all volunteer based response, with 54% of the regions providers being volunteer.

Rural EMS agencies continue to face a challenge in recruitment and retention of volunteer providers with an aging volunteer population and increasing costs for initial courses. This impact on agencies creates a challenge in meeting the response and transport needs of the community without prevailing upon a neighboring EMS agency for assistance. Mobile Integrated Healthcare may provide an opportunity for communities to address those challenges.

The current Min/Max numbers were reviewed for both EMS Agencies and designated trauma services in preparation for the 2015-2017 plan; no changes were identified, see Appendix 1 for Min/Max.

Prehospital Verified & Licensed Services*

County	ALS Amb	ILS Amb	BLS Amb	BLS Aid
Chelan	4 V		2 V	6 V 4 L
Douglas**			3 V	2 V
Grant	3 V		7 V	6 V € 1 L
Okanogan	2 V	1 V	4 V	4 V

* Numbers are current as of June 2015

**ALS Amb services provided in Douglas County by mutual aid agreements with Chelan county ALS Amb services

V = Verified Trauma

L = Licensed; not trauma verified

€ Grant County has two BLS response areas that depend on neighboring agencies to assist with coverage due expired agency licensure and lack of responders.

Designated Trauma Services*

Adult Level III	Adult Level IV	Adult Level V	Pediatric Level III	Rehab Level II
1	7	2	1	1

* Numbers are current as of June 2015

Categorized Cardiac and Stroke Facilities*

Cardiac Level I	Cardiac Level II	Stroke Level II	Stroke Level III
1	8	1	8

- Numbers are current as of June 2015

The North Central Region was established as part of the Emergency Medical Service (EMS) and Trauma Care System Legislation in 1990. RCW and WAC states Regional Council membership is comprised of mandatory membership positions: Local Government, Prehospital, and Hospital agencies. Additional positions can be Medical Program Directors, Law Enforcement, Tribal, Dispatch, Emergency Management, Local Elected Official and Consumers. RCW and WAC authorize counties to have local EMS & Trauma Care Councils and provide EMS & Trauma System leadership. Local County membership parallels the membership of the Regional Council. The Local Councils provide input and recommend membership to represent their local EMS & Trauma System on the Regional Council. The North Central Region's Local Councils include: Greater Wenatchee EMS Council (Chelan & South Douglas Counties), Okanogan/North Douglas EMS Council (Okanogan and North Douglas Counties), and Grant County EMS Council.

The North Central Region's Strategic EMS & Trauma Care System Plan is comprised of goals adapted from the State Strategic EMS & Trauma Care System Plan. The Regional Council utilizes input and recommendations from the local council representatives and stakeholders to meet the goals of the State and Region through development of applicable objectives and strategies.

The North Central Region has established committees and workgroups to address Recruitment and Retention, Education for EMS Providers, Injury and Violence Prevention, and Public Information:

- Executive/Finance Committee: Comprised of the Council President, Vice President, Treasurer, Secretary, and the Chair of any standing Committee. Provides oversight of Administration and governance of the Regional Council.

- Training and Education Committee: Comprised of members of the Regional and Local Council to review regional training needs, develop regional training

programs based on the needs assessment, and quality improvement for training, and education to improve patient outcomes.

- Prehospital and Transportation Workgroup: Comprised of members of the Regional and Local Council to review, revise, and provide education on Minimum and Maximum numbers, Regional Patient Care Procedures, and County Operating Procedures.

- Injury and Violence Prevention Workgroup: Comprised of members of the Regional and Local Council, Regional QI Committee organized by the highest level designated hospital to collect data and analyze patterns and trends in patient care, and IVP Partners to review regional injury and violence statistics; development of regional strategic plan goals and objectives to correlate with highest risk populations in our region for targeted interventions, injury prevention, and public education.

- Mobile Integrated Healthcare Workgroup: Comprised of members of the Regional and Local Council, Medical Program Directors, Critical Access Hospital, Hospital Based EMS Agencies, Emergency Room Trauma Coordinators, and other system stakeholders who participate in State and National Initiatives for a Community based Paramedicine and/or Mobile Integrated Healthcare System that promotes collaboration of healthcare partners within the North Central Region to address community challenges for care and/or transport of patients.

- Customer Service Committee: Comprised of members of the Regional Council for recruitment of Council membership, membership recognition, board development education, and public information and awareness of the EMS system in collaboration with the Department of Health Plan.

The Regional Council has adopted the following DBA name, mission and motto that are incorporated into the regional planning process and vision for the future of North Central Region.

DBA Name: North Central Emergency Care Council

Mission: "To Promote and Support a Comprehensive Emergency Care System"

Vision: "Getting the Right Patient, to the Right Place in the Right Amount of Time"

GOAL 1

A sustainable regional system of emergency care services that provides appropriate capacity and distribution of resources to support high-quality trauma, cardiac and stroke patient care.

It is imperative our regional partners be included in the discussion and decisions of distribution of resources throughout our region. In an effort to maintain on-going, free-flowing conversation, we involve our local EMS councils and regional Trauma and Emergency Cardiac and Stroke CQI partners to provide input on designation and min/max distribution. This approach has resulted in long-term partnerships between our regional system partners and an understanding of local and regional prehospital and hospital issues.

There are ten designated trauma services in North Central Region. Confluence Health-Central Washington Hospital campus, located in Wenatchee is the only Level III and the highest designated hospital facility in the region, as well as the only facility with Pediatric Designation. The majority of our trauma designated facilities are in rural communities with a geographic distance of 75 -100 miles from each other. The North Central Region relies on the Department of Health's standardized methodology to determine the need for minimum and maximum numbers for both trauma service designation and EMS agency verification. The Department has categorized levels of Cardiac and Stroke services. The Regional and County Councils have developed regional Patient Care Procedures and County Operating Procedures for patient transport to trauma services and cardiac and stroke services. The Regional Council relies on input and recommendations form County Councils and County Medical Program Directors to identify and recommend minimum and maximum numbers for Prehospital levels of licensed and verified agencies, as well as trauma response area maps.

Objective 1. By November 2016, Regional Council will utilize Department of Health standardized methodology to determine minimum and maximum numbers and levels of trauma designated services in the North Central Region and forward any recommended revisions to the Department of Health. *Open designation letter 1/2017*	**Strategy 1.** By July 2016, Regional Council Chair will appoint a representative to be the Regional Council liaison at the Regional QI Committee meetings.
	Strategy 2. By August 2016, Regional Council representative will request time on Regional QI agenda to present current trauma designated min/max numbers and request input from Regional QI committee for any suggested revisions.
	Strategy 3. By October 2016, Regional Council representative will report Regional QI recommendations to Regional Council for discussion.
	Strategy 4. By November 2016, Regional Council will consider recommended revisions of current min/max numbers to be included in the 2017-2019 Regional Strategic Plan.

	Strategy 5. By November 2016, Regional Council will forward any recommended trauma designated min/max revisions to Department of Health.
Objective 2. By March 2017, the Regional Council will utilize the Washington State Department of Health standardized methodology to determine minimum and maximum numbers and levels of verified service types in each county and provide recommendations to the Department of Health.	**Strategy 1.** By October 2016, the Prehospital and Transportation Workgroup will provide the Department of Health Standardized Methodology to Local EMS Councils for determining min/max numbers, levels, and types of Prehospital verified services.
	Strategy 2. By December 2016, Prehospital and Transportation Workgroup will request Local EMS Council submit recommended min/max changes for review.
	Strategy 3. By February 2017, Prehospital and Transportation Workgroup will report any Local EMS Council min/max recommended changes to the Regional Council for approval.
	Strategy 4. By February 2017, Regional Council will consider min/max recommendations to be included in the 2017-2019 Regional Strategic Plan.
	Strategy 5. By February 2017, Regional Council will forward any recommended Prehospital min/max revisions to Department of Health.
Objective 3. By March 2016, the Regional Council will develop, review, revise and implement Regional Patient Care Procedures	**Strategy 1.** By October 2015, Prehospital and Transportation Workgroup will present current Regional Patient Care procedures to County MPDs with request for review and recommended revisions.
	Strategy 2. By December 2015, Prehospital and Transportation Workgroup will review current approved Patient Care Procedures and recommended revisions from County MPDs and forward recommended changes to Regional Council.
	Strategy 3. By February 2016, Regional Council will forward recommended revisions of Patient Care Procedures to the Department of Health for approval.
	Strategy 4. On an ongoing basis, Regional Patient Care Procedures will be distributed through the Regional Information Distribution Network and placed on the NCECC.org website.
	Strategy 5. By August 2016, current approved Patient Care Procedures will be utilized by the Regional Plan Development Workgroup to develop strategies for the 2017-2019 Regional Strategic Plan.

