

**NORTH CENTRAL REGION
EMERGENCY MEDICAL SERVICES
& TRAUMA SYSTEM**

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

July 1, 2017 – June 30, 2019

Submitted by the North Central Region EMS and Trauma Care Council

Approved by EMS & Trauma Steering Committee
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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 250,953 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 and Trauma Verified aid and ambulance response agencies within North Central Region; 33 of which are all volunteer based response, with 55% of the regions providers being volunteers.

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. The North Central Regional Council and County Councils addressed several mergers of agencies within the region and the disbanding of two agencies in the Northern counties due to failing leadership, funding, and a decline in providers. This created a challenge in meeting the response and transport needs of the community and prevailed upon a neighboring EMS agency for assistance. At this time there is no trauma response area identified by County Councils or Department of Health without EMS coverage.

The North Central Regional Council established a Community Paramedicine Mobile Integrated Healthcare workgroup that participates with the North Central Accountable Communities of Health Partners and the Washington Rural Health Association to establish collaborative efforts in the development of an affordable, efficient, and comprehensive community based system. We believe Community Paramedicine to be part of the solution for agencies facing a decline in reimbursement rates, future funding streams, and a positive impact towards recruitment and retention.

The current Min/Max numbers were reviewed for both EMS Agencies and designated trauma services in preparation for the 2017-2019 plan; no changes were identified, see Appendix 1 for Min/Max.

Prehospital Verified Services

County	AMBV-ALS	AMBV-ILS	AMBV-BLS	AIDV-ALS	AIDV-ILS	AIDV-BLS
Chelan	4	0	3	0	0	4
Douglas	0	0	3	0	0	2
Grant	3	0	8	0	0	5
Okanogan	2	1	3	0	0	4

Numbers are current as of date submitted.

Prehospital Non-Verified Services

County	AMB-ALS	AMB-ILS	AMB-BLS	AID-ALS	AIV-ILS	AID-BLS
Chelan	0	0	0	0	0	3
Douglas	0	0	0	0	0	1
Grant	0	0	0	0	0	1
Okanogan	0	0	1	0	0	0

Numbers are current as of date submitted

Designated Trauma Services

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

Numbers are current as of date submitted

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 date submitted

The North Central Regional Council 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 Regional Council and East Regional Council have successfully consolidated administrative services via contract since July 2013. This consolidation has reduced duplication of administrative services, significantly reducing expenses. It also allows both regions to accomplish the work of the DOH contract while maintaining the same level of system support.

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”

The North Central Regional Council’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 Regional Council 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.
- North Central Region QI Committee: Comprised of members of each designated facility’s medical staff, the RN Coordinator of each service, EMS Providers, Medical Program Directors, and Regional Council members. The Mission of the North Central Region QI Committee is “strives to optimize Emergency Systems of Care through a collaborative multidisciplinary approach 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.
- Community Paramedicine 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.

This workgroup participates with the North Central Accountable Communities of Health Partners and the Washington Rural Health Association to establish a collaborative efforts in development of an affordable, efficient, and comprehensive community based system.

The North Central Regional Council is a sub-recipient with Chelan-Douglas Public Health of the Public Health Emergency Preparedness Response contract to facilitate the Hospital Preparedness Program deliverables. The North Central Region has been involved in this capacity since its inception and was instrumental in the establishment of the Region 7 Healthcare Coalition. Region 7 includes Okanogan, Chelan, Douglas, Grant, and Kittitas Counties. Coalition members are comprised of representatives from Hospitals, Health Districts, Community Health Centers, and Emergency Management.

The North Central Regional Council structure includes County Emergency Management members who participate on the Region 7 Healthcare Coalition; thus providing guidance to the Council on wildfire and EMS Response plans in the North Central Region. North Central Regional Council members and regional staff participate in Region 7 Healthcare Coalition meetings, review and revision of the Region 7 All Hazards Plan, tabletop and functional exercises.

The Mission of the Healthcare Coalition is:
Planning for surge capacity and capability for region-wide resource management in large scale emergencies.

The Regional Council has had a number of successes during the 2015-2017 planning period:

- Accomplished the work outlined in the 2015-2017 strategic plan including the review of min/max numbers, trauma response area maps, and review of agency information provided by the Department of Health.
- Completed Council roles and responsibilities education mandated by the State of Washington.
- Completed State Assessment Audits of financial accountability without findings.
- Provided leadership assistance to County Councils addressing strategic planning, licensure, certification, financial documentation, and council structure.
- Provided training grants to County Councils for provider requested training specific to their County needs that included ongoing training required for recertification, PreHospital Trauma Life Support (PHTLS), Mass Casualty

Incident training, partial funding of Initial EMS Courses, and EMS Evaluator renewal courses.

