

Regional and Local EMS and Trauma Care Council Resource Handbook



Office of Community Health Systems
EMS and Trauma Systems Regional Support

2016 Update

The Resource Handbook is available on the Department website at:

<http://www.doh.wa.gov/Portals/1/Documents/Pubs/346058.pdf>

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Introduction

The purpose of this handbook is to provide information on the history and operations of the emergency medical services and trauma care system (EMS and TCS) in Washington State. The main audience is members of regional and local EMS and trauma care councils in the state. It is also a tool for orienting new local or regional council members and others interested in the system. The Washington State Department of Health (department), Office of Community Health Systems (OCHS) is responsible for updating the handbook, which is available for download as a [PDF document](#) from the Department of Health website.

Here are the overarching visions from RCW, which started the Washington State EMS and trauma care system 26 years ago:

- It is in the best interest of the citizens, [residents, and visitors] of Washington State to establish an efficient and well-coordinated statewide emergency medical services and trauma care system to reduce costs and incidence of inappropriate and inadequate trauma care and emergency medical service, and minimize the human suffering and costs associated with preventable mortality and morbidity (RCW 70.168.010)
- “Trauma care system” means an organized approach to providing care to trauma patients that provide personnel, facilities, and equipment for effective and coordinated trauma care... The trauma care system includes prevention, prehospital care, hospital care, and rehabilitation. (RCW 70.168.015) – Definitions.

Through operational guidance by the regions and the department, prehospital emergency response to and hospital capabilities and specialization in treating trauma, cardiac, and stroke patients are established and integrated into the system. Whether trauma, cardiac, stroke, or other medical issue, the best possible patient outcome is a principal goal for the system.

Regional systems support and help sustain the statewide system so there is continuity in EMS and trauma care. Regardless of where in Washington State someone is injured or sick, first responders and hospital staff members are trained; have the right equipment and tools; and, know the protocols and systems to help residents and visitors reduce their risk of disability and death. This is a “TEAM” approach: “Together Everyone Achieves More.”

Brief History of EMS and Trauma Systems in the United States

Before 1969

Until the late 1960s, few areas in the nation had adequate prehospital emergency medical care. The thought was care began in the hospital emergency department. Rescue techniques were crude, ambulance attendants poorly trained, and equipment minimal. There was no radio communication and no physician involvement. Before 1966, morticians, private ambulance services, or fire departments did most emergency transport services.

In 1966, federal highway traffic safety funds were granted to states to improve their EMS systems. This helped make substantial improvement in basic life support systems, especially in EMS training and communications. In November 1973, Congress passed Public Law 93-154, otherwise known as the Emergency Medical Services Systems Act, directing funds to develop regional EMS systems.

In 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) passed Congress, effectively eliminating all federal funding for EMS. The EMS grant program folded into the federal Preventive Health Block Grant, jointly administered by Department of Transportation (DOT) and Department of Health and Human Services (DHHS). Only a small portion of this money was available for EMS programs.

Washington State EMS-Trauma System Legislation - over the years

1970 – 1989

In 1971, the Washington State legislature amended the Revised Code of Washington (RCW) 18.71.200 to include paramedic certification as part of the Physicians' Practice Act. This RCW was again revised in 1978 to appoint the Washington Department of Social and Health Services (DSHS) and the University of Washington as certifying agencies of paramedic personnel. It also established three levels of advanced life support personnel: I.V. technician, airway technician, and paramedic. Specific educational and skill maintenance requirements were set for each level.

In 1973, the legislature created RCW 18.73, (Emergency Medical Care and Health Services Act). This legislation established minimum baseline standards for patient care. The law provided for the state to inspect and license prehospital emergency services.

In 1979, the EMS system was further expanded and improved. RCW 18.73 was changed to provide guidelines for the continued development and improvement of EMS systems. The law created eight regional EMS councils as a key component in the state EMS planning process. About \$2.5 million biennially funded the state's regional EMS program.

In 1983, the legislature revised the EMS legislation to include First Responders. This law also gave legal standing to county Medical Program Directors (MPDs) and local EMS councils. In 1989, the legislature created the Washington State Department of Health (DOH), and moved the state's EMS oversight from DSHS to DOH.

In 1988, legislation passed requiring a study to determine the need for a trauma system in the state. The study and final report described the need for, and necessary components of, a functional and effective statewide trauma care system. This report to the 1990 legislature established the Washington State EMS and trauma care system (EMS and TCS) in RCW 70.168. The EMS system was expanded to include trauma response and care.

1990 – Forward

The statewide Emergency Medical Services and Trauma Care System Act substantially amended state law related to ambulance and aid services. It included verification of personnel and services responding to trauma cases; and, included trauma training requirements for basic life support (BLS) and advanced life support (ALS) personnel.

Requirements were established for the designation of five levels of trauma care facilities (hospitals and clinics). This act is the basis for a well-coordinated, integrated, statewide emergency medical services and trauma care system that includes prevention, prehospital care, hospital care, and rehabilitation. The DOH Office of Community Health Systems is responsible for the overall management, oversight, contracts, and compliance of the statewide EMS and trauma care system.

In 1997, the state legislature established dedicated funding for trauma care through the Trauma Care Services Fund Act. This fund is used to compensate trauma care providers for unreimbursed care of trauma patients. The sources of funding are a \$5 surcharge on all vehicle moving violations, and \$4 of a \$6.50 administrative fee on the sale or lease of a new or used vehicle. Fund collection began January 1, 1998.

Recipients include:

- Verified prehospital agencies,
- Designated trauma care services,
- Physicians who provide trauma care at designated trauma services; and,
- Designated trauma rehabilitation services.

A summary of fund performance is available from the DOH Office of Community Health Systems.

In May 2006, more than 120 stakeholders from across the state had a planning retreat to begin work on a Washington State EMS and trauma care system strategic plan. Participants completed system assessments to use in developing strategic plan goals, objectives, and strategies to move the system forward over a five year period. The five-year planning cycle continues to guide system work. Progress is reviewed regularly, and the plan is updated every three years.

The 2010 state legislature added emergency cardiac and stroke (ECS) care to the EMS and trauma care statute. In the intent section of the law, it recognizes: “The minutes after the onset of heart attack, cardiac arrest, and stroke are as important as the ‘golden hour’ in trauma. When treatment is delayed, more brain or heart tissue dies. Timely treatment can mean the difference between returning home or becoming permanently disabled, living at home, or living in a nursing home. It can be the difference between life and death. Ensuring most patients will get lifesaving care in time requires preplanning and an organized system of care.”

The ECS system work includes more consistent training and standards for prehospital providers; expanding access to ECS care in rural and underserved areas; voluntary hospital participation and categorization by meeting national standards of care; and quality improvement through data collection, reporting, and sharing.