Objective 4. By August 2016, the Regional Council will review Local Council County Operating Procedures for congruency and alignment with Regional Patient Care Procedures.	**Strategy 1.** By April bi-annually, Prehospital and Transportation Workgroup will review County Operating Procedures for congruency with Regional Patient Care Procedures.
	Strategy 2. By April, biannually, Prehospital and Transportation Workgroup will request Local EMS Councils review and revise County Operating Procedures incongruent with Regional Patient Care Procedures utilizing the Department of Health approval process algorithm.
	Strategy 3. By June, biannually, Regional Council will assist Local EMS Councils in submitting updated County Operating Procedures to Department of Health for approval.
	Strategy 4. On an ongoing basis, County Operating Procedures will be distributed through the Regional Information Distribution Network and placed on the NCECC.org website.
	Strategy 5. By August 2016, current approved County Operating Procedures will be utilized to develop strategies for the 2017-2019 Regional Strategic Plan.
Objective 5. By June 2016, the Region Council will reconcile Prehospital agency contact information, personnel resources, and level of service.	**Strategy 1.** By February 2016, the Prehospital and Transportation workgroup will obtain from the Department of Health a detailed list of Prehospital agency information.
	Strategy 2. By May 2016, the Prehospital and Transportation workgroup and Local EMS Councils will utilize the regional needs assessment to update agency contact information.
	Strategy 3. By May 2016, the Prehospital and Transportation workgroup will reconcile the information to ensure it is correct and up to date.
	Strategy 4. By June 2016, the Regional Council will provide updated agency information to Department of Health.
Objective 6. By April 2017, the Regional Council will review the categorization levels for Cardiac and Stroke	**Strategy 1.** By September 2015, Regional Council Chair will appoint a regional representative to be a liaison on the Regional QI Committee for Emergency Cardiac and Stroke.

facilities.	**Strategy 2.** By December 2015, Regional Council representative will request time on Regional QI agenda to present current cardiac and stroke categorization numbers and request input from the QI Committee for any revisions.
	Strategy 3. By February 2016, Regional council representative will report regional Cardiac and Stroke QI recommendations to Regional Council for discussion and approval.
	Strategy 4. By April 2016, Regional Council will consider Cardiac and Stroke categorization level recommendations to be included in the 2017-2019 Regional Strategic Plan.
	Strategy 5. By April 2016, Regional Council will forward any recommended Cardiac and Stroke categorization revisions to Department of Health.

GOAL 2

A strong, efficient region-wide system of emergency care services that prepares for, responds to, and recovers from public health threats and is coordinated by the Regional Councils.

Regional Councils are comprised of multi-disciplinary coalitions of health care providers, and partners who are fully engaged in regional and local emergency care services system activities.

In an effort to maintain and expand our vested partners in Emergency Medical and Trauma Care, we continue to request input and involvement from our local and regional networks to ensure a comprehensive representation of regional stakeholders involved in system planning.

RCW and WAC identify and define roles and responsibilities of the Regional and Local EMS & Trauma Care Councils. The Regional Council, as the lead organization, works closely with our Local EMS & Trauma Care Councils, MPDs, EMS providers, hospital trauma services, public health, injury prevention networks, emergency management, dispatch agencies, community networks and other system stakeholders to assure a multi-disciplinary approach to EMS and Trauma Care system development.

Objective 1. During July 2015 – 2017, the Regional Council will implement the Regional EMS and Trauma Strategic Plan.	**Strategy 1.** By August 2015, or when the Plan is approved by Department of Health, the Regional Council will distribute the updated 2015-2017 Plan to Local Councils, MPDs, and post the Plan on the NCECC.org website.
	Strategy 2. Throughout the Plan timeframe, contract deliverable reports will be shared at Regional Council meetings identifying plan work progress and accomplishments.
Objective 2. By February 2017 Regional Council will develop a 2017- 2019 Emergency Medical Services and Trauma Care Council Strategic Plan.	**Strategy 1.** By August 2016, Plan Development Workgroup will use 2015-2017 Plan accomplishments to develop strategies for the 2017-2019 Strategic Plan.
	Strategy 2. By December 2016, Regional Council will review the draft 2017-2019 Regional Strategic Plan for approval.
	Strategy 3. By February 2017, Region approved 2017-2019 Strategic Plan will be submitted to Department of Health for review and approval.
	Strategy 4. By April 2017, Department of Health reviewed and approved 2017-2019 Plan will go forward to Steering Committee for approval.
Objective 3. During the Plan cycle the Regional Council	**Strategy 1.** On an on-going basis, office staff will distribute and share via email and Regional Council

will facilitate the exchange of information throughout the emergency care system.	website, pertinent local, regional, state and national information with emergency care system partners.
	Strategy 2. During 2015-2017 Strategic Plan cycle, office staff will share contract deliverable report information with Local EMS Councils and MPDs.
Objective 4. The Regional Council will work with the State Department of Health and the State Auditor's Office to ensure the Regional Council business structure and practices remain compliant with RCW.	**Strategy 1.** On an on-going basis, North Central Region representative will attend Department of Health meetings and trainings offered for Regional Councils to facilitate business practice compliance with RCW per State Auditor and Department of Health recommendations and guidance.
	Strategy 2. On an on-going basis, North Central Region Council will implement business practice recommendations from State Auditors Office and Department of Health for compliance with RCW.
	Strategy 3. By June annually, the North Central Region Council will review a year-end report compiled by the Executive Director, Regional Training and Education Committee, and members of the Executive and Finance Committees, for effective and efficient management of Regional Council activities and operations.
	Strategy 4. By June, bi-annually or as needed, Regional Council will review current Bylaws, Policies and Procedures, and facilitate Council elections as outlined as the business structure and RCW.
	Strategy 5. On an on-going basis, Regional Council will offer assistance to Local EMS Councils to review their current business structure for compliance with RCW.
	Strategy 6. Annually, Region Council will work with Department of Health, state Regional Advisory Committee, and stakeholders to coordinate Board Development training opportunities that address business and Board best-practice education.
	Strategy 7. On an ongoing basis, Regional Council will provide Board education topics for training, based on the needs of the Council, at regular Council meetings.

GOAL 3

A sustainable regional emergency care system utilizing standardized, evidence-based procedures and performance measures that address emergency health care and identifies areas to reduce preventable premature death and disability.

The North Central Region has multi-disciplinary workgroups and committees, Local EMS Councils, and County MPDs involved in regional programs provided to strengthen the emergency care system.

The Regional Training and Education Committee utilizes feedback from regional MPDs regarding compliance with state approved Key Performance Indicators in addition to the Regional Needs Assessment results to determine funding for educational programs for Prehospital providers. They also utilize the approved Training Program with the Department of Health to maintain quality assurance of initial EMS courses.

The Injury and Violence Prevention workgroup utilizes regional data provided by Department of Health and other system partners to determine targeted interventions, injury prevention activities, and public education programs to reduce preventable/premature death and disabilities.

The Prehospital and Transportation workgroup reviews County Operating Procedures, Regional Patient Care Procedures, and Min/Max numbers in determining un-served or underserved areas. The workgroup will collaborate with the regional Training and Education Committee to distribute and educate providers on the Regional Patient Care Procedures and County Operating Procedures.