- Provided EMS System information presentations to County Councils and County Commissioners.
- Collaborated with regional MPD's on development of a regional set of MPD Protocols. This project will benefit providers who work in more than one county within the region and provide consistent patient care across Chelan, Douglas, Okanogan, and Grant Counties.
- Maintained status of the Department of Health approved Training Program for initial EMS course. The Training Program works closely with the Senior EMS Instructors, EMS Evaluators, Lead Instructors, and MPD's to ensure quality courses are provided consistent with National Education Standards and WAC.
- Provided funding to Injury Prevention Partners for continuation of programs that address senior falls, bicycle safety, distracted driving, driving under the influence, and babysitting safety for the child and sitter.
- Collaborated with Region 7 Healthcare Coalition to provide education, training, and equipment to EMS providers and agencies for Ebola and other highly infectious diseases.
- Participated in Regional Advisory Committee, Prehospital TAC, Licensing and Verification Adhoc Workgroup, EMS Education Workgroup, and attended State Steering Committee meetings.

The North Central Regional Council has encountered ongoing challenges of Council Board vacancies, dissemination of Department of Health updates and information at the EMS Provider level, and updated Regional Patient Care Procedures and County Operating Procedures that will be addressed in the 2017-2019 Regional Council Strategic Plan.

GOAL I

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

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 50 -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, cardiac, and stroke services. The Regional Council relies on input and recommendations from County Councils and County Medical Program Directors to identify and recommend minimum and maximum numbers for Prehospital levels of licensed and verified agencies.

Objective 1. By November 2018, Regional Council will utilize Department of Health standardized methodology to determine minimum and maximum numbers and levels of trauma designated and rehabilitation services in the North Central Region and forward any recommended	Strategy 1. By June 2018, Regional Council will request time on Regional QI agenda to present current trauma designated and rehab services min/max numbers and request input from Regional QI committee for any suggested revisions.
	Strategy 2. By September 2018, Regional QI recommendations will be reported to the Regional Council for discussion.

<p>revisions to the Department of Health.</p> <p><i>Open designation letter and intent to apply in 9/2017</i> <i>Department announced designation decisions in 4/2018</i></p>	<p>Strategy 3. By October 2018 Regional Council will forward any recommended trauma designated and rehab services min/max revisions, including unserved or underserved areas to Department of Health.</p>
<p>Objective 2. By June 2019, 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.</p>	<p>Strategy 1. By October 2018, 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.</p> <p>Strategy 2. By December 2018, Prehospital and Transportation Workgroup will request Local EMS Council submit recommended min/max changes for review.</p> <p>Strategy 3. By February 2019, Prehospital and Transportation Workgroup will report any Local EMS Council min/max recommended changes to the Regional Council for approval.</p> <p>Strategy 4. By April 2019, Regional Council will forward any recommended Prehospital min/max revisions, including any unserved or underserved areas to Department of Health.</p>
<p>Objective 3. By March 2018, the Regional Council will develop, review, revise and implement Regional Patient Care Procedures.</p>	<p>Strategy 1. By August 2017, Prehospital and Transportation Workgroup will present current Regional Patient Care procedures and Department of Health PCP Guidelines to County MPDs with request for review and recommended revisions.</p> <p>Strategy 2. By December 2017, Prehospital and Transportation Workgroup will review current approved Patient Care Procedures and recommended revisions from County MPDs and forward recommended changes to Regional Council.</p> <p>Strategy 3. By February 2018, Regional Council will forward recommended revisions of Patient Care Procedures to the Department of Health for approval.</p>

	<p>Strategy 4. On an ongoing basis, Regional Patient Care Procedures will be distributed to regional EMS providers, agencies, and MPD's, and placed on the NCECC.org website.</p>
<p>Objective 4. By October 2018, the Regional Council will review Local Council County Operating Procedures for congruency and alignment with Regional Patient Care Procedures.</p>	<p>Strategy 1. By June 2018, Prehospital and Transportation Workgroup will review County Operating Procedures for congruency with Regional Patient Care Procedures.</p>
	<p>Strategy 2. By July 2018, 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.</p>
	<p>Strategy 3. By October 2018, Regional Council will assist Local EMS Councils in submitting updated County Operating Procedures to Department of Health for approval.</p>
	<p>Strategy 4. On an ongoing basis, County Operating Procedures will be distributed to regional EMS providers, agencies, and MPD's and placed on the NCECC.org website.</p>
<p>Objective 5. By June 2018, the Region Council will reconcile Prehospital agency contact information, personnel resources, and level of service.</p>	<p>Strategy 1. By February 2018, the Prehospital and Transportation workgroup will obtain from the Department of Health a detailed list of Prehospital agency information.</p>
	<p>Strategy 2. By May 2018, the Prehospital and Transportation workgroup and Local EMS Councils will utilize the agency survey to update contact information.</p>
	<p>Strategy 3. By June 2018, the Prehospital and Transportation workgroup will reconcile the information to ensure it is correct and up to date.</p>
	<p>Strategy 4. By June 2018, the Regional Council will provide updated agency information to Department of Health.</p>
<p>Objective 6. By November 2018, the Regional Council will review the categorization levels for Cardiac and Stroke</p>	<p>Strategy 1. By June 2018, Regional Council 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.</p>