More information and a current list of categorized emergency cardiac and stroke hospitals are at [www.doh.wa.gov/Emergency Cardiac and Stroke System](http://www.doh.wa.gov/Emergency%20Cardiac%20and%20Stroke%20System).

Starting July 16, 2015, the federal Centers for Disease Control and Prevention (CDC) funded the Paul Coverdell National Acute Stroke Prevention Grant in Washington State. The grant lasts until June 29, 2020. The grant's goals are:

- Improve public recognition of stroke warning signs, and increase quick activation of the EMS system.
- Improve transitions from EMS to ED, and improve transitions from hospital to home or rehabilitation settings and return to primary care provider.
- Enhance patient and caregiver education; improve understanding of on-going post-stroke care, ongoing rehabilitation and prevention of further strokes.
- Improve systems of stroke care through coordination of stroke prevention and care activities.
- Reduce time to treatment.
- Improve EMS quality of care; improve ED and hospital quality of care as measured by adherence to established guidelines for care and quality metrics.
- Improve cholesterol, hypertension, and tobacco control; improve early medication adherence post-hospital.
- Improve access to community services and rehabilitation.
- Improve receipt and understanding of on-going post-stroke care.
- Reduce 30-day hospital readmissions and 30-day mortality following acute stroke.
- Develop and use an integrated data collection system that can link across the continuum of care for EMS, hospital, and post-hospital care to address data-driven QI in these different care settings.
- Strengthen statewide infrastructure to reduce the burden of stroke morbidity and mortality, and eliminate disparities in care for stroke.
- Identify patient needs in the early post-discharge period.
- Build community systems of coordinated quality improvement for stroke.
- Publish and disseminate lessons learned.

In 2015, a law was passed allowing emergency medical services ambulances and aid services to transport patients from the field to mental health or chemical dependent services (rather than always to an emergency department). Participation is voluntary. Through a multi-disciplinary workgroup, the department developed a guideline for implementing the law; it was distributed to stakeholders in July 2016. Regions shall develop patient care procedures (PCPs) to guide medical program directors and EMS agencies to operationalize transport of patients to these alternative services. Contact your regional council office or county MPD for more information.

Regional EMS and Trauma Care Systems

As established by RCW 70.168, there are eight EMS and trauma care regions in Washington State. The eight regions and their counties are:

- **Central Region:** King
- **East Region:** Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Whitman
- **North Region:** Island, San Juan, Skagit, Snohomish, Whatcom
- **North Central Region:** Chelan, Douglas, Grant, Okanogan
- **Northwest Region:** Clallam, Jefferson, Kitsap, Mason
- **South Central Region:** Benton, Columbia, Franklin, Kittitas, Walla Walla, Yakima
- **Southwest Region:** Clark, Cowlitz, Klickitat, south Pacific, Skamania, Wahkiakum
- **West Region:** Grays Harbor, Lewis, north Pacific, Pierce, Thurston

Regional EMS and trauma care councils

Each of the eight EMS and TC regions has a regional council organized to develop, operate, plan, and help sustain the EMS and trauma system as grass-roots entities that support the statewide system. The councils include members from local EMS and trauma care (EMS-TC) councils, other EMS-related stakeholders, and partners from across the region. Each council elects its own executive board, the makeup of which varies per its bylaws.

Regional council business models

Regional councils operate as quasi-municipal entities; functional equivalents of public agencies. They are funded by both state and federal grants, and are subject to audit by the State Auditor's Office. Council members have fiduciary and legal responsibilities to the regional council as a corporate entity, as well as responsibilities defined in RCW and WAC; (RCW 70.168.120; WAC 246-976-960).

When performing their duties as defined in statute, regional EMS-TC councils act as public agencies as defined in RCW 42.30.020 (1)(c), and are subject to the Open Public Meetings Act (OPMA) RCW 42.30, and the Public Disclosure Act RCW 42.56.

Regional council membership

Appointment to a regional council is a formal process. Applicants submit new and renewal membership applications to the regional council, after the approval of the local council. Local council appointments to the regional council must reflect a balance of hospital and prehospital trauma care and emergency medical service providers, local elected officials, consumers, local law enforcement, some federal agencies such as U.S. Coast Guard, National Park Service, and local government agencies.

Membership is specified in RCW 70.168.120 (2) and the regional council by-laws. Regional councils may announce vacant positions and membership needs, but do not recommend potential members to the department. That is the role of the local EMS-TC council. In areas where there is no local council, regional council members may recommend people for membership.

The regional council application, appointment process, and how to apply is on-line at <http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EMSandTrauma/CouncilsandCommittees/RegionalCouncilStaff>. Regional council member term of office is three years; council members may be reappointed every three years thereafter. The department sets no term limits.

Regional council appointment process

The regional council membership process works to ensure members appointed to the council are connected to the local council or community they represent. The process for council appointment is:

- 1) People seeking appointment to a regional council need to download and complete the membership application. Application is on the department and regional council websites.
- 2) Applicants who will represent a local agency must get the signature of the appointing authority.
- 3) The applicant must get the local council chair to sign the application form.
- 4) The local council chair sends the application to regional council.
- 5) Regional council staff review for local council signature, organization signature (if needed), and confirm position the candidate will fill. Regional staff members mail, or scan and email, the completed application to the department. Incomplete applications are returned to the applicant.
- 6) Department staff members log the application into the department internal tracking system, and compile an appointment packet for the Office of the Assistant Secretary, Health Systems Quality Assurance.
- 7) The Department of Health's assistant secretary for Health Systems Quality Assurance makes membership appointments.
- 8) Department staff members send letter of appointment to the council member. A copy of the letter is sent to the regional council, and to the department EMS and TC regional support staff.

Regional EMS and trauma care council member responsibilities

1. Responsibility to the general public:

Make the best decisions to ensure the EMS and trauma system functions in a timely, safe, and appropriate manner. Ensure regional council work is carried out in a fiscally responsible manner. The public needs to know about the work of the regional EMS-TC council, and needs an avenue to resolve issues that arise in the system. The councils must hold open public meetings. Meetings will be advertised and announced in advance, with minutes taken and made public.

2. Responsibility to an agency or organization you are representing:

Act as a liaison between the regional EMS-TC council, and the agency or organization the member represents; and share information, challenges, and outcomes with each to improve and sustain the regional system. Council members must consider the needs of the overall EMS-TC system to work well for the whole region.

3. Responsibility to the Department of Health:

Provide unbiased recommendations to maintain, improve, and sustain a high-quality, statewide EMS-trauma care system. Regional council members monitor finances of the regional council by reviewing and approving the annual budget, and distribution of regional resources, most of which the department contracts to the region.

4. Responsibility to other council members:

Attend meetings regularly, listen to other members, consider their views and contributions, and work to make decisions and solve problems in the best interests of an effective and efficient regional system that supports the statewide system.