Objective 1. By June annually, the Regional Council will allocate funding, as outlined in Department of Health contract, to support Emergency Care Education Programs.	**Strategy 1.** By February, annually, the Regional Council will conduct an Emergency Care System needs assessment by requesting input from agencies, Local EMS Councils, MPDs, and Regional QI Committee.
	Strategy 2. By March, annually, the Executive Committee and Executive Director will review available Department of Health contract funds to determine the Fiscal year allocations for Administrative and Regional Programs, to include training and education and injury and violence prevention programs and activities.
	Strategy 3. By June annually, the Executive Committee and Executive Director will submit the Fiscal year budget that includes Administrative and Program Budget items, to the Regional Council for approval.
	Strategy 4. By, March, annually, the Regional Council will utilize identified Emergency Care System needs to develop strategies for the 2017-2019 Regional Strategic

	Plan.
Objective 2. Annually by June, the Training and Education Committee will provide Emergency Care Education for providers in the North Central Region.	**Strategy 1.** Annually by July, the Training and Education Committee will review Needs Assessment results and determine education to be funded.
	Strategy 2. Annually by August, the Training and Education Committee will elicit education Contract proposals from Local EMS Councils, Regional Instructors, and/or outside training providers.
	Strategy 3. Annually by September, the Executive Director will work with the Training and Education Committee to secure Contracts outlining deliverables with Local EMS Councils, Regional Instructors, and/or outside training providers.
	Strategy 4. Annually by October, the Training and Education Committee will publish a training calendar for the North Central Region for distribution via email and the NCECC.org website.
	Strategy 5. On an on-going basis, Training and Education Committee Chair will provide training updates and reports to the Regional Council, Local EMS Council, and County MPDs.
	Strategy 6. On an ongoing basis the Training and Education Committee Chair will review provider participation feedback from training sessions and Key Performance Indicators from Regional QI and County MPDs.
	Strategy 7. Annually by May, education Contracts will be reviewed for compliance and opportunities for renewal.
Objective 3. The Regional Training and Education Committee will work with Senior EMT Instructors, Department of Health, MPDs, and Local EMS Councils to maintain a quality Training Program for initial EMS courses.	**Strategy 1.** On an ongoing basis, the Training and Education Committee will assist Senior EMS Instructors with Initial EMS Course approval, commencement, and completion.
	Strategy 2. On an ongoing basis, the Training and Education Committee will correlate student completion of initial courses, completion of National Registry testing, and Department of Health Credentialing.
	Strategy 3. On an ongoing basis, the Training and Education Committee will report correlated data for student completion of Initial EMS Courses to County MPDs.
	Strategy 4. Annually, by March, Training and Education Committee will hold a Senior EMS Instructor workshop for Instructors aligned with Regional Training Program.

	Strategic 5. On an ongoing basis, Senior EMS Instructors aligned with Regional Training Program will participate in Quality Assurance and Improvement Program requirements.
	Strategy 6. By February 2017, the Regional Training and Education Committee will utilize Training Program data to develop strategies for the 2017-2019 Regional Strategic Plan.
Objective 4. By March 2017, the North Central Region Council will implement Department of Health approve Key Performance Indicators in the regional emergency care system.	**Strategy 1.** By August 2015, the Regional Training and Education Committee will review the Regional QI plan for current Prehospital Key Performance Indicators.
	Strategy 2. By October 2015, the Regional Training and Education Committee will provide County MPDs and Local EMS Councils with current Region QI Key Performance Indicators from the plan with request for review and input.
	Strategy 3. Throughout the Plan timeframe, the Regional Training and Education Committee will distribute Prehospital Key Performance Indicators currently being monitored to regional Prehospital system stakeholders. (MPDs, SEIs, EMS Evaluators, agency directors and providers.)
	Strategy 4. Throughout the Plan timeframe, the Regional Training and Education Committee will provide quarterly Key Performance Indicator reports from the Regional QI Committee and County MPD's to Local EMS Councils, County MPD QI meetings and County Agencies.
	Strategy 5. By February 2017, the Regional Training and Education Committee will utilize Regional QI Key Performance Indicators to develop strategies for the 2017-2019 Regional Strategic Plan.
	Strategy 6. By December 2016, the Regional Council will work with Department of Health representative to provide a Regional WEMSIS forum to increase agency utilization.
Objective 5. Annually, the Regional Council will review relevant data from Department of Health and other data sources, and utilize regional injury and violence prevention partners to identify and recommend evidence-based	**Strategy 1**. By August annually, the Injury and Violence Prevention workgroup will review relevant regional/injury data, and identify regional partners that will provide best-practice prevention programs.
	Strategy 2. By October annually, Regional Council will choose regionally funded prevention activities to support based upon presentations/recommendations provided by Injury and Violence Prevention workgroup.

and/or best- practice activities to support prevention efforts in North Central Region.	**Strategy 3.** By December annually, Executive Director will secure deliverable contracts with selected injury prevention partners to provide injury prevention programs.
	Strategy 4. Biannually, contracted injury prevention partners will provide Regional Council with program activity reports and accomplishments as outlined in the contract agreement; these reports will be posted on the NCECC.org website for viewing.
	Strategy 5. By June 2017, as funding allows, Regional Council and staff will participate in community and agency injury prevention education.

GOAL 4

Develop a comprehensive Public Education Program to promote and enhance public awareness and knowledge of the Emergency Care Systems of Washington.

The State and Regional Council recognizes there is a significant lack of knowledge from the provider level to the public on what the Emergency Medical Services and Trauma Care Systems is and how it functions in our state and region.

The North Central Region has developed a regional presentation and public information videos for education on the Emergency Care System; and will be participating in the distribution of educational materials made available from the State Ad hoc Committee for Public Outreach.

Objective 1. During July 2015 - June 2017, the Regional Council will collaborate to educate the public and our partners on the Emergency Care System	**Strategy 1.** By August annually, current Regional and State Public Information presentations available will be reviewed and revised as needed by the regional Customer Service Committee, Executive Committee and Regional Council staff for education of the Emergency Care System.
	Strategy 2. By September annually, Customer Service Workgroup will present updated Public Information brochures and media to the Regional Council for approval.
	Strategy 3. By October annually, updated approved Public Information brochures and media will be posted on the NCECC.org website and made available to regional and state partners.
	Strategy 4. On an on-going basis as requested, informational presentations on the regional and statewide Emergency Care System will be provided throughout the region utilizing Regional Council staff and representatives.

GOAL 5

Work toward sustainable emergency care funding and enhancing workforce development to optimize patient outcomes.

The State and Regional Council recognizes there is a significant change in availability of and funding for services within our communities. This will require a multidisciplinary collaborative approach to delivering healthcare in a more efficient and fiscally responsible way in getting "The right patient, to the right facility, with the right transportation, at the right cost, in the right amount of time."

The North Central and East Region Councils continue to coordinate resources for administrative services and evaluate other areas of possible consolidation to provide for a more effective utilization of funding sources.

Objective 1. During July 2015- June 2017 Strategic Plan cycle, East and North Central Region Councils will continue sharing of coordinated resources and determine areas of possible consolidation.	**Strategy 1.** Annually, by April, the Administrative Services contract will be reviewed by the East and North Central Region Council, Executive Board, and Executive Director to determine revisions as needed.
	Strategy 2. Annually, by June, North Central Region Council will review and approve an Administrative Services Contract between the East and North Central Region Council.
	Strategy 3. Throughout the plan timeframe, the Executive Committee, Training and Education Committee, Injury and Violence Prevention Workgroup, and the Executive Director will review current training and education processes, injury and violence prevention programs, and regional office administration components to determine areas of viable consolidation and/or sharing of resources.
Objective 2. During July 2015 – June 2017 Regional Mobile Integrated Healthcare Workgroup will establish collaborative multidisciplinary efforts to develop an affordable, efficient, and comprehensive community based system of care.	**Strategy 1.** By July 2015, Mobile Integrated Healthcare Workgroup will establish a Regional Mission and Vision.
	Strategy 2. By September 2015, Mobile Integrated Healthcare Workgroup will establish a work plan congruent with State and Regional Stakeholder input.
	Strategy 3. Bi-annually, the Mobile Integrated Healthcare Workgroup will provide status reports, Department of Health updates, and stakeholder feedback to Regional Council.

Objective 3. During July 2015-June 2017 Strategic Plan cycle, the Regional Council will determine methods to increase funding sources compliant with State regulations.	**Strategy 1.** Throughout the plan timeframe, the Executive Director will collaborate with Regional Director's and the Department of Health to develop a fundraising template.
	Strategy 2. Throughout the plan timeframe, the Executive Director, Executive Committee, and Finance Committee will review and consider opportunities for Regional Grant funding.