facilities.	Strategy 2. By September 2018, regional Cardiac and Stroke QI recommendations will be reported to Regional Council for discussion.
	Strategy 3. By October 2018 Regional Council will forward any recommended Cardiac and Stroke categorization revisions, including unserved or underserved areas to Department of Health.

WA State Department of Health Resource links:

[Trauma Designated Services List](#)

[Cardiac and Stroke Categorized Facilities](#)

[Interactive Emergency Medical Care Map](#)

GOAL 2

A strong, efficient region-wide system of emergency care services coordinated by the Regional Councils, comprised of health and medical care providers, and other partners, who are fully engaged in the regional and local emergency care services system that supports the statewide system.

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.

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 in an attempt to bridge the gap of knowledge from the provider to the public; and will be participating in the distribution of educational materials made available from the State Ad hoc Committee for Public Outreach.

<p>Objective 1. During July 2017 – June 2019, the Regional Council will implement the Regional EMS and Trauma Strategic Plan.</p>	<p>Strategy 1. By August 2017, or when the Plan is approved by Department of Health, the Regional Council will distribute the updated 2017-2019 Plan to Local Councils, MPDs, and post the Plan on the NCECC.org website.</p>
	<p>Strategy 2. Throughout the Plan timeframe, contract deliverable reports will be shared at Regional Council meetings identifying plan work progress and accomplishments.</p>
<p>Objective 2. By April 2019 Regional Council will develop a 2019- 2021 Emergency</p>	<p>Strategy 1. By October 2018, Plan Development Workgroup will use 2017-2019 Plan accomplishments to develop strategies for the 2019-2021 Strategic Plan.</p>

<p>Medical Services and Trauma Care Council Strategic Plan.</p>	<p>Strategy 2. By December 2018, Regional Council will review the draft 2019-2021 Regional Strategic Plan for approval.</p> <p>Strategy 3. By February 2019, Region approved 2019-2021 Strategic Plan will be submitted to Department of Health for review and approval.</p> <p>Strategy 4. By April 2019, Department of Health reviewed and approved 2019-2021 Plan will go forward to Steering Committee for approval.</p>
<p>Objective 3. During the Plan cycle the Regional Council will facilitate the exchange of information throughout the emergency care system.</p>	<p>Strategy 1. On an on-going basis, office staff will distribute and share via email and Regional Council website, pertinent local, regional, state and national information with emergency care system partners.</p> <p>Strategy 2. During 2019-2021 Strategic Plan cycle, office staff will share contract deliverable report information with Local EMS Councils and MPDs.</p>
<p>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.</p>	<p>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.</p> <p>Strategy 2. On an on-going basis, North Central Region Council will implement business practice recommendations from State Auditor’s Office and Department of Health for compliance with RCW.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

<p>Objective 5. During July 2017 - June 2019, the Regional Council will collaborate to educate the public and our partners on the Emergency Care System</p>	<p>Strategy 1. By October annually, current Regional and State Public Information presentations available will be reviewed and revised as needed by the Regional Council for education of the Emergency Care System.</p>
	<p>Strategy 2. By November annually, Regional Council will approve updated Public Information brochures and media.</p>
	<p>Strategy 3. By December annually, updated approved Public Information brochures and media will be posted on the NCECC.org website and made available to regional and state partners.</p>
	<p>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 to the public, healthcare facilities, and organizations utilizing Regional Council staff and representatives.</p>

GOAL 3

A sustainable regional pre-hospital EMS system using standardized, evidence-based procedures and performance measures that address out-of-hospital emergency trauma and medical care.

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 Quality Improvement Committee regarding compliance with state approved Key Performance Indicators in addition to the Local Council Training Survey 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 by monitoring Instructor's, participant success with National Registry Testing, and providing reports to County MPD's.