5. General regional council member responsibilities:

- a. Be an active member of the organization you represent on the regional council.
- b. Routinely share information from the regional council to their local council, and vice versa.
- c. Regularly attend regional council meetings.
- d. Engage and actively participate in regional council committees and workgroups.
- e. Help develop and implement the regional plan and track its progress.
- f. Be accountable for work required in the regional plan.
- g. Be accountable for deliverables required in regional contracts with the Department of Health.
- h. Hold regional council staff members accountable for submitting contract deliverables to the department, on time and complete, in accordance with contract requirements.

Regional EMS and trauma care council executive board

1) Membership:

Each council elects its own executive board. Executive board makeup varies by region, according to its bylaws. Officers typically include chair, vice chair, and secretary-treasurer.

2) In addition to the general responsibilities of regional council membership, executive board members:

- a. Have fiduciary oversight of the regional council work, budget and finances, contracts, grants, etc.
- b. Help develop and oversee the annual regional budget and fiscal actions, how money is gained, and how it is spent.
- c. Act reasonably, prudently, and in the best interests of the regional council, to avoid negligence and fraud.
- d. Stays informed and ask questions.
- e. Avoid conflicts of interest.
- f. Develop and implement clear and concise administrative policies and/or procedures.
- g. Provide operational direction and guidance to the regional council.
- h. Actively monitor implementation and outcomes of the regional plan.
- i. Sign all contracts.
- j. Are responsible for oversight of contractual deliverables.

- k. Hold regional staff members accountable for submitting contract deliverables to the department, on time and complete, in accordance with contract requirements.
- l. Executive board members review the regional executive director's performance.

Local EMS and trauma care councils

If a county or group of counties creates a local EMS-TC council, by rule (WAC 246-976-970), it must include, at least: hospital and prehospital providers, local elected officials, consumers, local law enforcement, local government agencies, physicians, and prevention specialists involved in the delivery of EMS-TC. Local council by-laws establish the standards for their membership, membership appointments, and council operations. In areas with no local EMS-TC council, the regional council performs the required duties with help from local providers.

Local EMS and trauma care council member responsibilities

1) **Responsibility to the general public:**

Make the best decisions to ensure the local EMS-TC system functions in a timely, safe, and appropriate manner. Inform the public about the work of the local council, and have an avenue to resolve issues that may arise in the system. The councils must hold open public meetings, with the meetings advertised and announced in advance, and minutes taken and made public.

2) **Responsibility to a represented agency or organization:**

Actively participate in the organization they represent, and be a liaison between the local EMS-TC council and the entity they represent. Share information and challenges between the local council and their member organizations to improve the regional system.

3) **Responsibility to other council members:**

Attend meetings regularly, listen to other members, consider their views and contributions, and work together to make decisions and solve problems in the best interests of an effective and efficient local, regional, and statewide system.

4) **In addition** to responsibilities in Chapter 70.168 RCW and WAC 246.976.970, local council members must:

- a. Participate in determining the minimum and maximum number of verified prehospital agencies needed in the county for the regional EMS and trauma plan.
- b. Recommend to DOH appointment of potential regional council members.

Ethics, confidentiality and the Open Public Meetings Act

Department of Health appoints regional council members under RCW 70.168.120. Even though councils are considered quasi-governmental agencies, state law considers EMS and trauma regional council members to be state officers who are expected to adhere to the ethics of public service. More about public service ethics is in [RCW 42.52](#).

RCW 70.160.130 gives authority for DOH to provide grants to EMS and trauma regional councils.

RCW 70.168 allows the Department of Health's Office of Community Health Systems to contract with regional EMS and trauma care councils in Washington State. This provides funding for assessment, planning, implementation, and tracking outcomes of regional EMS and trauma care systems. The grant-based funding is done through annual or biennial contracts. The Legislature appropriates funding for these grants from state general funds. This funding is to support the regional councils in their duties under RCW 70.168.100.

The department works with regional council leadership to determine deliverables for the contract period. The scope of work in regional contracts focuses on implementing the comprehensive regional EMS-TC system strategic plans, and on advancing regional systems. These plans align with the goals of the State of Washington emergency medical services and trauma system strategic plan, yet are specific to the unique needs of each region.

Regional councils may receive gifts and payments from various sources as stated in RCW 70.168.100. The councils may contract with entities other than the department.

Progress Reporting and Payment Process

Regional councils must follow the department's contracting requirements in the contract-grant award and agreement. This includes the general terms and conditions, statements of work, and all exhibits and reporting documents. Regional councils must notify the department, and have written approval from DOH, if they plan to subcontract these funds. The regional councils are responsible for assuring any subcontractor meets all contract requirements of the department.

On a regular schedule, regional councils submit reports to the department detailing work implementing regional plan goals, objectives, and strategies. The contract outlines the timelines and deliverables. Progress on deliverables must be made and documented for approval of payment. At the end of the contract period, each deliverable must be complete, as defined in the contract, before approval for final payment. If they are not complete, there must be an explanation about why they are not complete and a plan for completing them. A State of Washington A-19 Invoice Voucher must be done and submitted by the regional council to the department for payment of deliverables.

Regional Plans

Regional strategic plan content

The cornerstone in the maintenance, improvement, and sustainability of the state's EMS and trauma care system is the regional strategic plans. Based on plan guidance and a format template from the department, regional councils develop in-depth strategic documents every two years with input from local councils, county medical program directors, and stakeholders in the region. Plans focus on work the regional councils will accomplish. Goals, objectives, strategies, and measuring progress form the heart of the plans.

Regional plans include:

Minimum and maximum numbers of verified and designated trauma care services

Each regional plan includes proposed minimum and maximum numbers of prehospital trauma verified services and designated trauma services (hospitals and clinics). The department grants verification and designation for set periods.

Local EMS-TC councils identify the minimum and maximum numbers of verified prehospital ground services needed in an area, and recommend them to the regional EMS-TC council. Factors to consider for minimum and maximum numbers include: call volume, population density and age distribution, response distances, goal response time, backup unit requirements on major trauma, tiered response, and preventing duplication of service.

The regional councils identify minimum and maximum numbers and levels of designated trauma care services for the regional plan. The EMS and trauma steering committee reviews minimum and maximum numbers, as well as regional plans, and recommends approval or changes to the department.

Regional Patient Care Procedures

Regional patient care procedures (PCPs) define how each EMS-TC system operates. Regional councils develop PCPs with input from county medical program directors (MPDs) and other system stakeholders. All regional plans have PCPs to address basic system functions. Regional councils develop other PCPs as needed in the region. The EMS-TC steering committee and the department review PCPs, which are included as part of each approved regional plan.

County Operating Procedures

County operating procedures (COPs) are included in some regional plans. Local councils and MPDs develop COPs to further define how regional PCPs are applied at the specific county level. COPs cannot conflict with regional PCPs and are not required under law. The EMS-TC steering committee and the department review COPs, which may be included as part of the approved regional plan.

Four Required Goals with Objectives and Strategies

- Goal 1: 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.
- Goal 2: A strong, efficient region-wide system of emergency care services coordinated by the regional councils, comprising 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.
- 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.
- Goal 4: Reduce preventable and premature death and disability from trauma, stroke, and cardiac illness.

- Other goals, with objectives and strategies may be added to meet the needs of the region. Some recent optional goals relate to EMS and trauma leadership sustainability and succession; and, emergency preparedness coordination and planning.

Regional Plan Review and Approval

When the regional EMS-TC system plans are drafted, they are submitted to the department. Department staff members do an internal review and ask for clarifications. Members of the EMS-TC steering committee review the plans and recommend full approval or required and suggested changes. Based on the plan reviews, the department formally approves the plans and notifies the regional councils. Plans are operational for the period defined in the approved plans.

The approved regional EMS and trauma care system regional plans are on the [department and regions' website](#).

Changes and Updates to Regional EMS-TC System Plans

The department reviews and may approve proposed changes to the regional plans. There are two types of changes: substantive and minor or technical. Substantive changes are related to patient care procedures (PCPs), minimum or maximum numbers of designated (hospital) or verified (prehospital) trauma services, higher than minimum standards, and any contested changes to the plan. All other changes are minor or technical.

For a substantive change, the region uses available data and information to write the proposed change, has it reviewed and approved by regional council members (this can be done by email, webinar, in-person, or other method, as long as there is council input) , and submits the need and justification for change to the department. Once reviewed by the department, the proposed change is presented to the EMS-TC steering committee, which makes final recommendations to the department for approval or disapproval of any changes.

Minor or technical changes to the plan must meet current standards. The regional council shares proposed changes to stakeholders for input. If proposed changes are contested, they need to be resolved before submitting to the department. The department reviews, approves or disapproves uncontested minor or technical changes, and notifies the regional council of the action.

Trauma Service Verification and Facility Designation

Prehospital agencies apply to the Department of Health to be a trauma-verified service. The department also designates hospitals and other health care facilities that apply to meet Washington State trauma care standards to provide trauma care.

Prehospital - Trauma Service Verification

The department's Office of Community Health Systems (OCHS) administers the trauma verification application and evaluation process for basic, intermediate, and advanced life support aid and ambulance services. Ground service verification decisions, for both aid and ambulance agencies, are based on county and regional system needs. Applications for verified trauma services must be within the minimum and maximum numbers in the approved regional plan. Air medical verified services needs are determined statewide. All related trauma verification documents are on the agency website at:

<http://www.doh.wa.gov/PublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EMSandTrauma/Publications.aspx#Regional%20EMS%20and%20Trauma%20Documents>

Maps of trauma response areas are in the specific regional EMS and trauma care council offices and on the agency website. <http://ww4.doh.wa.gov/gis/EMS.htm>

Trauma Service Designation – Hospital-Health Care Facility

Designated trauma services are part of the comprehensive statewide EMS and trauma care system. Trauma service designation standards and processes for each level are in WAC 246-976-485. There are five levels of designated trauma care services. In order of resource needs they are level I (highest), II, III, IV, and V. The minimum and maximum number and levels of designated trauma services needed in the regional systems, is determined by each regional council, and is part of each regional strategic plan.

Applicant health care facilities send a letter of intent to apply, followed by a complete application. The department reviews the application, does an on-site review, fully or provisionally designates the facilities, and notifies regional councils when facilities are designated. The department manages the designation process using a regional approach.

Law requires the department use an external review team for levels I, II, and III designations. The review team and department designation staff members evaluate the facility's capability to meet requirements and provide trauma care. Designation of level IV and V does not require the external team, and is generally based on staff review. Trauma service designation is a competitive process established in RCW 70.168, based on the final minimum and maximum numbers of designated trauma services in regional plans. In a competitive situation, the agency designates the health care facilities it considers most qualified to provide trauma care services. Designation is for three years. Detailed information about the designation process is available at:

<http://www.doh.wa.gov/PublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/TraumaSystem/TraumaDesignation.aspx>

Appendices

Appendix A: Link to Washington State EMS-Trauma System Legislation

EMS/Trauma System - Revised Code of Washington (RCW):

<http://www.doh.wa.gov/PublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EMSandTrauma/Statutes.aspx>

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EMS-Trauma System - Washington Administrative Code (WAC):

<http://www.doh.wa.gov/PublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EMSandTrauma/Rules.aspx>

Appendix B: RAC TAC Information

Regional Advisory Committee (RAC)

The RAC is a technical advisory committee to the state EMS and Trauma Care Steering Committee. It includes regional executive directors and chairs from each of the EMS-TC regional councils, is staffed by the department, and meets every other month.

RAC TAC CHARTER

Adopted March 2013; reviewed and reapproved September 2015

Mission: Advise the EMS and Trauma Steering Committee on EMS and trauma issues, and share information across regional systems.

Purpose: Support the EMS and trauma care system as outlined in the state strategic plan.

Objectives:

- The RAC will assist state EMS and Trauma Steering Committee and DOH with accomplishing work of the EMS and trauma strategic plan.
- The RAC will serve as a conduit for sharing information between the EMS and Trauma Steering Committee, technical advisory committees, and local and regional EMS and trauma care systems.

Membership:

- Membership is limited to people from those regions of the State of Washington, as defined in RCW 70.168.110 and by DOH.
- The designee and alternate designee shall be selected by the region council.

Leadership:

- The RAC chair will be appointed by the EMS and Trauma Steering Committee.
- The RAC vice chair will be a RAC member and will lead the TAC in the chair's absence.

Member Responsibilities:

- Attend state steering committee, TACs and system stakeholder association meetings, including those meetings designated by the RAC TAC.
- Attend and participate in all RAC TAC meetings.

Meetings:

- A quorum will be a simple majority
- Meetings will be conducted in accordance with Washington statute and rule – Open Public Meetings Act.
- The meetings will be scheduled bimonthly on the day before the EMS and Trauma Steering Committee meeting, and otherwise as needed.
- DOH will be responsible for the meeting venue, arrangements, and agenda.
- Each regional council will have one vote.
- The RAC chair votes only in case of a tie.
- Updates from other TACs and stakeholder association meetings will be provided, as available.
- DOH will staff the meetings, including taking minutes.
- DOH will archive approved minutes.

**Regional Advisory Committee Technical Advisory Committee (RAC TAC)
Member List Updated August 29, 2016**

Central Region EMS and Trauma Care Council (King County)

Rachel Cory, Executive Director
22414 87th Ave. W.
Edmonds, WA 98026
206-909-8038

rachelcory@comcast.net

Website: www.centralregionems.org

Chris Martin, Chair
Airlift Northwest
6505 Perimeter Road S. No. 200
Seattle, WA 98108

clmartin@uw.edu

East Region EMS and Trauma Care Council

Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Whitman counties

Rinita Cook, Executive Director
123 Ohme Garden Road, Suite B
Wenatchee, WA 98801
509-664-4032

FAX: 509-436-0019

rcook@ncecc.org

Website: www.eastregion-ems.org

Adam Richards, Chair
Sacred Heart Medical Center
Emergency Department
101 W. Ninth Ave.
Spokane, WA 99204

509-474-3374

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North Region EMS and Trauma Care Council

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Appendix C: Resources

Washington State EMS and trauma system information on the Department of Health website:

Contact Us	How to contact Health Services Quality Assurance.
EMS Topics A-Z	Alphabetical list of EMS and trauma systems web content.
EMS Systems	Overview of Washington State's emergency medical services systems.
EMS and Trauma System	EMS and trauma mission, background and links to other trauma programs.
ECS System	Information about Washington State's Emergency Cardiac and Stroke System.
Trauma Designation	Trauma facility designation.
Agency and Vehicle Licensing	Agency and facilities licensing and verification.
Certification and Recertification	EMS medical services education for provider certification and recertification.
Publications (EMS and Trauma)	EMS and trauma publications.
WEMISIS	Washington's EMS information system for prehospital data.
Injury and Violence Prevention	Injury and violence prevention information.
Hearings Information	Information on health profession discipline hearing process.

Regional Council Planning and Procedure Resources

Prehospital trauma triage procedure:

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

Prehospital cardiac destination procedure:

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

Prehospital stroke destination procedure:

<http://www.doh.wa.gov/Portals/1/Documents/Pubs/346049.pdf>

Current state EMS and trauma system strategic plan

<http://www.doh.wa.gov/portals/1/Documents/Pubs/530107.pdf>

Current EMS and trauma care system regional plans

http://www.doh.wa.gov/hsqa/emstrauma/publications.htm#Regional_Plan

Appendix D: Definitions from RCW 70.168.015

(1) "**Cardiac**" means acute coronary syndrome, an umbrella term used to cover any group of clinical symptoms compatible with acute myocardial ischemia, which is chest discomfort or other symptoms due to insufficient blood supply to the heart muscle resulting from coronary artery disease. "Cardiac" also includes out-of-hospital cardiac arrest, which is the cessation of mechanical heart activity as assessed by emergency medical services personnel, or other acute heart conditions.

(2) "**Communications system**" means a radio and landline network which provides rapid public access, coordinated central dispatching of services, and coordination of personnel, equipment, and facilities in an emergency medical services and trauma care system.

(3) "**Department**" means the department of health.

(4) "**Designated trauma care service**" means a level I, II, III, IV, or V trauma care service or level I, II, or III pediatric trauma care service or level I, I-pediatric, II, or III trauma-related rehabilitative service.

(5) "**Designation**" means a formal determination by the department that hospitals or health care facilities are capable of providing designated trauma care services as authorized in RCW [70.168.070](#).

(6) "**Emergency medical service**" means medical treatment and care that may be rendered at the scene of any medical emergency or while transporting any patient in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities.

(7) "**Emergency medical services and trauma care planning and service regions**" means geographic areas established by the department under this chapter.

(8) "**Emergency medical services and trauma care system plan**" means a statewide plan that identifies statewide emergency medical services and trauma care objectives and priorities and identifies equipment, facility, personnel, training, and other needs required to create and maintain a statewide emergency medical services and trauma care system. The plan also includes a plan of implementation that identifies the state, regional, and local activities that will create, operate, maintain, and enhance the system. The plan is formulated by incorporating the regional emergency medical services and trauma care plans required under this chapter. The plan shall be updated every two years and shall be made available to the state board of health in sufficient time to be considered in preparation of the biennial state health report required in *RCW [43.20.050](#).

(9) "**Emergency medical services medical program director**" means a person who is an approved program director as defined by RCW [18.71.205](#)(4).

(10) "**Facility patient care protocols**" means the written procedures adopted by the medical staff that direct the care of the patient. These procedures shall be based upon the assessment of the patients' medical needs. The procedures shall follow minimum statewide standards for trauma care services.

(11) "**Hospital**" means a facility licensed under chapter [70.41](#) RCW, or comparable health care facility operated by the federal government or located and licensed in another state.

(12) "**Level I-pediatric rehabilitative services**" means rehabilitative services as established in RCW [70.168.060](#). Facilities providing level I-pediatric rehabilitative services provide the same

services as facilities authorized to provide level I rehabilitative services except these services are exclusively for children under the age of fifteen years.

(13) "**Level I pediatric trauma care services**" means pediatric trauma care services as established in RCW [70.168.060](#). Hospitals providing level I services shall provide definitive, comprehensive, specialized care for pediatric trauma patients and shall also provide ongoing research and health care professional education in pediatric trauma care.

(14) "**Level I rehabilitative services**" means rehabilitative services as established in RCW [70.168.060](#). Facilities providing level I rehabilitative services provide rehabilitative treatment to patients with traumatic brain injuries, spinal cord injuries, complicated amputations, and other diagnoses resulting in functional impairment, with moderate to severe impairment or complexity. These facilities serve as referral facilities for facilities authorized to provide level II and III rehabilitative services.

(15) "**Level I trauma care services**" means trauma care services as established in RCW [70.168.060](#). Hospitals providing level I services shall have specialized trauma care teams and provide ongoing research and health care professional education in trauma care.

(16) "**Level II pediatric trauma care services**" means pediatric trauma care services as established in RCW [70.168.060](#). Hospitals providing level II services shall provide initial stabilization and evaluation of pediatric trauma patients and provide comprehensive general medicine and surgical care to pediatric patients who can be maintained in a stable or improving condition without the specialized care available in the level I hospital. Complex surgeries and research and health care professional education in pediatric trauma care activities are not required.

(17) "**Level II rehabilitative services**" means rehabilitative services as established in RCW [70.168.060](#). Facilities providing level II rehabilitative services treat individuals with musculoskeletal trauma, peripheral nerve lesions, lower extremity amputations, and other diagnoses resulting in functional impairment in more than one functional area, with moderate to severe impairment or complexity.

(18) "**Level II trauma care services**" means trauma care services as established in RCW [70.168.060](#). Hospitals providing level II services shall be similar to those provided by level I hospitals, although complex surgeries and research and health care professional education activities are not required to be provided.

(19) "**Level III pediatric trauma care services**" means pediatric trauma care services as established in RCW [70.168.060](#). Hospitals providing level III services shall provide initial evaluation and stabilization of patients. The range of pediatric trauma care services provided in level III hospitals are not as comprehensive as level I and II hospitals.

(20) "**Level III rehabilitative services**" means rehabilitative services as established in RCW [70.168.060](#). Facilities providing level III rehabilitative services provide treatment to individuals with musculoskeletal injuries, peripheral nerve injuries, uncomplicated lower extremity amputations, and other diagnoses resulting in functional impairment in more than one functional area but with minimal to moderate impairment or complexity.

(21) "**Level III trauma care services**" means trauma care services as established in RCW [70.168.060](#). The range of trauma care services provided by level III hospitals are not as comprehensive as level I and II hospitals.

(22) "**Level IV trauma care services**" means trauma care services as established in RCW [70.168.060](#).

(23) "**Level V trauma care services**" means trauma care services as established in RCW [70.168.060](#). Facilities providing level V services shall provide stabilization and transfer of all patients with potentially life-threatening injuries.

(24) "**Patient care procedures**" means written operating guidelines adopted by the regional emergency medical services and trauma care council, in consultation with local emergency medical services and trauma care councils, emergency communication centers, and the emergency medical services medical program director, in accordance with minimum statewide standards. The patient care procedures shall identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility, mental health facility, or chemical dependency program to first receive the patient, and the name and location of other trauma care facilities, mental health facilities, or chemical dependency programs to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients shall be consistent with the transfer procedures required in chapter [70.170](#) RCW.

(25) "**Pediatric trauma patient**" means trauma patients known or estimated to be less than fifteen years of age.

(26) "**Prehospital**" means emergency medical care or transportation rendered to patients prior to hospital admission or during interfacility transfer by licensed ambulance or aid service under chapter [18.73](#) RCW, by personnel certified to provide emergency medical care under chapters [18.71](#) and [18.73](#) RCW, or by facilities providing level V trauma care services as provided for in this chapter.

(27) "**Prehospital patient care protocols**" means the written procedures adopted by the emergency medical services medical program director that direct the out-of-hospital emergency care of the emergency patient which includes the trauma patient. These procedures shall be based upon the assessment of the patients' medical needs and the treatment to be provided for serious conditions. The procedures shall meet or exceed statewide minimum standards for trauma and other prehospital care services.

(28) "**Rehabilitative services**" means a formal program of multidisciplinary, coordinated, and integrated services for evaluation, treatment, education, and training to help individuals with disabling impairments achieve and maintain optimal functional independence in physical, psychosocial, social, vocational, and avocational realms. Rehabilitation is indicated for the trauma patient who has sustained neurologic or musculoskeletal injury and who needs physical or cognitive intervention to return to home, work, or society.

(29) "**Secretary**" means the secretary of the department of health.

(30) "**Trauma**" means a major single or multisystem injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability.

(31) "**Trauma care system**" means an organized approach to providing care to trauma patients that provides personnel, facilities, and equipment for effective and coordinated trauma care. The trauma care system shall: Identify facilities with specific capabilities to provide care, triage trauma victims at the scene, and require that all trauma victims be sent to an appropriate trauma facility. The trauma care system includes prevention, prehospital care, hospital care, and rehabilitation.

(32) "**Triage**" means the sorting of patients in terms of disposition, destination, or priority. Triage of prehospital trauma victims requires identifying injury severity so that the appropriate care level can be readily assessed according to patient care guidelines.

(33) "**Verification**" means the identification of prehospital providers who are capable of providing verified trauma care services and shall be a part of the licensure process required in chapter [18.73](#) RCW.

(34) "**Verified trauma care service**" means prehospital service as provided for in RCW [70.168.080](#), and identified in the regional emergency medical services and trauma care plan as required by RCW [70.168.100](#)

Appendix E: Definitions from WAC 246-976-010

Definitions in RCW [18.71.200](#), [18.71.205](#), [18.73.030](#), and [70.168.015](#) and the definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "**Activation of the trauma system**" means mobilizing resources to care for a trauma patient in accordance with regional patient care procedures.

(2) "**Adolescence**" means the period of physical and psychological development from the onset of puberty to maturity, approximately twelve to eighteen years of age.

(3) "**Advanced cardiac life support (ACLS)**" means a course that includes the education and clinical interventions used to treat cardiac arrest and other acute cardiac related problems.

(4) "**Advanced emergency medical technician (AEMT)**" means a person who has been examined and certified by the secretary as an intermediate life support technician as defined in RCW [18.71.200](#) and [18.71.205](#).

(5) "**Advanced first aid**" means an advanced first-aid course prescribed by the American Red Cross or its equivalent.

(6) "**Advanced life support (ALS)**" means invasive emergency medical services requiring the advanced medical treatment skills of a paramedic.

(7) "**Agency**" means an aid or ambulance service licensed by the secretary to provide prehospital care or interfacility ambulance transport.

(8) "**Agency response time**" means the interval from dispatch to arrival on the scene.

(9) "**Aid service**" means an agency licensed by the secretary to operate one or more aid vehicles, consistent with regional and state plans.

(10) "**Ambulance service**" means an agency licensed by the secretary to operate one or more ground or air ambulances.

(11) "**Approved**" means approved by the department of health.

(12) "**ATLS**" means advanced trauma life support, a course developed by the American College of Surgeons.

(13) "**Attending surgeon**" means a physician who is board-certified or board-qualified in general surgery, and who has surgical privileges delineated by the facility's medical staff. The attending surgeon is responsible for care of the trauma patient, participates in all major therapeutic decisions, and is present during operative procedures.

(14) "**Available**" for designated trauma services described in WAC [246-976-485](#) through [246-976-890](#) means physically present in the facility and able to deliver care to the patient within the time specified. If no time is specified, the equipment or personnel must be available as reasonable and appropriate for the needs of the patient.

(15) "**Basic life support (BLS)**" means emergency medical services requiring basic medical treatment skills as defined in chapter [18.73](#) RCW.

(16) "**Board certified**" or "**board-certified**" means that a physician has been certified by the appropriate specialty board recognized by the American Board of Medical Specialties. For the purposes of this chapter, references to "board certified" include physicians who are board-qualified.

(17) "**Board-qualified**" means physicians who have graduated less than five years previously from a residency program accredited for the appropriate specialty by the accreditation council for graduate medical education.

(18) "**BP**" means blood pressure.

(19) "**Certification**" means the secretary recognizes that an individual has proof of meeting predetermined qualifications, and authorizes the individual to perform certain procedures.

(20) "**Consumer**" means an individual who is not associated with the EMS-TC system, either for pay or as a volunteer, except for service on the steering committee, or regional or local EMS-TC councils.

(21) "**Continuing medical education method**" or (CME method) means prehospital EMS recertification education required after initial EMS certification to maintain and enhance skill and knowledge. The CME method requires the successful completion of department-approved knowledge and practical skill certification examinations to recertify.

(22) "**County operating procedures**" or "**COPS**" means the written operational procedures adopted by the county MPD and the local EMS council specific to county needs.

(23) "**CPR**" means cardiopulmonary resuscitation.

(24) "**Critical care transport**" means the interfacility transport of a patient whose condition requires care by a physician, RN or a paramedic who has received special training and approval by the MPD.

(25) "**Department**" means the Washington state department of health.

(26) "**Dispatch**" means to identify and direct an emergency response unit to an incident location.

(27) "**Diversion**" means the EMS transport of a patient past the usual receiving facility to another facility due to temporary unavailability of care resources at the usual receiving facility.

(28) "**E-code**" means external cause code, an etiology included in the International Classification of Diseases (ICD).

(29) "**ED**" means emergency department.

(30) "**Emergency medical procedures**" means the skills that are performed within the scope of practice of EMS personnel certified by the secretary under chapters [18.71](#) and [18.73](#) RCW.

(31) "**Emergency medical services and trauma care (EMS-TC) system**" means an organized approach to providing personnel, facilities, and equipment for effective and coordinated medical treatment of patients with a medical emergency or injury requiring immediate medical or surgical intervention to prevent death or disability. The emergency medical services and trauma care system includes prevention activities, prehospital care, hospital care, and rehabilitation.

(32) "**Emergency medical responder (EMR)**" means a person who has been examined and certified by the secretary as a first responder to render prehospital EMS care as defined in RCW [18.73.081](#).

(33) "**Emergency medical technician (EMT)**" means a person who has been examined and certified by the secretary as an EMT to render prehospital EMS care as defined in RCW [18.73.081](#).

(34) "**EMS**" means emergency medical services.

(35) "**EMS provider**" means an individual certified by the secretary or the University Of Washington School Of Medicine under chapters [18.71](#) and [18.73](#) RCW to provide prehospital emergency response, patient care, and transport.

(36) "**EMS-TC**" means emergency medical services and trauma care.

(37) "**General surgeon**" means a licensed physician who has completed a residency program in surgery and who has surgical privileges delineated by the facility.

(38) "**ICD**" means the international classification of diseases, a coding system developed by the World Health Organization.

(39) "**Injury prevention**" means any combination of educational, legislative, enforcement, engineering and emergency response initiatives used to reduce the number and severity of injuries.

(40) "**Interfacility transport**" means medical transport of a patient between recognized medical treatment facilities requested by a licensed health care provider.

(41) "**Intermediate life support (ILS)**" means invasive emergency medical services requiring the advanced medical treatment skills of an advanced EMT (AEMT).

(42) "**IV**" means a fluid or medication administered directly into the venous system.

(43) "**Local council**" means a local EMS-TC council authorized by RCW [70.168.120\(1\)](#).

(44) "**Medical control**" means oral or written direction of medical care that certified prehospital EMS personnel provide to patients of all age groups. The oral or written direction is provided by the MPD or MPD delegate.

(45) "**Medical control agreement**" means a written agreement between two or more MPDs, using similar protocols that are consistent with regional plans, to assure continuity of patient care between counties, and to facilitate assistance.

(46) "**Medical program director (MPD)**" means a person who meets the requirements of chapters [18.71](#) and [18.73](#) RCW and is certified by the secretary. The MPD is responsible for both the supervision of training and medical control of EMS providers.

(47) "**MPD delegate**" means a physician appointed by the MPD and recognized and approved by the department. An MPD delegate may be:

(a) A prehospital training physician who supervises specified aspects of training EMS personnel; or

(b) A prehospital supervising physician who provides online medical control of EMS personnel.

(48) "**Ongoing training and evaluation program (OTEP)**" means a continuous program of prehospital EMS education for EMS personnel after completion of initial training. An OTEP is approved by the MPD and the department. An OTEP must meet the EMS education requirements and core topic content required for recertification. The OTEP method includes evaluations of the knowledge and skills covered in the topic content following each topic presentation.

(49) "**PALS**" means a pediatric advanced life support course.

(50) "**Paramedic**" or "**physician's trained emergency medical service paramedic**" means a person who has been trained in an approved program to perform all phases of prehospital emergency medical care, including advanced life support, under written or oral authorization of an MPD or approved physician delegate, examined and certified by the secretary under chapter [18.71](#) RCW.

(51) "**Pediatric education requirement (PER)**" means the pediatric education and training standards required for certain specialty physicians and nurses who care for pediatric patients in designated trauma services as identified in WAC [246-976-886](#) and [246-976-887](#).

(52) "**PEPP**" means pediatric education for prehospital professionals.

(53) "**PHTLS**" means a prehospital trauma life support course.

(54) "**Physician**" means an individual licensed under the provisions of chapters [18.71](#) or [18.57](#) RCW.

(55) "**Physician with specific delineation of surgical privileges**" means a physician with surgical privileges delineated for emergency/life-saving surgical intervention and stabilization of a trauma patient prior to transfer to a higher level of care. Surgery privileges are awarded by the facility's credentialing process.

(56) "**Postgraduate year**" means the classification system for residents who are undergoing postgraduate training. The number indicates the year the resident is in during his/her postmedical school residency program.

(57) "**Practical skills examination**" means a test conducted in an initial course, or a test conducted during a recertification period, to determine competence in each of the practical skills or group of skills specified by the department.

(58) "**Prehospital index (PHI)**" means a scoring system used to trigger activation of a hospital trauma resuscitation team.

(59) "**Prehospital patient care protocols**" means the department-approved, written orders adopted by the MPD under RCW [18.73.030](#)(15) and [70.168.015](#)(27) which direct the out-of-hospital care of patients. These protocols are related only to delivery and documentation of direct patient treatment. The protocols meet or exceed statewide minimum standards developed by the department in rule as authorized in chapter [70.168](#) RCW.

(60) "**Prehospital provider**" means EMS provider.

(61) "**Prehospital trauma care service**" means an agency that is verified by the secretary to provide prehospital trauma care.

(62) "**Prehospital trauma triage procedure**" means the method used by prehospital providers to evaluate injured patients and determine whether to activate the trauma system from the field. It is described in WAC [246-976-930](#)(2).

(63) "**Public education**" means education of the population at large, targeted groups, or individuals, in preventive measures and efforts to alter specific injury, trauma, and medical-related behaviors.

(64) "**Quality improvement (QI)**" or "**quality assurance (QA)**" means a process/program to monitor and evaluate care provided in the EMS-TC system.

(65) "**Regional council**" means the regional EMS-TC council established by RCW [70.168.100](#).

(66) "**Regional patient care procedures**" means department-approved written operating guidelines adopted by the regional emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communication centers, and the emergency medical services medical program director, in accordance with statewide minimum standards. The patient care procedures identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients are consistent with the transfer procedures in chapter [70.170](#) RCW. Patient care procedures do not relate to direct patient care.

(67) "**Regional plan**" means the plan defined in WAC [246-976-960](#) (1)(b) that has been approved by the department.

(68) "**Registered nurse**" means an individual licensed under the provisions of chapter [18.79](#) RCW.

(69) "**Rural**" means an unincorporated or incorporated area with a total population of less than ten thousand people, or with a population density of less than one thousand people per square mile.

(70) "**Secretary**" means the secretary of the department of health.

(71) "**Senior EMS instructor (SEI)**" means an individual approved by the department to be responsible for the administration, quality of instruction and the conduct of initial emergency medical responder (EMR) and emergency medical technician (EMT) training courses.

(72) "**Special competence**" means that an individual has been deemed competent and committed to a medical specialty area with documented training, board certification and/or experience, which has been reviewed and accepted as evidence of a practitioner's expertise:

(a) For physicians, by the facility's medical staff;

(b) For registered nurses, by the facility's department of nursing;

(c) For physician assistants and advanced registered nurse practitioners, as defined in the facility's bylaws.

(73) "**State plan**" means the emergency medical services and trauma care system plan described in RCW [70.168.015](#)(7), adopted by the department under RCW [70.168.060](#)(10).

(74) "**Steering committee**" means the EMS-TC steering committee created by RCW [70.168.020](#).

(75) "**Suburban**" means an incorporated or unincorporated area with a population of ten thousand to twenty-nine thousand nine hundred ninety-nine or any area with a population density of between one thousand and two thousand people per square mile.

(76) "**System response time**" for trauma means the interval from discovery of an injury until the patient arrives at a designated trauma facility.

(77) "**Training program**" means an organization that is approved by the department to be responsible for specified aspects of training EMS personnel.

(78) "**Trauma rehabilitation coordinator**" means a person designated to facilitate early rehabilitation interventions and the trauma patient's access to a designated rehabilitation center.

(79) "**Trauma response area**" means a service coverage zone identified in an approved regional plan.

(80) "**Trauma service**" means the clinical service within a hospital or clinic that is designated by the department to provide care to trauma patients.

(81) "**Urban**" means:

(a) An incorporated area over thirty thousand; or

(b) An incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square mile.

(82) "**Verification**" means a prehospital agency is capable of providing verified trauma care services and is credentialed under chapters [18.73](#) and [70.168](#) RCW.

(83) "**Wilderness**" means any rural area not readily accessible by public or private maintained road.



Washington Coverdell Acute Stroke Program (WACASP) *Frequently Asked Questions*

What is WACASP?

WACASP is a quality improvement initiative to reduce death and disability from stroke by increasing the public's recognition of stroke, reducing the time it takes to get treatment, coordinating care across the continuum from emergency medical services to the hospital to post-acute care, and working to continuously improving that care. Ultimately, the goal is to save time, lives, money, and improve quality of life for stroke patients and their families.

Who is the funder?

In 2015, the Centers for Disease Control (CDC) awarded the Department of Health a Paul Coverdell National Acute Stroke Program grant along with eight other states: California, Georgia, Massachusetts, Michigan, Minnesota, New York, Ohio, and Wisconsin.

How long is the grant? Five years, July 16, 2015 to June 29, 2020

How much is the award? \$750,000 per year for a total of \$3.75 million

Who is Paul Coverdell and why is he associated with this grant?

Paul Coverdell (January 20, 1939 – July 18, 2000) was a United States Senator from Georgia who died from a stroke while serving in the Senate. The CDC was directed by Congress in 2001 to implement state-based registries to measure and track acute stroke care to improve the quality of that care. Congress named this the Paul Coverdell National Acute Stroke Registry (PCNASR) in memory of Senator Coverdell. It was originally a registry for acute care but has since expanded to cover improvement across the continuum of care, from emergency medical services (EMS) to acute care, rehabilitation, and primary care once patients return home. More history on the PCNASR is at http://www.cdc.gov/dhdsr/programs/pcnasr_history.htm

What are the program goals and strategies?

- Increase the public's recognition of signs and symptoms of stroke and the use of EMS.
- Reduce time to treatment by developing a well-coordinated stroke system.
- Standardize EMS stroke assessment, triage based on assessment result, and early notification to hospitals.
- Provide rapid, evidence-based treatment at hospitals.
- Improve post-acute care and outcomes through effective patient and caregiver education, rehabilitation services, coordination between hospitals and post-acute healthcare providers, and direct follow up with patients.
- Reduce 30-day hospital readmissions and 30-day mortality following acute stroke.

- Establish an integrated data management system linking prehospital, hospital, and post hospital follow up data for tracking and assessing quality of care and outcomes.
- Analyze and use data to improve care and transitions of care (EMS-hospital, hospital-home, etc.)
- Coordinate stroke quality improvement efforts by providing training and opportunities to collaborate and learn from each other; analyzing data and providing reports to EMS, hospitals, and others to drive improvement; facilitating feedback among providers; and integrating WACASP quality improvement into existing Emergency Cardiac and Stroke/EMS and Trauma quality improvement forums.

Who coordinates the program?

- WACASP is located in the Rural Health Section in the Office of Community Health Systems (CHS), Health Systems Quality Assurance Division of the Department of Health. The EMS and Trauma System is also managed in CHS, facilitating coordination between the Stroke and EMS and Trauma systems.
- Pat Justis, Rural Health Section Manager, is the designated project manager, and oversees the program and staff.
- Kim Kelley is the Coverdell Stroke Program Coordinator, responsible for managing the grant and carrying out the work plan.
- Jim Jansen is the Coverdell Stroke Program Epidemiologist, responsible for data coordination, analysis, reporting, and program evaluation.
- The Stroke Guidance Team (SGT), a subcommittee of the Emergency Cardiac and Stroke Technical Advisory Committee, provides clinical expertise and program guidance. David Tirschwell, MD, leads the SGT. Members represent EMS, hospitals, post-acute providers, and other partners.

Who does DOH work with to achieve the program goals?

- Over the five years of the grant, DOH will work with EMS agencies; hospitals; rehabilitation services in hospitals, nursing homes, and outpatient settings; primary care; public health; pharmacies; community and social services, and others as needed.
- In the first year, the work was focused in Pierce and Pacific counties. In year two, we will expand to Spokane, Pend Oreille, and Stevens counties. We will invite all stroke centers in the state to participate in the acute care registry. In years three through five we will gradually expand to include more EMS agencies and post-hospital providers.

Are there other organizations involved besides healthcare providers?

- The American Heart Association/American Stroke Association
- Local Health Jurisdictions
- Area Agencies on Aging
- The Washington State Pharmacy Association (future).

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