APPENDICIES

Appendix 1. Approved Min/Max of Verified Trauma Services

Approved Min/Max numbers of Verified Trauma Services by Level and Type by County (repeat for each county)

Chelan County:

Chelan County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
	Aid – BLS	4	6	6
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	3	3	3
	Amb – ILS	0	0	0
	Amb - ALS	4	4	4

Douglas County:

Douglas County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
	Aid – BLS	1	2	2
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	3	3	3
	Amb – ILS	0	0	0
	Amb - ALS	0	0	0

Grant County:

Grant County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
	Aid – BLS	4	11	6
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	4	8	7
	Amb – ILS	0	5	0
	Amb - ALS	1	4	3

Okanogan County:

Okanogan County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
	Aid – BLS	1	5	4
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	3	4	4
	Amb – ILS	0	1	1
	Amb - ALS	1	2	2

Appendix 2. Trauma Response Areas

Trauma Response Areas by County

Chelan County

Chelan County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS as available	Type and # of Verified Services available in each Response Areas (*use key below- **see explanation)
	#1	Current Boundaries of Chelan County Fire District #1 Proper	A1, F2
	#2	Current Boundaries of Chelan County Fire District #3 Proper	A1, F3
	#3	Current Boundaries of Chelan County Fire District #4 Proper	F3
	#4	Current Boundaries of Chelan County Fire District #6 Proper	A1, F3
	#5	Current Boundaries of Chelan County Fire District #8 Proper	D1, F3
	#6	Current Boundaries of Chelan County PHD #2 Proper	F1
	#7	Current Boundaries of City limits of Cashmere Proper	D1, F2
	#8	Current Boundaries of City limits of Wenatchee proper	A1, F2
	#9	Town of Stehekin and surrounding wilderness area	F2
	U-1	East border encompasses NF7340, NF7322. NW Border encompasses Colchuck Lake, 8 Mile Lake and westerly riverbed. Northern most border includes NF7601, NF11 and borders the southern border of trauma response area U-2. Northeastern border follows the southwestern border of trauma response area #4. Eastern border, borders western border of U-17, encompassing Sand Creek Road, the westerly border of trauma response area U-19, including Devils Gulch Trail.	F3
	U-2	Western border includes Trout Lake heading north to Donell Lakes. Northern border includes trauma response area U-4's southern border, Chwaukum Lake, Winton	A1, F3

		Road, Carl Road, Hill Street. Eastern borders include the Western boundary of trauma response area #2 and trauma response area #3, including Alder Street.	
	U-3	Southwest border follows trauma response area U-2 northwest boundary, including NF125, and Derby Canyon. Northwest border encompasses trauma response area U-5 SE border, including NF020, NF 7503 NF 7500. Eastern border includes trauma response area U-10 western border, including Ollala Canyon Road, NF7410.	A1, F3
	U-4	Western border includes Upper Mill Creek Road, Yodelin Place, Smithbrook Road, north to the eastern end of the Little Wenatchee River Bed, encompassing NF400. Northwestern border includes 65 Road, NF6506, NF6400, NF6200, Eastern border includes NF1408. Southeastern border includes NF1409, Chikamin Ridge Road, and includes northwestern boundary of trauma response areas U-6 and trauma response area U-9. Southeastern boundary includes NF6208, NF6102, NF300 and borders the trauma response area U-12 northwestern boundary. Southern boundary includes CR22, Bretz Road, Riche Road and borders the trauma response area U-2 north boundary.	F3
	U-5	Western boundary follows the trauma response area #2 and trauma response area #3 eastern boundaries. Northern boundary includes NF6103 eastern boundary borders the western trauma response area U-12 boundary, including NF315, NF7801, NF7502. Southern boundary includes NF7502, NF7500, NF7503, NF7401 and borders the trauma response area U-3 NW boundary.	F3
	U-6	West boundary includes NF1409, and borders the NE trauma response area U-4 boundary. Northern boundary includes the northern Entiat River Bed, encompasses NF5100, Hope Ridge Road, NF1433, NF112 and the trauma response area U-16 southern border. Eastern border includes NF1443,	F3

		NF116, NF1448, NF211, Johnson Creek Road and borders the west trauma response area U-7 border and the trauma response area #5 west border. South border includes north border of trauma response area U-8 and NF5300, NF5320, NF114. The southwestern border encompasses the bordering northern section of trauma response area #4, to include NF5390, NF312, and NF5503.	
	U-7	Western border includes NF8410, NF118, NF114, Shady Pass Road, and the trauma response area U-6 eastern border. North border includes Shady Pass Road, NF5900, NF127 and the SE corner of trauma response area U-16. Eastern border includes NF127, NF233 and the western border of trauma response area #6. Southern border includes NF1448, and the southeastern border of trauma response area U-6.	F1
	U-8	Western border encompasses the section of NE trauma response area #4, including NF5305, NF5310, and County Road 287. The Northern border includes trauma response area U-6 southern border, NF114, NF5320, Mudd Creek Road and County Road 63. Eastern Border includes trauma response area #5's western border from County Road 63 to Tiny Canyon Road. Southern border follows the NE section of trauma response area #4, including Tiny Canyon Road, NF302.	D1, F2
	U-9	Southwest border encompasses NF500 and the trauma response area U-12 NE border, Western border encompasses Mad Lake and the trauma response area U-4 NE border. Northern border includes the trauma response area U-6 S border and eastern border is the NW section of the trauma response area #4, including NF5702, NF5700, NF400, and NF800.	D1, F2
	U-10	West Border includes the east border of trauma response area U-3, NF7410, Ollala Canyon Road, North Fork Road; Northern border encompasses a portion of the trauma response area U-12 south border, including	D1, F2

		NF11. Eastern border, borders trauma response area U-11 West border, NF5200, Orchid Street and the northwestern section of trauma response area #7. South border includes the north section of trauma response area #7 including Hay Canyon and NF7410.	
	U-11	West border includes the east border of trauma response area #7, NF7415, Orchid Street, North border includes NF6210, South border of trauma response area U-12 and northern section of trauma response area #4, including Mills Canyon Road. Eastern border is the west boundary of trauma response area #4, including Swakane Road. Southern border includes northern trauma response area #8, including Burch Mtn. Road.	A1, D1, F2
	U-12	Western border includes east border of trauma response area U-5, NF6102, NF300, NF6104. North border is the south boundary of trauma response area U-9, including NF5700. Eastern border includes the western boundary of trauma response area #4 including Mad River Road, NF110, Roaring Creek Road. Southern border includes the North boundary of trauma response area U-11 and trauma response area U-10, including NF6210.	D1, F2
	U-13	West border is the trauma response area #5 east border. North border is the trauma response area #6 south border, including Foot Trail. East border follows the western border of trauma response area #6. South border is the northern border of trauma response area #5.	F1
	U-14	West border is the eastern shore of Lake Chelan from the North section of trauma response area #6 to the south border of trauma response U-15. NW border includes the trauma response area U-15 border and NF8200. NE border is the County Line, including NF8220, NF3107, NF430, NF3107, NF8210. South border is the north section of trauma response area #6 including NF8045.	F1

	U-15	West and southwest border is the eastern shore of Lake Chelan from trauma response area U-14 NW border, encompassing the entire trauma response area #9. The western border follows the northern shores of Lake Chelan. The northwest and north borders encompass trauma response area #9. The north and eastern borders follow the Okanogan County Line encompassing the Sawtooth Wilderness Area in Chelan County. The southern border is the northern border of trauma response area U-14.	F1
	U-16	Western border is the eastern border of ARCA#1. The Northwestern border encompasses Lyman Lake, continues north to the NW corner of trauma response area U-15. The Northern border includes Battalion Lake and the NW border of trauma response area U-15. Eastern border is the south shore of Lake Chelan, including NF112, the southern border includes the northern borders of trauma response area U-7 and trauma response area U-6.	F1
	U-17	Western border includes Sand Creek Road, Tripp Canyon Road, and the eastern border of trauma response area U-1. Northern and eastern border is the southern and western borders of trauma response area #7. Southern border includes GR11 and the SE border of trauma response area #7.	D1, F2
	U-18	Western borders area the eastern boundary of trauma response area #7, including Mission Creek Road, Northern borders area the southern borders of trauma response area #7, including Yaksum Canyon Road. The eastern border is the southern border of trauma response area #7. The Southern borders are the northern border of trauma response area U-19, including Horse Lake Road.	D1, F2
	U-19	Western border includes NF9712, Devils Gulch and the Eastern border of trauma response area U-1. Northern border includes the southern border of trauma response area U-18 and the southern border of trauma response area #7. Eastern border includes	A1, F2

		the western border of trauma response area #1and trauma response area #8, NF7101, Upper Reservoir Loop Road, Stemilt Loop Road, Upper Hedges Road, Jump Off Road, the southern borders are the county line, including Ingersoll Road, Schaller Road, and Naneum Ridge Road as well as NF330, NF9712.	

*Key: For each level the type and number should be indicated
Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F
Explanation: The *type and number* column of this table accounts for the level of care available in a specific trauma response area that is provided by verified services. Some verified services (agencies) may provide a level of care in multiple trauma response areas therefore the **total type and number of verified services depicted in the table may not represent the actual number of State verified services available in a county; it may be a larger number in Trauma Response Area table. The verified service minimum/maximum table will provide accurate verified service numbers for counties.

Douglas County:

Douglas County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS as available	Type and # of Verified Services available in each Response Areas (*use key below **see explanation)
	# 1	Current Boundaries of Douglas County Fire District #1 Proper	D1, F1
	#2	Current Boundaries of Douglas County Fire District #2 Proper	A1, F2
	#3	Current Boundaries of Douglas County Fire District #3 Proper	D2
	#4	Current Boundaries of Douglas County Fire District #4 Proper	A1, F3
	#5	Current Boundaries of Douglas County Fire District #5 Proper	D1, F1
	#6	Current Boundaries City of Bridgeport Proper	D1, F1

	U-1	Encompassed by response area #1 to the West, North and East borders. Southern border is the north west border of trauma response area U-9 including the south Jamison Lake Road.	D1, F2
	U-2	Western and Southern border is the east border of trauma response area U-3, North border is the south border of trauma response area #6. East border is the west border of trauma response area #3.	D1
	U-3	West border is the Douglas County Line, including Bailey Way. North border is the South border of U-10, including CR73960, Grange Road NE, Moe Road NE. East border is the county line and west border of trauma response area #6. Southern border is the north border of trauma response area #5, including CR72300.	E1
	U-4	Southwest and North borders area encompassed by trauma response area #1. The east border is encompassed by trauma response area U-9.	None
	U-5	West border is the east border of trauma response area U-6. North border is the south border of trauma response area #1, including Ponderosa Drive. Northern border is encompassed by trauma response area #1 and trauma response area U-9. The East border is the southwest trauma response area U-9 boundary, and includes Road C SE. The South border is the North border of trauma response area #10 and the north border of trauma response area U-8, including Road 12 SE, Douglas/Grant shared and Grant County Route.	D1, F1

	U-6	Southwest border is the NE boundary of trauma response area U-7. North border is the South border of trauma response area #1. East border is the west trauma response area U-5 border. South border is the north border of trauma response area U-8, including Road 24 NW.	D1, F1
	U-7	Southwest border is the NE border of trauma response area #2. NW border is the SE border of trauma response area #1. NE Border is the SW border of trauma response area U-6, and the SE border is the NW border of trauma response area #1.	D1, F2
	U-8	West border is the east border of trauma response area U-7. North border is the south border of trauma response area U-6 and trauma response area U-5 including Road 24 NW. The east border is the northwest border of trauma response area #10. The south border is the north border of trauma response area #1.	D1, F1
	U-9	West border includes Road C SE, and the west borders of trauma response area U-5, trauma response area U-4 and trauma response area U-1. The North border includes the southern border of trauma response area #5, including Road 6 NE, St Andrews West Road NE, St. Andrews East Road NE, Road O NE. The East and SE borders are the Grant County Line, including Road 6 SE. South border follows the Grant County Line, including Road 24 NW.	D1
	U-10	To the West, East and North borders the Okanogan County Line, including Chambers Road. South border follows the North border of trauma response area U-3, including CR74690 and CR73960.	E1

*Key: For each level the type and number should be indicated

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

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

Grant County:

Grant County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS as available	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	#1	The current boundaries of Grant County Fire District #3 Proper	A1, D2, F2
	#2	The current boundaries of Grant County Fire District #4 Proper	A1, E1, F1
	#3	The current boundaries of Grant County Fire District #5 Proper	D1, E1, F1
	#4	The current boundaries of Grant County Fire District #6 Proper	D3
	#5	The current boundaries of Grant County Fire District #7 Proper	A1, D2, E1, F1
	#6	The current boundaries of Grant County Fire District #8 Proper	D1, E1, F1
	#7	The current boundaries of Grant County Fire District #10 Proper	A1, F1
	#8	The current boundaries of Grant County Fire District #11 Proper	D1, E1, F1
	#9	The current boundaries of Grant County Fire District #12 Proper	D2, E1, F1
	#10	The current boundaries of Grant County Fire District #13 Proper	D1, E1, F1
	#11	The current boundaries of Grant County Fire District #14 Proper	D1, E1, F1
	#12	The current boundaries of Grant County Fire District #15 Proper	D1, E1, F1
	#13	The current boundaries of City Limits of Coulee City Proper	D1, E1, F1
	#14	The current boundaries of City Limits of Ephrata Proper	F1
	#15	The current boundaries of City Limits of Grand Coulee Proper	D1, E1, F1
	#16	The current boundaries of City Limits of Moses Lake Proper	E1, F1

	#17	Port District boundaries, Grant County International Airport & surrounding industries.	A1, E1, F1
	U-1	Northrup Canyon area between Grant County Fire District #14 south & Grant County Fire District #6 east.	D1
	U-2	Banks Lake North, south of Grant County Fire District #14 – Section 16 North, west of Grant County Fire District #6, North of Million Dollar Mile.	D1
	U-3	Banks Lake South of Coulee City Area, Section 26: Township 26N: Range 28E, south and west of Grant County Fire District #6 to Douglas County Line.	D1
	U-4	Sun Lakes West and North, west to Grant County Fire District #7 – Over to County Line; west of Park Lake, west of Blue Lake.	A1, D2, E1, F1
	U-5	West Lake Lenore.	A1, D2, E1, F1
(3 Devils Grade Area)	U-6	North of Grant County Fire District #7 boundary, along shoreline of Lake Lenore, along Grant County Fire District #7 boundary, over to county line.	A1, D2, E1, F1
	U-7	South of Road 24 NW west to County line. 1 mile south, 2 miles west, 1 mile south, 4 miles east to Grant County Fire District #13 boundary. West 2 miles to County Line (Road 24 NW).	A2, F1
	U-8	Between Grant County Fire District #7 and Grant County Fire District #13: North of Road 20 NE.	D2, E1, F1
	U-9	East of Grant County Fire District #7; North of Grant County Fire District #13; Canal Bank NE; South of Road 19NE; South of E SW.	D2, E1, F1
	U-10/10A	South and east of Grant County Fire District #12 to County Line. North of Grant County Fire District #5, North of Road 12 NE; west of County Line; north to Road 16 NE	D2, E1, F1

		over to V NE, 1 mile north – 1 mile west – 3 miles south – 2 miles west – south to Road 12 NE.	
	U-11	East of Grant County Fire District #5, north of Grant County Fire District #13, east of Grant County Fire District #3, west of Potholes Reservoir, West Potholes Reservoir edge to 4 miles, one piece is north and east of Grant County Fire District #11/east of Potholes. West – 3 miles south.	D1, E1, F1

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

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

Okanogan County:

Okanogan County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that **can be mapped** and encompass the entire trauma response area – may use GIS as available	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	#1	The current boundaries of Okanogan County Fire District #1 Proper	D1
	#2	The current boundaries of Okanogan County Fire District #2 Proper	D2

	#3	The current boundaries of Okanogan County Fire District #3 Proper	A1, F1
	#4	The current boundaries of Okanogan County Fire District #4 Proper	D1
	#5	The current boundaries of Douglas/Okanogan County Fire District #15 Proper	E1
	#6	The current boundaries of Aero Methow Rescue Response area	A1, F1
	#7	The current boundaries of Okanogan County Fire District #7 Proper	A1, F1
	#8	The current boundaries of Okanogan County Fire District #8 Proper	A1, D1, E1, F1
	#9	The current boundaries of Okanogan County Fire District #9 Proper	A1, F1
	#10	The current boundaries of Okanogan County Fire District #10 Proper	A1, D1, E1, F1
	#11	The current boundaries of Okanogan County Fire District #11 Proper	D1
	#12	The current boundaries of Okanogan County Fire District #12 Proper	D2
	#13	The current boundaries of the Colville Tribal Reservation within Okanogan County	D2
	U-1	East Boundary: West boundary of trauma response area #7. North Boundary: Encompasses Chewiliken Road, east to NF125, Southeast through NF200 and NF30. South Boundary is a portion of the North border of trauma response area #13.	A1, F1
	U-2	West border of trauma response area #4, encompassing areas to the north, Longaneker Road. Northwestern boundary includes Talkire Lake Road, heading southwest, along vehicle road. Southern boundary along northern boundary of trauma response area U-1.	A1, D1, E1, F1
	U-3	Aeneas Valley	D1

	U-4	Western boundary includes NF3820 along Cecile Creek Road, heading north to Chopaka Lake, north to Canadian Border. Northwest border encompasses Chopaka Road heading south to Palmer Lake, southwest to Palmer Mt. Road, southwest to Wannacut Lake Road, heading west to trauma response area #1 western border continuing south to trauma response area #4 westerly border. South boundary encompasses Silver Star Mine Road, Horse Springs Coulee Road and the northern border of trauma response area U-6.	A1, D1, E1, F1
	U-5	West border meets the western border of trauma response area U-4. Northern border encompasses Loomis/Oroville Road and north to the Canadian Border. Eastern border is the western border of trauma response area #1. Southern border includes trauma response area U-4's northern border.	D1
	U-6	Western border includes NF3820 and reaches to trauma response area U-7's eastern border. Northern border encompasses trauma response area U-4's southern border including Sinlahekin Road. Eastern trauma response area U-6 border meets trauma response area #4's western border, trauma response area #7, trauma response area #9 and trauma response area #3 eastern borders. Southwestern border includes Old 97 Highway, Monse South Road, and follows the Columbia River south to trauma response area #5 northern border. Follows Okanogan County Line to the west encompassing NF4330 to FS Trail 408-North to the southern border of trauma response area #6.	A2, D1

	U-7	Western border meets trauma response area #6 eastern border; north border is the Canadian Border; western border encompasses eastern border of trauma response area U-4, including NF3820, eastern border of trauma response area U-6 and eastern border of trauma response area #9, including Medicine Lake, County Road 2017, Buzzard Lake Road. Southwest border encompasses trauma response area #3 border including B&O West Road; south border includes Davis Canyon Road, NF115 over to NF325.	A3, F2
	U-8	Responded to out of Ferry County. Unsure of the defined boundaries by State Mapping.	D1
	U-9	City Limits of Twisp	A1, F1

*Key: For each level the type and number should be indicated

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Aid-ILS = B	Ambulance-ILS = E
Aid-ALS = C	Ambulance-ALS = F

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

EMS and Trauma Response Area Maps for Washington State, region and county can be accessed on the Department of Health website by clicking on the link below.
http://ww4.doh.wa.gov/gis/EMS.htm

Appendix 3. Min/Max of Designated Trauma Facilities

Approved Min/Max numbers of Verified Designated Trauma Care Services in the Region (General Acute Trauma Services) by Level

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

Level	State Approved		Current Status
	Min	Max	
II	1	1	0
III	2	2	1
IV	4	7	7
V	3	3	2
II P	1	0	0
III P	1	1	1

B: Approved Minimum/Maximum (Min/Max) numbers of Rehabilitation Care Services

Level	State Approved		Current Status
	Min	Max	
II	1	1	1
III*			0

*There are no restrictions on the number of Level III Rehab Services

Appendix 4. Patient Care Procedures

Dispatch of Agencies
North Central Region Patient Care Procedure
Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised: May 2008

Purpose:
To provide timely & appropriate care to all emergency medical & trauma patients as identified in WAC 246-976-390.
To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
To establish uniform & appropriate dispatch of response agencies.
To utilize criteria-based EMD trained dispatchers to identify potential major trauma incidents & activate the Trauma System by dispatching the appropriate services.

Standards:
Licensed aid and/or licensed ambulance services shall be dispatched by trained dispatchers to all emergency medical incidents.
Verified aid and/or verified ambulance services shall be dispatched by trained dispatchers to all known injury incidents which meet Trauma Registry Inclusion Criteria.
All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.

Procedure:
The nearest appropriate aid and/or ambulance service shall be dispatched per the above standards as identified in the North Central Region EMS/Trauma Care response area maps, or as defined in local and/or county operating procedures.

Definition:
"Response Time" per WAC 246-976-010, is defined as "the time from agency notification until the time of first EMS personnel arrive at the scene."
"Appropriate" is defined as "the verified or licensed service that normally responds within an identified service area."

Quality Improvement:
The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Response Times
North Central Region Patient Care Procedure
Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised: May 2008

Purpose:
To define prehospital response times for emergency medical & trauma incidents to urban, suburban, rural and wilderness areas in the North Central Region.
To define urban, suburban, rural and wilderness response areas.
To provide trauma patients with appropriate & timely care.

Standards:
All verified ambulance & aid services shall respond to emergency medical & trauma incidents in a timely manner in accordance with WAC 246-976-390. All licensed ambulance & aid services shall respond to emergency medical incidents in a timely manner.

Procedure:
The Regional Council, with input from prehospital providers and Local Councils, shall identify response areas & times as urban, suburban, rural and wilderness.
Verified/licensed ambulance & verified/licensed aid services shall collect & submit documentation to ensure the following response times are met or exceeded as established by PCP, COP or WAC 246-976-430.

	Aid Vehicle	**Ambulance**
Urban	8 minutes	10 minutes
Suburban	15 minutes	20 minutes
Rural	45 minutes	45 minutes
Wilderness	ASAP	ASAP

Verified aid & ambulance services shall provide documentation on major trauma cases to show the above response times are met 80% of the time.
County Operating Procedures must meet or exceed the above standards.
Verified/licensed ambulance & verified/licensed aid are encouraged to set the "Golden Hour" as a goal for wilderness response times.

Definition:
An agency response area or portion thereof:
"Urban" an incorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 & a population density over 2,000 per square mile.
"Suburban" an incorporated or unincorporated area with a population of 10,000 to 29,999 or any area with a population density of 1,000 to 2,000 per square mile.

"Rural" an incorporated or unincorporated area with a total population less than 10,000 or with a population density of less than 1,000 per square mile.
"Wilderness" any rural area not readily accessible by public or private road.

Definition: Continued
"Agency Response Time" is defined as the time from agency notification until the time of first EMS personnel arrive at the scene. (This is defined in WAC and constitutes "activation time" plus "en route time.")

Quality Improvement:
The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Timely & Appropriate EMS Response
North Central Region Patient Care Procedure
Adopted by Regional Council: 04/04/2001
Approved by DOH: 04/01/2002
Revised: May 2008

Purpose:
To ensure that emergency medical and trauma patients who live in an area that is serviced by two or more ambulance providers, which have the same level of licensure, receive the timeliest & highest level of care that is available.

Standards:
If available, the highest-level "appropriately staffed" ambulance within the designated area shall be dispatched to emergency medical & trauma incidents.

Procedure:
Except when "extraordinary circumstances" exist, the highest-level "appropriately staffed" licensed ambulance shall respond to all emergency medical & trauma incidents. When a licensed ambulance provider is unable to immediately respond an "appropriately staffed" ambulance to an emergency medical or trauma incident, and there exists another ambulance which is "appropriately staffed" and capable of responding to the incident in a timely manner, then the service that was originally dispatched shall transfer the call to the second ambulance for response.
This procedure shall only apply to emergency calls received through the county 911dispatch center.

Definition:
"Extraordinary Circumstances" shall be defined as situations out-of-the-usual when all available ambulances from local licensed ambulance providers are committed to calls for service.
"Appropriately staffed" shall be defined as an ambulance which immediately initiates its response to an emergency medical or trauma incident staffed with at least two crew members which are certified to a level that is commensurate with the standard of care that has been set in the local area (i.e., Paramedic/EMT, ILS-EMT/EMT, EMT.EMT or EMT/1st Responder).
"Highest- Level" shall be defined as the service within the response area that has the highest level of certified personnel available, at the time of the call.

Quality Improvement:
The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Helicopter Response
North Central Region Patient Care Procedure
Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised: May 2008

Purpose:
To define who may initiate the request for on-scene emergency air medical services and under what circumstances non-medical personnel may request on-scene air medical services.
To institute a program of continuous evaluation to determine the best utilization of air medical services in our region.

Standards:
Early activation of air ambulance services should be initiated as soon as the medical condition of the patient and scene location/conditions would favor, by at least 15 minutes, air transport of the major trauma or critical medical patient.

Procedure:
Air ambulance services should be used when it will reduce total out-of-hospital time for a major trauma patient by 15 minutes or more.
Air ambulance services may be used for medical and non-major trauma patient under special circumstances and only with clearance by medical control.
Prehospital personnel en route to the scene should make the request to place an air ambulance service on standby, or initiate a request for an on-scene response.
The call must be initiated through the appropriate medical emergency dispatching agency.
The helicopter communications staff will always give an approximate launch time, flight time and advise "when lifted" to the dispatchers requesting services.
The responding helicopter will make radio contact with the receiving hospital at, or shortly after liftoff from the scene.
An air ambulance that has been launched or placed on standby can only be cancelled by the highest level of transporting prehospital personnel dispatched to the scene.

Definition:
"Standby" Upon receiving the request, dispatch will notify the pilot and crew of the possible flight. The crew will respond to the aircraft and ensure they are in a flight ready status. The crew will then remain at or near the aircraft until such time as they are launched or released from the standby.
"Launch Time" Launch time is the time the skids lift the helipad en route to the scene location.

Quality Improvement:
A regional helicopter response report form for each flight or standby request, including cancelled flights, must be submitted to the QI Committee at the end of each calendar

quarter. These will be reviewed, with local input to develop a definition of the most appropriate circumstances for helicopter requests.

Identification of Major Trauma & Emergency Medical Patients
North Central Region Patient Care Procedure
Adopted by Regional Council: 10/23/1998
Approved by DOH: 10/23/1998
Revised: May 2008

Purpose:
To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedures.
To ensure that all emergency medical patients are transported to the closest most appropriate facility in the shortest time possible.
To ensure that all major trauma patients are transported to the most appropriate facility capable of meeting the patient's need in accordance with WAC 246-976-390
To allow the designated facility sufficient time to activate their emergency medical and/or trauma resuscitation team. (See WA 246-976-550 (d).

Standards:
Major trauma patients will be identified in the initial EMS field assessment using the most current State of Washington Prehospital Trauma Triage (Destination) Procedures as published by the Department of Health.
Major trauma patients will be identified by the region's prehospital services and hospitals for the purposes of state trauma registry inclusion, using the trauma registry inclusion criteria as outlined in WAC 246-976-430.
Major trauma patients will be identified for the purposes of regional quality improvement as patients who meet the Trauma System Activation criteria of the most current version of the State of Washington Prehospital Triage Procedures, and the patients who activate hospital resource teams and those who meet the hospital trauma patient registry criteria.
Patients not meeting the criteria to activate the trauma system will be transported to the closest most appropriate local facility as outlined in local procedures.

Procedure:
The first certified EMS/TC provider to determine that a patient:
- Meets the trauma triage criteria *and/or*
- Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure)
- Needs definitive medical care, should contact the nearest/appropriate highest/ designated facility via the H.E.A.R. frequency (or other means as conditions dictate).

Radio contact with the receiving facility should be preceded with the phrase: "This is a major trauma or major heart alert."
The receiving facility shall be provided with the following information, as outlined in the Prehospital Destination Tool:
- Identification of EMS agency.
- Patient's age
- Patient's chief complaint or problem.

- If injury, identification of the biomechanics of anatomy of the injury.
- Vital signs
- Level of consciousness
- Other factors that require consultation with medical control
- Number of patients (if more than one)
- Amount of time it would take to transport the patient from scene to the nearest appropriate hospital (transport time)

When determined that a patient meets the trauma triage criteria, a Washington State Trauma Registry Band should be attached to the patient's wrist or ankle as soon as appropriate.

Whenever possible, ILS or ALS service should be dispatched to the scene by ground or air as appropriate. If unavailable, rendezvous will be arranged with the highest possible level of care.

While en route to the receiving facility the transporting agency shall provide complete report to the receiving hospital regarding the patient's status.

All information shall be documented on an appropriate medical incident report (MIR) form approved by the county medical program director.

Quality Improvement:

The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Inter-Facility Transfer
North Central Region Patient Care Procedure
Adopted by Regional Council: 10/23/1998
Approved by DOH: 10/23/1998
Revised: May 2008
Revised: February 3, 2010

Purpose:
To ensure that trauma patients receive treatment in facilities that have made a commitment to the provision of designated trauma service.
To define the referral resources for inter-facility transfers of patients requiring a higher level of care or transfer, due to situational inability to provide care.
To recommend criteria for inter-facility transfer of major trauma patients from receiving facility to a higher level of care.

Standards:
Written transfer agreements will be in place among all facilities in the region and tertiary care facilities commonly referred to which are out of the region.
All inter-facility transfers shall be in compliance with current OBRA/COBRA regulations and consistent with RCW 70.170.060(02).
Level IV and V facilities will transfer the following adult and pediatric patients to a Level III or higher facility for post resuscitation care:

- Central Nervous System Injury Dx
- Head injury with any one of the following:
- Open, penetrating, or depressed skull fracture
- Severe coma (Glasgow Coma Score <10)
- Deterioration in Coma Score of 2 or more points
- Lateralizing signs
- Unstable spine
- Spinal cord injury (any level)
- Chest Injury Dx
- Suspected great vessel or cardiac injuries
- Major chest wall injury
- Patients who may require protracted ventilation
- Pelvis Injury Dx
- Pelvic ring disruption with shock requirement more than 5 units of blood transfusion
- Evidence of continued hemorrhage
- Compounded/open pelvic fracture or pelvic visceral injury
- Multiple System Injury Dx
- Severe facial injury with head injury
- Chest injury with head injury
- Abdominal or pelvic injury with head injury
- Burns with head injury
- Specialized Problems
- Burns > 20% BSA or involving airway

- Carbon Monoxide poisoning
- Barotrauma
- Secondary Deterioration (Late Sequelae)
- Patients requiring mechanical ventilation
- Sepsis
- Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation systems)

All pediatric patients less than 15 years who are triage under Step I or II of the Prehospital triage tool, or are unstable after ED resuscitation or emergent observation intervention at hospital with general designations should be considered for immediate transfer to a higher level designated pediatric trauma center.
For inter-facility transfer of critical major trauma patients, air or ground ALS transport is the standard. Trauma verified services shall be used for all inter-facility transfers of major trauma patients.
Transport of patients out of region shall be consistent with these standards.

Procedure:
The General and Pediatric Trauma Transfer Criteria established by the Department of Health should be followed. Each designated trauma facility is required to develop procedures, protocols, and criteria defining which patients they keep or transfer.
The transferring facility must make arrangements for the appropriate level of care during transport.
The receiving facility must accept the transfer prior to the patient leaving the sending facility.
All appropriate documentation must accompany the patient to the receiving facility.
The transferring physician's order shall be followed during transport as allowed by MPD protocols. Should the patient's condition change during the transport, the transferring/sending physician, if readily available, should be contacted for further orders.
The receiving facility will be given the following information:

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

MPD approved Prehospital Protocols will be followed during transport, unless direct medical orders are given to the contrary.
Level IV and V trauma facilities should consider having trauma patients transferred by either ground or air according to the facility's interfacility transport plan.
Air transport should be considered for interfacility transfer in the North Central Region based on patient acuity and consideration of total out of hospital time, in consultation with the receiving physician. .

Quality Improvement:
The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Designated Trauma Center Diversion
North Central Region Patient Care Procedure
Adopted by Regional Council: 10/23/1998
Approved by DOH: 10/23/1998
Revised: May 2008

Purpose:
To define implications for initiation of trauma center diversion (bypass) status in the Region.
To define the methods for notification of initiation of trauma canter diversion.
To identify situations when a facility must consider diverting major trauma patients to another designated trauma center.

Standards:
Designated trauma centers in the North Central Region will go on diversion for receiving major trauma patients based on the facilities' ability to provide initial resuscitation, diagnostic procedures, and operative intervention at the designated level of care. Diversion will be categorized as partial or total based on the inability of the facility to manage specific types of major trauma or all major traumas at the time. Hospitals must consider diversion when:

- Surgeon is unavailable
- OR is unavailable
- CT is down if Level II
- ER unable to manage more major trauma
- Beds are unavailable
- Shortage of needed staff

Each designated trauma center will have a hospital-approved policy to divert patient to other designated facilities on the ability to manage each patient at a particular time. A diversion log will be kept indicating the time of diversion and the reason for partial or total diversion.
All facilities initiating diversion must provide notification to other designated trauma centers in Region.

Procedure:
Trauma centers will consider diverting major trauma patients based on the above standards.
A designated trauma center on partial or total diversion shall notify other designated trauma centers in the Region.

Quality Improvement:
The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Mass Casualty Incident (MCI)
North Central Region Patient Care Procedure
Adopted by Regional Council: 12/06/2006
Approved by DOH: December 2006
Revised: Reviewed May 2008

Purpose:
To develop and communicate information for response, prior to an MCI.
To implement county MCI plans during an MCI.
Severe Burns: To provide trauma and burn care to severely injured adults and pediatric patients per region.
To provide safe mass transportation with pre-identified EMS personnel, equipment, and supplies per the approved County Disaster Plan and/or the Hazardous Mitigation Plan.

Standards:
EMS personnel, licensed ambulance and licensed aid services shall respond to a Mass Casualty Incident (MCI) as identified in this document.
All verified ambulance and verified aid services shall respond to an MCI per the county MCI plans.
Licensed ambulance and licensed aid services shall assist during an MCI, per county MIC plans, when requested by command through dispatch in support of county MCI Plan and/or in support of verified EMS services.
Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
All EMS agencies working during an MCI event shall operate within the National Incident Management System (NIMS) or the Incident Command System (ICS) as identified in the jurisdiction that has authority, protocol and MCI plan.

Procedure:
Incident Commander (IC) shall follow the county MCI Plan to inform medical control and possible appropriate medical facilities when an MCI condition exists. (Refer to county- specific Department of Emergency Management Disaster Plan).
Medical Program directors agree that protocols being used by the responding agency should continue to be used throughout the transport of the patient, whether it is in another county, region or state. This ensures consistent patient care will be provided by personnel trained to use specific medicines, equipment, procedure, and/or protocols until delivery at the receiving facility has been completed.
EMS personnel may use the Prehospital Mass Casualty Incident General Algorithm (attached) during the MCI incident.

Definitions:
"CBRNE" Chemical, Biological, Radiological, Nuclear, Explosive
"County Disaster Plan" County Emergency Management Plan (CEMP)
"Medical Control" MPD authority to direct medical care provided by certified EMS personnel in the prehospital system.

Quality Improvement:
The North Central Region Training & Education Committee will review this PCP upon receipt of suggested modifications from a regional provider, the North Region Quality Improvement (QI) Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

NORTH CENTRAL REGION EMS/TC COUNCIL
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE

Mass Casualty Incident (MCI)
Prehospital Mass Casualty Incident (IC) General Algorithm

Receive dispatch

Respond as directed

Arrive at scene and establish Incident Command (IC)

Scene assessment and size-up

Determine if mass casualty conditions exist

Implement county MCI plan

Request additional resources as needed

The dispatch center shall coordinate notification and dispatch of required agencies and resources including notification of the County Department of Emergency Management (DEM) and possible receiving facilities. The Local Health Jurisdiction (LHJ) 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 or similar tactical worksheet

Upon arrival at hospital/medical center, transfer care of patients to facility's staff (Hospital/medical center should activate their respective MCI Plan as necessary)

Prepare transport vehicle and return to service

EMS Provider Described Trends
North Central Region Patient Care Procedure
Adopted by Regional Council: 12/06/2006
Approved by DOH: December 2007
Revised: Reviewed May 2008

Purpose:
To provide EMS with a mechanism to report trends/clusters or suspicions to the ED staff of infectious disease symptoms or possible trends that could be related to acts of terrorism.
To alert ED staff of suspicious symptoms or trends/clusters identified by EMS in the field ED staff will follow established hospital procedures to notification Public Health of symptoms or trends as warranted.

Standards:
Emergency Medical Services (EMS) Providers, who recognize/identify trends/clusters in possible highly infectious disease or symptoms that could be related to terrorism or any unusual biological activity or event, will convey suspicions to Emergency Department (ED) staff.

Procedure:
Any EMS Provider who recognized a trend or clusters of patient symptoms such as, but not limited to, flu-like symptoms, respiratory symptoms, rash or unusual burns, will inform the ED staff.
ED staff will evaluate the EMS Provider's suspicions and follow established hospital procedures for reporting to Public Health as warranted.

Definitions:
"ED Staff" Emergency Department physician or nurse.

Quality Improvement:
The North Central Region Training & Education Committee will review this PCP upon receipt of suggested modifications from a regional provider, the North Region Quality Improvement (QI) Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

Emergency Cardiac and Stroke
North Central Region Patient Care Procedure
Adopted by Regional Council: 3/3/2011
Approved by DOH: 4/6/ 2011

Purpose:
To implement regional policies and procedures for all cardiac /stroke patients who meet criteria for cardiac /stroke triage activation as described in the Washington Pre-Hospital Cardiac/Stroke Triage Procedure.
To ensure that all cardiac/stroke patients are transported to the most appropriate categorized facility as described in RCW 70.168.150
To allow the receiving facilities adequate time to activate their Cardiac/Stroke response team.

Standards:
All ambulance & aid services shall comply with the Washington Pre-hospital Cardiac / Stroke Triage Procedures.
All ambulance services shall transport patients to the most appropriate categorized cardiac or stroke facility as identified in County Operating Procedures (COPS).
All categorized receiving facilities will determine when it is appropriate to divert ambulances to another categorized facility.

Procedure:
The first certified EMS provider determines that a patient:

- Presents with signs, symptoms, or past medical history suggesting a cardiac or stroke (in accordance with the Washington Cardiac/Stroke Pre-hospital Triage Procedure).
- Meets the cardiac/stroke triage criteria.
- The provider provides care for the patient as described in the Medical Program Director's (MPD) patient care protocol for cardiac or stroke patients.

The provider then determines destination based upon the criteria identified and the following:

- For patients meeting Cardiac/Stroke Triage criteria, transport destinations will comply with the triage tool and COP's.
- Agencies unable to meet the transport destination criteria will utilize Online Medical control for determination of transport mode.
- Online medical control for all counties shall be accessed per County Operating Procedures (COP's).

The EMS provider will initiate communication with the receiving facility as soon as possible, to allow the receiving facility adequate time to activate their cardiac/stroke response teams:

- The receiving facility will notify the transporting ambulance service about diversion according to COP's.

- Medical control and/or the receiving facility will be provided with patient information, as outlined in the Prehospital Destination Tool and COPs.

All information shall be documented on:

- An appropriate medical incident report (MIR) form approved by the County MPD.

Quality Improvement:

The North Central Regional EMS Council will review this PCP upon receipt of suggested modifications from a local provider, the North Central Regional QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least annually.

The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

All EMS providers are encouraged to use the "North Central Regional Cardiac / Stroke EMS Data Form" to capture QI data to identify areas for system improvement.

All hospital providers are encouraged to utilize the "North Central Regional Cardiac / Stroke Hospital Data Collection Tool" to capture QI data to identify areas for system improvement.

APPENDICIES ADDITIONAL

Appendix A. County Operating Procedures (COP's) are available upon request in the Regional Council Office and on the NCECC.org website.

Greater Wenatchee EMS Council
http://ncecc.net/chelan-s-douglas-county/county-protocols/

Okanogan – North Douglas County EMS Council
http://ncecc.net/n-okanogan-douglas-county/county-protocols/

Grant County EMS Council
http://ncecc.net/grant-county/county-protocols/

Washington State Department of Health Geographic Information System
http://ww4.doh.wa.gov/gis/EMS.htm