The Prehospital and Transportation workgroup reviews County Operating Procedures, Regional Patient Care Procedures, and Min/Max numbers in determining unserved 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.

<p>Objective 1. By June annually, the Regional Council will allocate funding, as outlined in Department of Health contract, to support Emergency Care Education Programs.</p>	<p>Strategy 1. 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.</p>
	<p>Strategy 2. 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.</p>
<p>Objective 2. Annually by June, the Training and Education Committee will provide Emergency Care Education for providers in the North Central Region.</p>	<p>Strategy 1. Annually by May, the Training and Education Committee will determine a budget for Local County Councils pre-hospital training and education.</p>
	<p>Strategy 2. Annually by July, the Training and Education Committee will advise Local County Councils of budget and provide guidance for use of funds based off previous fiscal year agency training survey.</p>
	<p>Strategy 3. Annually by September, Local County Councils must provide an outline and/or proposal for use</p>

	<p>of training funds to the Regional Training and Education Committee for review and approval.</p>
	<p>Strategy 4. On an on-going basis, the Local County Councils will provide activity reports and participant feedback forms to the Regional Training and Education Committee.</p>
	<p>Strategy 5. On an ongoing basis the Training and Education Committee will review Local County Councils activity reports and participant feedback and distribute report to the Regional Council, Local County Councils, and Medical Program Directors.</p>
<p>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.</p>	<p>Strategy 1. On an ongoing basis, the Training and Education Committee will assist Senior EMS Instructors with Initial EMS Course approval, commencement, and completion.</p>
	<p>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.</p>
	<p>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.</p>
	<p>Strategy 4. Annually, by March, Training and Education Committee will hold a Senior EMS Instructor workshop for Instructors aligned with Regional Training Program.</p>
	<p>Strategy 5. On an ongoing basis, Senior EMS Instructors aligned with Regional Training Program will participate in Quality Assurance and Improvement Program requirements.</p>
	<p>Strategy 6. Annually, by June, the Regional Training and Education Committee will review the Regional Training Program Policy and Procedures manual and make necessary revisions congruent with WAC, RCW, and Department of Health guidance documents.</p>
<p>Objective 4. By March 2018, the North Central Region Council will distribute Department of Health approved Key Performance Indicators to stakeholders in the North Central Region.</p>	<p>Strategy 1. By December 2017, the Regional Training and Education Committee will review the Regional QI plan for current Prehospital Key Performance Indicators.</p>
	<p>Strategy 2. By March 2018, the Regional Training and Education Committee will provide County MPDs and Local EMS Councils with current Region QI Plan that includes Pre-hospital EMS Key Performance Indicators.</p>

	<p>Strategy 3. Throughout the Plan timeframe, the Regional Training and Education Committee will distribute Regional QI updates on Prehospital Key Performance Indicators currently being monitored to regional Prehospital system stakeholders. (MPDs, SEIs, EMS Evaluators, agency directors and providers.)</p>
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GOAL 4

Reduce preventable/premature death and disability due to trauma, stroke, and cardiac illness.

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 and premature death and disabilities.

Programs supported by the North Central Region include; Senior Falls/Fall Risk, Safe Kids for bicycle safety and helmet fittings, Safe Sitter for 11-13 year olds, Public Automated External Defibrillator training, and The Force is With You focused on teen injury prevention education. The Region provides funding to Wellness Place, which is the lead agency in collaboration with the Department of Health to administer the Stay Active and Independent for Life Program in Washington State.

<p>Objective 1. 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 and/or best- practice activities to support prevention efforts in North Central Region.</p>	<p>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.</p>
	<p>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.</p>
	<p>Strategy 3. By December annually, Executive Director will secure deliverable contracts with selected injury prevention partners to provide injury prevention programs.</p>
	<p>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.</p>

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 Region established a Community Paramedicine 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.

This workgroup participates with the North Central Accountable Communities of Health Partners and the Washington Rural Health Association to establish a collaborative efforts in development of an affordable, efficient, and comprehensive community based system.

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.

<p>Objective 1. During July 2017- June 2019 Strategic Plan cycle, East and North Central Region Councils will continue sharing of coordinated resources and determine areas of possible consolidation.</p>	<p>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.</p>
	<p>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.</p>
	<p>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.</p>

<p>Objective 2. During July 2017 – June 2019 Regional Community Paramedicine Mobile Integrated Healthcare Workgroup will establish collaborative multidisciplinary efforts to develop an affordable, efficient, and comprehensive community based system of care.</p>	<p>Strategy 1. By June 2019, Community Paramedicine MI Workgroup will work collaboratively with healthcare providers to host an educational Summit for Community Paramedicine partners.</p> <p>Strategy 2. Throughout the plan timeframe, Community Paramedicine MIH will establish workgroups and partnerships to promote Health Care Transformation and Telehealth.</p> <p>Strategy 3. Throughout the plan timeframe, the Community Paramedicine MIH Workgroup will provide status reports, Department of Health updates, and stakeholder feedback to Regional Council.</p>
<p>Objective 3. During July 2017-June 2019 Strategic Plan cycle, the Regional Council will determine methods to increase funding sources compliant with State regulations.</p>	<p>Strategy 1. Throughout the plan timeframe, the Executive Director will collaborate with Regional Advisory Committee and the Department of Health to develop a fundraising template.</p>
	<p>Strategy 2. Throughout the plan timeframe, the Executive Director, Executive Committee, and Finance Committee will review and consider opportunities for Regional Grant funding.</p>

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)
	AIDV – BLS	4	6	4
	AIDV –ILS	0	0	0
	AIDV – ALS	0	0	0
	AMBV –BLS	3	3	3
	AMBV – ILS	0	0	0
	AMBV - 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)
	AIDV – BLS	1	2	2
	AIDV –ILS	0	0	0
	AIDV – ALS	0	0	0
	AMBV –BLS	3	3	3
	AMBV – ILS	0	0	0
	AMBV - 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)
	AIDV – BLS	4	11	5
	AIDV –ILS	0	0	0
	AIDV – ALS	0	0	0
	AMBV –BLS	4	8	8
	AMBV – ILS	0	5	0
	AMBV - 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)
	AIDV – BLS	1	5	4
	AIDV –ILS	0	0	0
	AIDV – ALS	0	0	0
	AMBV –BLS	3	4	3
	AMBV – ILS	0	1	1
	AMBV - 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 Lake Wenatchee Fire and Rescue	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 borders include NF7601, NF11 and border 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 #1 and 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.	
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*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 over to V NE, 1 mile north – 1 mile west – 3 miles south – 2 miles west – south to Road 12 NE.	D2, E1, F1
	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

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

Aid-BLS = A Ambulance-BLS = D
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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	A2, D1

		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.	
	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.

WA State Department of Health

[Interactive Emergency Medical Care Map](#)

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

WA State Department of Health
[Trauma Designated Services List](#)

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 911 dispatch 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: 02/03/2016

I) Purpose:

- 1) 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.
- 2) To institute a program of continuous evaluation to determine the best utilization of air medical services in our region.

II) Standards:

- 1) Early activation of air ambulance services should be initiated as soon as scene location and patient conditions would favor, by at least 15 minutes, air transport of the critical trauma or critical medical patient to the highest level hospital within 30 minute flight time.

III) Procedure:

- 1) Air ambulance services should be used when it will reduce total out-of-hospital time for a critical trauma, cardiac, or stroke patient by 15 minutes or more or provide for the patient to arrive at a higher level trauma, cardiac, or stroke hospital within 30 minutes or less even if a lower level hospital is closer.
- 2) Air ambulance services may be used for a medical and non-major trauma patient under special circumstances and only with clearance by medical control.
- 3) Prehospital personnel en route to the scene should make the request for early activation of an air ambulance service or place them on standby for an on-scene response.
- 4) The call must be initiated through the appropriate medical emergency dispatching agency.
- 5) The helicopter communications staff will give an ETA to the dispatch center requesting a scene response. This ETA will include the total time for a helicopter to arrive on scene.
- 6) The responding helicopter will make radio contact with the receiving hospital at, or shortly after liftoff from the scene.
- 7) 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.
- 8) Scene flights; the helicopter responding to the scene will have ground contact with an agency on scene based on each Counties established air to ground frequency.
- 9) Air Medical resources should be strongly considered during an MCI. If such request is made the requesting agency should clearly communicate the need for either fixed wing or rotor wing, along with the number of each type of aircraft requested.

IV) Definition:

- 1) “*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.
- 2) “*Launch Time*” Launch time is the time the skids lift the helipad en route to the scene location.
- 3) “*Early Activation*” Departing for a requested scene prior to arrival of the first responders, based on a high suspicion that specialty services will be necessary.

V) Quality Improvement:

Air medical agencies operating in North Central Region will provide quarterly data reports with QI audit filters established and agreed upon by each local council / MPD.

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 center 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 MCI 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 Triage Tools links to most current document.

State of Washington Prehospital Trauma Triage Destination Procedure

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

State of Washington Prehospital Cardiac Triage Destination Procedure

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

State of Washington Prehospital Stroke Triage Destination Procedure

<http://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf>