Central Region EMS and Trauma Care System Plan
July 1, 2023 – June 30, 2025

Submitted by: Central Region EMS and Trauma Care Council on May 17, 2023

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INTRODUCTION

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

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

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

Background
The Central Region is located in King County, Washington. The largest metropolitan county in the State in terms of population, number of cities, and employment. The majority of the County's estimated 2.27 million residents live in urban and suburban communities located along the I-5 and I-405 corridors where emergency medical hospital services are located. This geography covers 2,131 square miles, bounded by the Puget Sound to the west and Cascade Range to the east. Except for rural Vashon Island in Central Puget Sound, the western county is covered by cities while the development patterns become gradually sparser to the east.

There are thirty-four (34) licensed EMS services in King County: five (5) provide advanced life support (ALS) service using paramedics, twenty-eight (28) provide basic life support (BLS) service using EMTs and there are five (5) emergency services supervisory organizations and one air ambulance service base located at Harborview Medical Center. There are eighteen hospitals and three stand-alone emergency departments in Central Region. There is one Level I trauma center, four Level III trauma centers, three Level IV trauma centers and two Level V trauma centers. Categorized Cardiac and Stroke Centers are also distributed in the heavily populated areas along I-5, I-405, and I-90. Currently there are twelve Level I and four Level II cardiac centers; and four Level I, seven Level II, and five Level III stroke centers in Central Region.

The Central Region EMS and Trauma Care (CREMS) Council is made up of members of the emergency care system community in King County. RCW 70.168 and WAC 246-976 identify the membership, and responsibilities of the regional and local EMS & trauma care councils. The Central Region EMS and Trauma Care Council membership includes local government, prehospital agencies, hospitals, medical directors, rehabilitation facilities, communication centers, training organizations and consumers. The Central Regional EMS and Trauma Care Council provides a forum for open discussion of EMS system and patient care issues and for sharing of information among system partners. Workgroups are formed on an ad hoc basis to discuss specific EMS system and patient care issues and to develop strategies to address those issues. The council has an Executive Board that is made up of seven members elected by the council. The board is comprised of the following positions: chair, vice chair, secretary, treasurer, and three board members. All meetings

are open public meetings, and members of the public are welcome and encouraged to attend. The council meets every other month, and the Executive Board meets monthly. Meetings may be held in a variety of formats including in person, conference call, or video call. The council also helps to coordinate a quality improvement forum, attended by representatives from hospitals and EMS agencies. Representatives from the Central Region participate on local and state planning committees, task forces, and workgroups so that EMS system issues, guidelines, plans, and information can be shared among local and state EMS partners.

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

The Central Region EMS and Trauma Care Council accomplished numerous goals in the 2021-2023 plan cycle. The strategic plan included some goals, objectives and strategies that are required in each plan cycle, and others that were unique to the specific needs of Central Region. In the fiscal year 2022 the region granted over $55,000 and in 2023 over $110,000 in funds to support the regional emergency care system. Recipients included hospitals, fire departments, EMS training organizations, schools, and those working with the older adult populations. These projects ranged from injury prevention, pre- and in-hospital provider training, and materials and equipment to support ongoing training. Within the grants provided the council was able to support the training of providers in rural areas, such as Vashon, Enumclaw and Skykomish. Recipients were chosen based on their significance to the strategic plan, community needs, relevance to top causes of morbidity and mortality, and the organizations feasibility in accomplishing the stated project.

Central Region has maintained a Psychiatric Patient Task Force, which has been active in the efforts to mitigate the impact of increasing census of psychiatric patients in emergency departments. The Task Force is continually working in pursuit of this goal. This group continues to meet to address behavioral health concerns in the context of the overall system. Including monitoring the use of Psychiatric Saturation by the core downtown hospitals, as well as the use of Psychiatric Divert by all hospitals. The group looks forward to exploring and furthering the use of data and metrics to evaluate the work.

Central Region boasts a uniquely robust EMS system, with few underserved geographical areas and pre-hospital EMS levy funding. Still the region is challenged by continually growing and changing population. The council actively seeks to include in meetings and membership those that support and participate in the overall system, such as dispatch communications, emergency managements and preparedness. The Central Region aims to maintain and expand as a diverse and dedicated group.

This 2023-2025 Central Region Strategic EMS & Trauma Care System Plan is made up of goals adapted from the State Strategic Emergency Care System Plan. The objectives and strategies are developed by the Regional Council and its stakeholders to meet needs of the region.

GOAL 1: MAINTAIN, ASSESS, AND INCREASE EMERGENCY CARE RESOURCES.

Need and Distribution of Services

Hospital Care: There are four Level III trauma centers and three Level IV trauma centers in Central Region located in the heavily populated communities along the I-5 and I-405 corridors. There are two Level V trauma centers; one is located along highway 410 in the mostly rural city of Enumclaw, and the other is in the rural area of Snoqualmie, near the I-90 mountain pass. The State's Level one trauma center is located in Seattle and serves patients from Washington, Alaska, Montana and Idaho.

Categorized Cardiac and Stroke Centers are also distributed in the heavily populated areas along I-5, I-405, and I-90. Currently there are twelve Level I and four Level II cardiac centers; and four Level I, seven Level II, and five Level III stroke centers in Central Region.

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

Prehospital Care: King County uses a tiered prehospital response system to ensure 9-1-1 calls receive medical care by the most appropriate care provider. Calls to 9-1-1 are received and triaged by professional dispatchers at five dispatch centers located throughout King County. Using Criteria Based Dispatch, the call receivers are trained to identify the most appropriate level of care needed. These 911-center representatives provide pre-arrival instructions for most medical emergencies, and guide the caller through life-saving steps, including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) instructions, until the Medic One/EMS provider arrives. Basic Life Support (BLS) personnel are dispatched first to an incident, providing rapid basic life support that includes advanced first aid and CPR/AED to stabilize the patient. Staffed by fire department Emergency Medical Technicians (EMTs), BLS units arrive at the scene in about five minutes on average.

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

RCW 70.168.100 authorizes EMS Regions to identify the need for and recommend distribution and level of care of prehospital services to assure adequate availability and avoid inefficient duplication and lack of coordination of prehospital services within the region. The Regional Council uses standardized methods provided by the Department of Health along with prehospital response times and call volumes to determine the need and distribution of trauma verified prehospital services in King County. Need and distribution of prehospital services are reviewed during each Plan cycle.

GOAL 1 Maintain, assess, and increase emergency care resources	
Objective 1: By November 2024 the CREMS Council will determine the recommended minimum and maximum numbers and levels of trauma designated services (including pediatric and rehabilitation services) and provide recommendations to the Washington State Department of Health, Office of Community Health Systems and the EMS & Trauma Steering Committee.	**Strategy 1:** By November 2024, the CREMS Council will review Central Region trauma data including population demographics and solicit input to determine the recommended min/max number and levels of trauma designated facilities in Central Region.
	Strategy 2: By January 2025, the CREMS Council will vote on the recommended number and levels of trauma designated services in Central Region.
	Strategy 3: By February 2025, the CREMS Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding the number and levels of trauma designated services in Central Region (King County).
	Strategy 4: By April 2025, the CREMS Council will submit designated services min/max number and level recommendations to the EMS & Trauma Steering Committee as needed.
Objective 2: By May 2024 the CREMS Council will use Washington State Department of Health, Office of Community Health Systems standardized methodology and King County EMS system data to determine the minimum and maximum numbers and levels of verified prehospital service types in King County and provide	**Strategy 1** By January 2024, the CREMS Council and EMS Stakeholders will review EMS data including response and transport times, service demands, and population to determine the minimum and maximum levels of verified prehospital services in Central Region (King County).
	Strategy 2: By March 2024, the CREMS Council will vote on the recommended minimum and maximum numbers of verified ALS and BLS aid and ambulance services in Central Region (King County). Assessment data will include, but is not limited to, dispatch times per annum and population growth since the prior

recommendations to the Washington State Department of Health Office of Community Health Systems and the EMS & Trauma Steering Committee.	review period. As necessary, needs assessments may be submitted by organizations wishing to modify their trauma verification status.
	Strategy 3: By May 2024, the CREMS Council will make any necessary recommendations to the Washington State Department of Health Office of Community Health Systems regarding the minimum and maximum numbers of verified ALS and BLS aid and ambulance services in Central Region.
	Strategy 4: By May 2024, the CREMS Council will submit verified services min/max and level recommendations to the EMS & Trauma Steering Committee as needed.
Objective 3: Throughout the planning cycle, the Regional Council will review the Patient Care Procedures and participate in statewide standardization.	**Strategy 1:** Throughout the planning cycle, the CREMS Council will review the list of currently categorized cardiac & stroke care centers and update the Patient Care Procedures (PCPs) so that they accurately reflect current appropriate cardiac & stroke patient destinations.
	Strategy 2: Throughout the planning cycle, the CREMS Council will consider and review additional PCPs to be added or amended.
	Strategy 3: Throughout the planning cycle, the CREMS Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding revisions to the Region' s PCPs.
	Strategy 4: Throughout the planning cycle, the CREMS Council will submit revisions to the Region's PCPs to the EMS & Trauma Steering Committee as needed.
Objective 4: By January 2024, CREMS will identify and communicate specific challenges as they relate to pre-hospital services.	**Strategy 1:** By November 2023, the CREMS board will conduct a survey of EMS agencies within the region to identify specific challenges facing the EMS workforce in the region. This survey will explore challenges related to recruitment, retention, training, and resources.
	Strategy 2: By January 2024, the CREMS council will summarize and share results of the prehospital survey with stakeholders at a regularly scheduled Council meeting. Results will be prioritized and solutions explored.

	Strategy 3: By May 2024, CREMS will summarize and provide a report of survey results with Washington State Department of Health Office of Community Health Systems and others as applicable.

GOAL 2: SUPPORT EMERGENCY PREPAREDNESS, RESPONSE, AND RESILIENCE ACTIVITIES.

Based upon experience, the Central Region EMS and Trauma Care Council has determined that an opportunity exists for the region to collaborate and coordinate with emergency preparedness groups in the area, to facilitate the smooth functioning of the EMS and Trauma System in the event of an emergency. The region already works with the several, such as the Northwest Healthcare Response Network (NWHRN), King County Emergency Management Advisory Committee (EMAC), and Public Health Seattle & King County and the division of King County EMS. These groups will continue to have opportunities to share information at regional council meetings. The Council will continue to seek, support, and expand these collaborations and partnerships.

Goal 2 Support emergency preparedness, response, and resilience activities	
Objective 1: Throughout the planning cycle, CREMS Council will collaborate with emergency management to support all hazards preparation and response.	**Strategy 1:** At each CREMS council meeting, representatives from NWHRN, WATrac, EMAC and WMCC will have the opportunity to present information to the region about emergency management and preparedness work that is happening in the region.
	Strategy 2: Throughout the plan cycle, CREMS Council staff will share opportunities for council members to actively participate in emergency preparedness activities in the region.

GOAL 3: PLAN, IMPLEMENT, MONITOR, AND REPORT OUTCOMES OF PROGRAMS TO REDUCE THE INCIDENCE AND IMPACT OF INJURIES, VIOLENCE, AND ILLNESS IN THE REGION.

The Central Region EMS Council uses DOH and King County EMS injury data to identify prevention needs and to develop activities to address those needs. During this Plan cycle, the Central Region EMS and Trauma Care Council will focus prevention activities on injury causes that are most prevalent in the region. In the 2021-2023 planning period, the top causes of injury and mortality included falls, overdoses, and suicide. In past years, the council has supported projects targeted at reduction in patient falls, suicide prevention, cardiac arrest care and hemorrhage control in the event of a mass casualty incident, among others.

Goal 3 Plan, implement, monitor, and report outcomes of programs to reduce the incidence and impact of injuries, violence, and illness in the region.	
Objective 1: By March 2025, the CREMS Council will identify prevention needs and support evidence based and/or promising practices as resources are available.	**Strategy 1**: By November 2023, the CREMS Council will review injury/illness data and identify injury and illness prevention needs in King County.
	Strategy 2: By January 2024, the CREMS Council will develop activities and programs to address one or more of the injury and/or illness prevention needs which were identified.
	Strategy 3: By May 2025, the CREMS Council will review outcomes data from council-supported prevention activities and programs.
	Strategy 4: By February 2025, the CREMS Council will incorporate the identified injury prevention activities in the 2025-2027 Regional Plan.
Objective 2: By September of 2023 and throughout the plan cycle, the CREMS Council will create and execute plans to address issues around transfer of care of patients from EMS into the hospital.	**Strategy 1:** By September of 2023, a subgroup of CREMS Council will explore options focused on hospital capacity and its effect on the time interval to transfer EMS patients, commonly referred to as wall times.
	Strategy 2: By December 2023, the subgroup will explore, develop, and communicate metrics to describe and raise awareness of the issues.
	Strategy 3: By March of 2024, the CREMS Council will evaluate outcomes of activities addressing and mitigating these issues.

GOAL 4: ASSESS WEAKNESSES & STRENGTHS OF QUALITY IMPROVEMENT PROGRAMS IN THE REGION.

The Central Region EMS and Trauma Care Council has an active Quality Improvement (QI) forum that usually meets four times per year. The QI group collectively presents & reviews case studies and specific incidents for education and improvement of emergency medical care in the region. During the Covid-19 pandemic, the QI meetings had diminished in frequency, due to scarce resources and increased time constraints on QI participants. During the 2021-2023 plan cycle, the region reinstated the forum in a virtual format and will maintain regular meetings in the region.

Goal 4 Assess weaknesses & strengths of quality improvement programs in the region	
Objective 1: The CREMS Council will coordinate with regional partners to maintain QI forums at regular intervals throughout the year.	**Strategy 1:** In September 2023 and annually, The CREMS Council staff will work with QI committee leadership to review, plan, and schedule QI meetings that will work for members in the region.

	Strategy 2: By November 2023, the CREMS Council will confirm and disperse the QI meeting schedule to regional council members. Throughout the plan cycle, CREMS Council staff will continue to assist with scheduling and coordinating regional QI meetings based upon the established schedule.
	Strategy 3: Throughout the plan cycle, QI leadership will maintain and promote attendance and participation by hospitals and EMS in the region for well-rounded attendance and participation.
Objective 2: By September 2023, annually, the CREMS Council will review the Key Performance Indicators (KPIs) developed by the Prehospital TAC and assess prehospital performance as necessary.	**Strategy 1:** By August 2023, annually, CREMS Council staff will coordinate with the MPD to review Key Performance Indicators and assess prehospital performance as necessary.
	Strategy 2: By September 2023, annually, any recommendations for performance improvements will be communicated to the appropriate prehospital agencies.
	Strategy 3: By November 2023, annually, any recommendations for performance improvements that affect all prehospital members of the CREMS Council will be communicated and addressed at a Regional Council meeting.
Objective 3: By May 2025, the Quality Improvement Forum will consider strategies to improve emergency care systems performance in areas highlighted by data analysis and reports presented at EMS & Trauma Care Steering Committee meetings.	**Strategy 1:** By May 2025, **t**he Quality Improvement Forum will seek out opportunities to further utilize data and reports shared at other settings.
	Strategy 2: Throughout the plan cycle, the Chair of QI Forum and Chair of the Board will consider if any data and reports from Steering Committee could be further reviewed at the local and regional levels.

GOAL 5: PROMOTE REGIONAL SYSTEM SUSTAINABILITY.

In Central Region emergency medical technicians receive more than 150 hours of basic training and hospital experience with additional training in defibrillation, along with at least 30 hours of continuing education annually. All paramedics in King County are graduates of the University of Washington Paramedic Training Program regardless of previous training. Paramedic candidates receive 2,500 hours of rigorous training, including classroom instruction, clinical rotations at Seattle Children's, University of Washington Medical Center, and Harborview Medical Center, as well as extensive field training supervised by experienced senior paramedics. Dispatch, BLS and some ALS continuing education is provided by the King County EMS Online program which is funded through the King County Medic One/EMS levy. Paramedics receive 30 hours of continuing medical education classes each year along with surgical airway management laboratories, advanced cardiac life support, and pediatric advanced life support classes. Paramedic continuing education is funded

through the Medic One Foundation and through the Medic One/EMS Levy. In the next plan cycle, the Central Region EMS Council will provide opportunity to request funding for additional training adjuncts.

Regional Patient Care Procedures (PCP)s are operating guidelines that are consistent with state standards that have been adopted by the Central Region Council in accordance with WAC 246-976-960. PCPs provide direction to emergency care system partners for activities such as triage, transport, and destination determination and have been developed by the Central Region Council in consultation with emergency care systems partners and EMS Medical Program Directors.

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

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

Goal 5 Promote regional system sustainability	
Objective 1: By July 2023 and throughout the plan cycle Central Region hospitals will continue to monitor and support the no diversion policy.	**Strategy 1:** By July 2023 and throughout the plan cycle, CREMS Council staff will monitor hospital diversion as reported by WATrac and provide monthly reports to hospitals and stakeholders.
	Strategy 2: By July 2023 and throughout the plan cycle, CREMS Council staff will monitor hospital ED status reports on WATrac and provide monthly reports to stakeholders on reporting frequency compliance and reporting errors.
	Strategy 3: By January 2024, CREMS will promote and provide continued education and training around the use and capabilities of WATrac.
Objective 2: By July 2023 and throughout the plan cycle, the CREMS Council will monitor psychiatric patient access to appropriate care in Central Region.	**Strategy 1:** Throughout the plan cycle, CREMS Council staff will schedule regular Psychiatric Patient Task Force (PPTF) meetings to discuss issues which affect psychiatric patient care in the region.
	Strategy 2: By July 2023, the PPTF will consider gathering and distributing data to measure and evaluate the impact of any

	issues and potential solutions.
	Strategy 3: By October of 2024, the PPTF will re-evaluate behavioral health catchment area maps and consider transport recommendations.
	Strategy 4: By July 2025 and throughout the plan cycle, the PPTF will discuss best practices for addressing psychiatric patient care issues that have been identified. The PPTF will consider any action plans to address identified psychiatric patient care issues.
	Strategy 5: Throughout the plan cycle, the Regional Council will evaluate the impact of the action plans on psychiatric patient care in the region.
Objective 3: By March 2024, and throughout the plan cycle, the CREMS Council will develop action plans to address increasing patient census in hospital emergency departments.	**Strategy 1:** By September 2023 and throughout the plan cycle, the CREMS Council will measure and evaluate patient census, wall times, and diversion in King County.
	Strategy 2: By January 2024, the CREMS Council will bring together appropriate groups and stakeholders to identify and develop action plans, as applicable, to mitigate the effects of high patient census in King County.
	Strategy 3: By May of 2024, the CREMS council will compile and disseminate best practices from, and for the use of, stakeholders around capacity management and EMS-to-Emergency department throughout.
	Strategy 4: Throughout the remainder of the plan cycle, the council will continually assess the action plans previously developed.
Objective 4: During the Plan cycle the CREMS Council will facilitate the exchange of information throughout the emergency care system.	**Strategy 1:** By July 2023, and throughout the plan cycle, the CREMS Council will provide and assist in hosting the virtual platforms for the Council and workgroups.
	Strategy 2: By July 2023, and throughout the plan cycle, CREMS Council members will participate in EMS stakeholder meetings including: King County EMS Advisory Council, Medical Directors Committee, Northwest Healthcare Response Network, EMS & Trauma Steering Committee, and associated Technical Advisory Committees and share information with the CREMS Council at regularly scheduled meetings.
	Strategy 3: Throughout the plan cycle, CREMS Council staff and EMS stakeholders will bring EMS system and patient care issues forward to the EMS and Trauma Care Steering Committee and other appropriate TACs as necessary.

Objective 5: During the plan cycle, the CREMS Council will work with the Washington State Department of Health Office of Community Health Systems and the State Auditor's Office to ensure the Regional Council business structure and practices remain compliant with RCW.	**Strategy 1:** By May 2024 annually, the CREMS Council will develop, approve, and submit the annual budget to the Washington State Department of Health Office of Community Health Systems.
	Strategy 2: By November 2023 annually, the CREMS Council staff will submit the previous year's financial information and related schedules to the Washington State Auditor's Office.
	Strategy 3: By January 2024 annually, the CREMS Board will review semi-annual budget vs. actual revenues & expenditures.
	Strategy 4: By July 2024 annually, the CREMS Board will review the end of fiscal year annual budget vs. actual revenues & expenditures.
	Strategy 5: By October 2024 annually, the CREMS Board will review the CREMS Council financial policies and Board/Staff roles and responsibilities.
Objective 6: At CREMS Council meetings, the Regional Council will identify areas to improve the quality of patient care provided by emergency care system partners and develop strategies to address the patient care issues.	**Strategy 1:** Throughout the plan cycle, the CREMS Council will discuss issues which affect patient care in the region.
	Strategy 2: Throughout the plan cycle, the CREMS Council will discuss best practices for addressing patient care issues that have been identified.
	Strategy 3: Throughout the plan cycle, the CREMS Council will develop action plans to address patient care issues which have been identified.
	Strategy 4: Throughout the plan cycle, the CREMS Council will evaluate the impact of the action plans on patient care in the region.
Objective 7: By May 2025, the CREMS Council will develop a FY 2025-2027 strategic plan.	**Strategy 1:** By October 2024, the CREMS Council and Regional Council Board will begin developing a FY 2023-2025strategic plan.
	Strategy 2: By February 2025, the CREMS Council will approve the plan.

	Strategy 3: By February 2025, the approved plan will be submitted to the Department of Health.
	Strategy 4: By March 2025, the CREMS Council will submit the FY 2023-2025 plan to the EMS & Trauma Steering Committee.
Objective 8: By October 2023 annually, the CREMS Council will allocate available funding to support EMS and trauma system training needs.	**Strategy 1:** By May 2023 annually, the CREMS Council will develop a budget for prehospital training support.
	Strategy 2: By October 2023 annually, the CREMS Council will allocate available funding for prioritized training needs.
	Strategy 3: By June 2024 annually, organizations that received grant funding will report on outcomes & accomplishments supported with this funding.
Objective 9: By May 2024 annually, the CREMS Council will provide any new or revised Patient Care Procedures to the Washington State Department of Health Office of Community Health Systems and the EMS & Trauma Steering Committee for review and approval.	**Strategy 1:** By January 2024 annually, the CREMS Council, MPD and other EMS stakeholders will review Central Region Patient Care Procedures and make revisions as necessary.
	Strategy 2: By March 2024 annually, the CREMS Council will submit any revised Patient Care Procedures to the Washington State Department of Health Office of Community Health Systems for review and approval.
	Strategy 3: By May 2024 annually, the CREMS Council will submit any revised Patient Care Procedures to the EMS & Trauma Steering Committee as needed.
Objective 10: Throughout the planning cycle, the CREMS Council will continually identify ways to improve Council membership, establish and cultivate relevant partnerships, and ensure the Central Region has representation and participation in statewide committees.	**Strategy 1:** By May 2025, CREMS Council staff will work to fill vacant council seats to ensure representation form a variety of organizations in accordance with the Bylaws.
	Strategy 2: By May 2025, CREMS Council will evaluate and identify ways to improve participation and representation in Washington State Department of Health Office of Community Health Systems and the various EMS and trauma Steering Committee Technical Advisory Committees.

APPENDICES:

Appendix 1: Adult and Pediatric Trauma Designated Hospital and Rehabilitation Facilities

https://doh.wa.gov/sites/default/files/2022-02/530101.pdf

Appendix 2: Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Hospitals

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

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

Level	State Approved		Current Status
	Min	Max	
II	4	6	1
III	0	1	0

*Numbers current as of date submitted. For real-time numbers, please see: Trauma Designated Services List

Appendix 4: Washington State Emergency Cardiac and Stroke (ECS) System Categorized Hospitals

A 2010 state law created the Emergency Cardiac and Stroke (ECS) System similar to the state's Trauma System. It's intended to save lives and reduce disability for heart attack, cardiac arrest, and stroke patients. Emergency medical services (EMS) take patients directly to hospitals that meet care requirements and choose to participate in the system. https://doh.wa.gov/sites/default/files/2022-02/345299.pdf

Appendix 5: EMS Resources, EMS Verified Services

EMS - Agency Resource and Transport

								Ground Vehicles	
Credential #	Credential Status	Agency Name	Mailing City	Expiration Date	Organization Type	Agency Type	Care Level	# AMB	# AID
AIRV.ES.60178312	ACTIVE IN RENEWAL	Airlift Northwest	Seattle	03/31/2023	Municipality (city/county)	AIRV	ALS	0	0
AMBV.ES.00000296	ACTIVE	American Medical Response	Tukwila	12/31/2023	Private for Profit	AMBV	BLS	91	0
AMBV.ES.00000260	ACTIVE	Bellevue Fire Department	Bellevue	07/31/2024	City Fire Department	AMBV	ALS	14	17
AMBV.ES.00000298	ACTIVE	Boeing Fire Department	Seattle	05/31/2024	Industrial Fire Department	AMBV	BLS	5	0
AMBV.ES.00000262	ACTIVE	Bothell Fire Department	Bothell	02/28/2024	City/Fire District Combination	AMBV	BLS	4	19
AMBV.ES.00000240	ACTIVE	Duvall - King County Fire District 45	Duvall	11/30/2023	Fire Distict	AMBV	BLS	3	3
AMBV.ES.61155981	ACTIVE	Eastside Fire & Rescue	Issaquah	01/31/2025	City/Fire District Combination	AMBV	BLS	13	45
AMBV.ES.00000263	ACTIVE	Enumclaw Fire Department	Enumclaw	08/31/2023	Fire Distict	AMBV	BLS	3	3
AMBV.ES.00000236	ACTIVE	King County Fire District #39	Federal Way	11/30/2024	Fire Distict	AMBV	BLS	6	12
AIDV.ES.00000224	ACTIVE	King County Fire District 2	Burien	09/30/2023	Fire Distict	AIDV	BLS	0	4
AMBV.ES.60230529	ACTIVE	King County Fire District 20	Seattle	03/31/2024	Fire Distict	AMBV	BLS	2	1
AMBV.ES.00000233	ACTIVE	King County Fire District 27	Fall City	09/30/2023	Fire Distict	AMBV	BLS	2	2
AID.ES.00000242	ACTIVE	King County Fire Protection Distrct #47	Ravensdale	05/31/2023	Fire Distict	AID	BLS	0	2
AIDV.ES.60274272	ACTIVE	King County International Airport	Seattle	11/30/2024	Municipality (city/county)	AIDV	BLS	0	2
AMBV.ES.00000294	ACTIVE	King County Medic One	Kent	10/31/2023	Municipality (city/county)	AMBV	ALS	17	2
ESSO.ES.60330466	ACTIVE	King County Sheriff Search and Rescue	Maple Valley	11/30/2024		ESSO		0	0
AMBV.ES.00000266	ACTIVE	Kirkland Fire Department	Kirkland	01/31/2025	City Fire Department	AMBV	BLS	8	15
AMBV.ES.00000267	ACTIVE	Mercer Island Fire Department	Mercer Island	06/30/2024	City Fire Department	AMBV	BLS	3	4
ESSO.ES.60378936	ACTIVE	Michael K Copass MD Harborview Medical Center	Seattle	06/30/2023		ESSO		0	0
AMBV.ES.00000239	ACTIVE	Mountain View Fire and Rescue	Auburn	04/30/2024	Fire Distict	AMBV	BLS	5	10
AIDV.ES.00000229	ACTIVE	Northshore Fire Department	Kenmore	02/28/2024	Fire Distict	AIDV	BLS	0	8
AMBV.ES.60818569	ACTIVE	Northwest Ambulance	Arlington	06/30/2023	Private for Profit	AMBV	BLS	1	0
ESSO.ES.60669992	ACTIVE	Pioneer Human Services	Seattle	06/30/2023		ESSO		0	0
AMBV.ES.60730439	ACTIVE	Port of Seattle Fire Department	Seatac	11/30/2024	Municipality (city/county)	AMBV	BLS	2	4
AMBV.ES.60247342	ACTIVE	Puget Sound Fire RFA	Kent	08/31/2024	Fire Distict	AMBV	BLS	6	31
AMBV.ES.00000270	ACTIVE	Redmond Fire Department	Redmond	01/31/2024	City/Fire District Combination	AMBV	ALS	13	25
AMBV.ES.60866037	ACTIVE	Renton Regional Fire Authority	Renton	06/30/2023	Fire Distict	AMBV	BLS	9	19
AMBV.ES.00000272	ACTIVE	Seattle Fire Department	Seattle	12/31/2023	City Fire Department	AMBV	ALS	23	0
AMBV.ES.00000225	ACTIVE	Shoreline Fire Department	Shoreline	02/28/2024	Fire Distict	AMBV	ALS	10	0
AMBV.ES.00000243	ACTIVE	Skykomish Fire Department/King County FPD #50	Skykomish	05/31/2023	Fire Distict	AMBV	BLS	3	2
AMBV.ES.60265555	ACTIVE	Snoqualmie Fire Department	Snoqualmie	09/30/2024	City Fire Department	AMBV	BLS	2	2
AMBV.ES.00000244	ACTIVE	Snoqualmie Pass Fire and Rescue	Snoqualmie Pass	05/31/2024	Fire Distict	AMBV	BLS	1	1
AID.ES.60429244	ACTIVE	Summit at Snoqualmie Ski Patrol	Snoqualmie Pass	11/30/2024	Private for Profit	AID	BLS	0	0
AMBV.ES.00000307	ACTIVE	Tri-Med Ambulance	Kent	03/31/2024	Private for Profit	AMBV	BLS	56	0
AIDV.ES.00000274	ACTIVE	Tukwila Fire Department	Tukwila	10/31/2023	City Fire Department	AIDV	BLS	0	8
AMBV.ES.00000310	ACTIVE	Valley Regional Fire Authority	Auburn	07/31/2023	Fire Distict	AMBV	BLS	5	10
AMBV.ES.00000228	ACTIVE	Vashon Island Fire and Rescue	Vashon	09/30/2023	Fire Distict	AMBV	BLS	5	0
ESSO.ES.60428351	ACTIVE	Washington Poison Center	Seattle	11/30/2023		ESSO		0	0
ESSO.ES.60372631	ACTIVE	Seattle Police Department	Seattle	10/31/2023		ESSO		0	0

Current as of 3/1/23

Appendix 6: Approved Min/Max numbers of Verified Trauma Services by Level and Type

County (Name)	Verified Service Type	State Approved – Minimum number	State Approved – Maximum number	Current Status (# Verified for each Service Type)
King	Aid – BLS	1	6	4
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	1	25	22
	Amb – ILS	0	0	0
	Amb – ALS	5	5	5

Numbers current as of 1/31/2023

Appendix 7: Trauma Response Areas (TRAs) by County

County	Trauma Response Area Number	Name of Agency Responding in Trauma Response Area	Description of Trauma Response Area's Geographic Boundaries	Number of Verified Services in response area
King	Primary Zone 1	Shoreline FD Northshore FD Bothell Fire & EMS Kirkland FD Redmond FD Eastside Fire & Rescue Kirkland FD Bellevue FD King Co. FD45 King Co. FD27 Snoqualmie FD Mercer Island FD	From NW border of Seattle; north to Snohomish County border; east along Snohomish County border to NE corner of FD 45; south along the eastern borders of FD 45 and Eastside Fire & Rescue and FD 27 FD 27 and continuing along the eastern border of Eastside Fire & Rescue, FD 27 borders to the NE border of Puget Sound RFA; west to NW border of Renton RFA, north along east side of Lake Washington, including Mercer Island to the Northeast border of Seattle and west to NW border of Seattle.	1 AIDV- BLS 9 AMBV-BLS 3 AMBV-ALS
King	NE Zone 1	Skykomish KCFD 50	Boundaries of FD 50	0 AIDV- BLS 1 AMBV-BLS 0 AMBV-ALS
King	E Zone 1	Snoqualmie Pass F&R /KCFD51 Bellevue Medic One	Boundaries of FD 51	0 AIDV- BLS 1 AMBV-BLS 1 AMBV-ALS

King	Zone 3	North Highline FD King Co. FD20 Burien FD Port of Seattle FD Puget Sound RFA Renton RFA South King F&R Valley RFA Tukwila FD Mountain View F&R Enumclaw FD King Co. FD47 Vashon Island F&R King County Medic One	South border of Seattle and south end of Lake Washington along north border of Renton and Maple Valley, east: along Kittitas County Border; south along Pierce County border; west along Puget Sound including Vashon Island.	2 AIDV- BLS 11 AMBV-BLS 1 AMBV-ALS
King	Zone 5	Seattle FD	City of Seattle	0 AIDV- BLS 0 AMBV-BLS 1 AMBV-ALS
King	Zone SW		North from SE border of Zone 3 along eastern borders of Zone 3 and Primary Zone 1 to the intersection of Primary Zone 1 and I-90; east along I-90 to intersection of 1-90 and E Zone 1; around the southern border of E Zone 1 to Kittitas County border; south along Kittitas County border to Pierce County border; west along Pierce County border to SE corner of Zone 3.	No designated service
King	Zone NW		From intersection of I-90 and Primary Zone 1; North along the eastern border of Primary Zone 1 to Snohomish County Border; east along Snohomish County border to NW border of NE Zone 1; south along western border of NE Zone 1 to SW corner of NE Zone 1; east along southern border of NE Zone 1 to Kittitas County border; south along Kittitas County border to intersection of E Zone 1 and Kittitas border; west and south around E Zone 1 to intersection of I-90 and E Zone 1, along I-90 to intersection of I-90 and Primary Zone 1.	No designated service

Central Region Trauma Response Area Map: https://fortress.wa.gov/doh/ems/index.html

Appendix 8: Approved EMS Training Programs

Credential #	Status	Expiration Date	Facility Name	Site City	Site County
TRNG.ES.60124884-PRO	APPROVED	03/31/2027	American Medical Response	Tukwila	King
TRNG.ES.60940802-PRO	APPROVED	03/31/2024	Fire Tech	Kirkland	King
TRNG.ES.60117628-PRO	APPROVED	03/31/2024	King County Emergency Medical Services	Seattle	King
TRNG.ES.60124347-PRO	APPROVED	03/31/2028	Michael K Copass, MD Paramedic Training Program	Seattle	King
TRNG.ES.60135401-PRO	APPROVED	03/31/2025	North Seattle College	Seattle	King

The above list is current as of 5/11/2023.

Appendix 9: Patient Care Procedures

CENTRAL REGION PATIENT CARE PROCEDURES

Approved date: 3/21/2023

TABLE OF CONTENTS

CONTACTS

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Department of Health, Emergency Care System

REGULATIONS

The following regulations provide guidance on subject matter contained in this document. Please note, that this is not an inclusive list. For more information please contact a Department of Health Emergency Care System representative.

1.1 REVISED CODE OF WASHINGTON (RCW):

- **RCW 18.73** – Emergency medical care and transportation services
  - RCW 18.73.030 - Definitions
- **RCW Chapter 70.168** – Statewide Trauma Care System
  - RCW 70.168.015 – Definitions
  - RCW 70.168.100 – Regional Emergency medical Services and Trauma Care Councils
  - RCW 70.168.170 – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

1.2 WASHINGTON ADMINISTRATIVE CODE (WAC):

- **WAC Chapter 246-976** – Emergency Medical Services and Trauma Care Systems
  - WAC 246-976-920 – Medical Program Director
  - WAC 246-976-960 – Regional emergency medical services and trauma care councils
  - WAC 246-976-970 – Local emergency medical services and trauma care councils

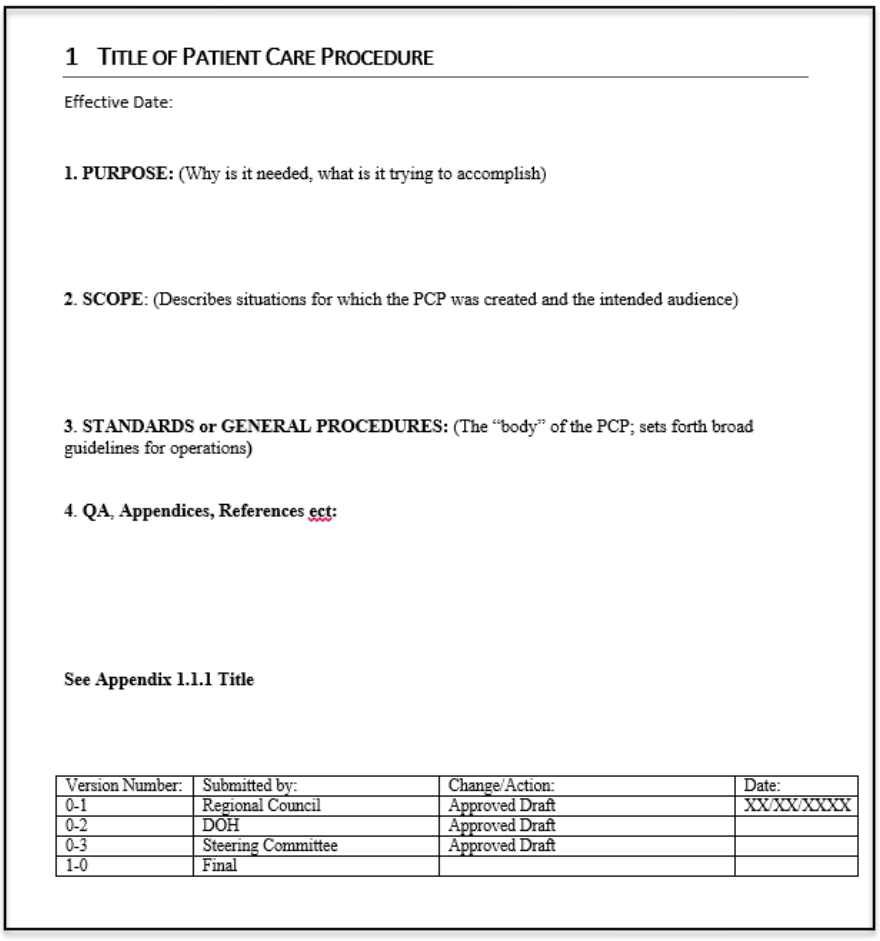
ANATOMY OF A PCP

RCW 18.73.030 – Defines a "Patient Care Procedure".

Other helpful definitions when building the anatomy of the PCP:

- **Purpose:** The purpose explains why it is needed and what it is trying to accomplish
- **Scope:** Describes the situations for which the PCP was created and the intended audience
- **Standards or General Procedures**: The "body" of the PCP, it sets forth broad guidelines for operations

Example:



1 TITLE OF PATIENT CARE PROCEDURE

Effective Date:

1. PURPOSE: (Why is it needed, what is it trying to accomplish)

2. SCOPE: (Describes situations for which the PCP was created and the intended audience)

3. STANDARDS or GENERAL PROCEDURES: (The "body" of the PCP; sets forth broad guidelines for operations)

4. QA, Appendices, References ect:

See Appendix 1.1.1 Title

Version Number:	Submitted by:	Change/Action:	Date:
0-1	Regional Council	Approved Draft	XX/XX/XXXX
0-2	DOH	Approved Draft	
0-3	Steering Committee	Approved Draft	
1-0	Final		

1 LEVEL OF MEDICAL CARE PERSONNEL TO BE DISPATCHED TO AN EMERGENCY SCENE

Effective Date: 2009

1. PURPOSE: To define guidelines for triage of trauma patients in the region.

2. **SCOPE**: This PCP applies to all 911 calls and EMS and trauma patients in the region.

3. **GENERAL PROCEDURES:**

Dispatch

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

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

Basic Life Support

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

BLS Code Red Response and Transport

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

1) The response mode from primary BLS response (fire department EMT personnel) shall be based on information made available to the EMS dispatchers and the decision for mode of travel made according to dispatch guidelines.
2) The default mode for travel to the scene for non-primary BLS responders shall be by non-emergency response unless a specific response for code-red (emergency response) is

made by primary responding EMS personnel at the scene or specific protocols

3) The default mode for BLS transport from scene to hospital shall be by non-emergency response unless a specific response for code-red transport is made by primary responding EMS personnel at the scene.
4) If a patient undergoing BLS transport to hospital deteriorates, the BLS personnel should contact the EMS dispatcher and ask for paramedic assistance, unless documentary evidence exists to travel code-red to hospital (such as travel to hospital can occur faster than waiting for paramedic assistance).

Advanced Life Support

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

Wilderness

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

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

2 GUIDELINES FOR RENDEZVOUS WITH AGENCIES THAT OFFER HIGHER LEVEL OF CARE

The Central Region EMS and Trauma Care Council does not currently have this patient care procedure.

3 AIR MEDICAL SERVICES - ACTIVATION AND UTILIZATION

Effective Date: 2019

1. **PURPOSE:**

   Air Medical Service activation and utilization provides expeditious transport of critically ill or injured patients to the appropriate hospital including designated/categorized receiving facilities.

2. **SCOPE**:

   Licensed and trauma verified aid and/or ambulance services utilize the county protocols and county operating procedures (COPs) consistent with current State of Washington Emergency Care Systems Air Ambulance Service Plan to identify and direct activation and utilization of air medical services.

3. **GENERAL PROCEDURES:** (content based on State Air Medical Procedure)
   a. For scene transport to be efficacious and optimize patient outcome, the air medical response should take significantly less time than it takes to travel by ground to the closest appropriate facility. Another strong consideration should be given to activating the helicopter from the scene, and rendezvous at the local hospital. This decision should be made as per local COPS in conjunction with local medical control.
   b. Responders should involve dispatch to contact and activate air medical response to maintain system safety and integrity. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units.
   c. Responding EMS service may activate air medical service prior to arrival on scene based on dispatch information or upon arrival on scene based on initial assessment.
   d. Air medical service will provide ETA of available fully staffed closest air ambulance.
   e. The final patient transport and destination decisions will be made on the scene.
   f. Air medical service will notify PSAP/dispatch when activated by a mechanism outside the emergency dispatch system.

   Air Medical transport is recommended for the following:
   Trauma – patient condition identified as a major trauma per the trauma triage tool. (see link to the WA Trauma Triage Destination Procedure in appendix)

   Non-trauma:
   a. Any patient airway that cannot be maintained.

b. Patient with cardiac disease and is experiencing a progressively deteriorating course, is unstable, and/or requires measures not available en route (e.g. ALS level care, cardiac catheterization, thrombolytic therapy.)
c. Patient is experiencing a severe neurological illness requiring neurosurgical or other intervention that is not available en route. (CVA, uncontrolled seizures, etc.)

Follow local COPs for exception and exclusion criteria.

4. **APPENDICES:**

Link to DOH website:
WA State Air Medical Plan
https://www.doh.wa.gov/portals/1/Documents/Pubs/530129.pdf
WA Trauma Triage Destination Procedure:
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

4 ON SCENE COMMAND

The Central Region EMS and Trauma Care Council does not currently have this patient care procedure.

5 PREHOSPITAL TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2009

1. PURPOSE: This patient care procedure provides guidance for patient triage and determination of the appropriate hospital destination.

2. **SCOPE**: This procedure applies to prehospital personnel in the field.

3. **GENERAL PROCEDURES:**

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

Factors including patient's choices may be:

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

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

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

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

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

IV. When in doubt, prehospital care providers should contact online medical control.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.1 TRAUMA TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2009

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

2. **SCOPE**: This procedure is for prehospital care providers and their medical control physicians.

3. **GENERAL PROCEDURES:**

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

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

3. Unstable trauma patients should be managed consistent with the State of Washington Prehospital Trauma Triage (Destination) Procedure. Unstable trauma patients are those needing a patent airway or who may benefit from the initiation of fluid resuscitation. EMS providers who are unable to secure an airway or establish an intravenous line should consider these factors in the following order:

a. time to arrival of responding medic unit
b. time to rendezvous with responding medic unit
c. time to nearest trauma center
d. time to arrival of Air Medical Transport.
e. time to nearest hospital with 24 hr emergency room
f. unusual events such as earthquakes and other natural disasters

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

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

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

Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104

All Central Region Trauma Care Facilities are as follows as of March 2023:

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

Level III Trauma Centers
MultiCare Auburn Medical Center
EvergreenHealth
Overlake Hospital Medical Center
Valley Medical Center

Level IV Trauma Centers
St. Anne Hospital
UW Medical Center - Northwest
St. Francis Hospital

Level V Trauma Center
St. Elizabeth Hospital
Snoqualmie Valley Hospital

4. **APPENDICES:**

DOH guidance document: Prehospital Trauma Triage and Destination Procedure.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
Regional Council	Update facility Names	9/12/2022	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.2 CARDIAC TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2018

1. PURPOSE: Provides guidance for the prehospital care and transport of cardiac patients in Central Region.

2. **SCOPE**: This procedure applies to prehospital providers caring for cardiac patients.

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

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

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

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

Current Approved Cardiac Care Centers, as of March 2023

Level I	MultiCare Auburn Medical Center
	EvergreenHealth
	Harborview Medical Center
	St. Anne Hospital
	UW Medical Center - Northwest
	Overlake Hospital Medical Center
	St. Francis Hospital
	Swedish Cherry Hill
	UW Medical Center - Montlake
	Valley Medical Center
	Virginia Mason Medical Center
	Swedish- Issaquah
Level II	Swedish First Hill
	Snoqualmie Valley Medical Center
	St. Elizabeth Hospital
	Swedish Ballard

4. **APPENDICES:** DOH guidance document on prehospital cardiac care.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
Regional Council	Update Facility Names	9/12/2022	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.3 STROKE TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2018

1. PURPOSE: To provide prehospital guidance on the transport and care of stroke patients.

2. **SCOPE**: This procedure is appropriate for prehospital providers who are caring for stroke patients.

3. **GENERAL PROCEDURES:** Stroke Patient Triage and Destination

These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which Stroke Center will receive the patient.
EMTs shall transport patient to the closest appropriate level Stroke Center consistent with the Washington State Stroke Patient Care Triage Destination Procedure and with regard to the patient or family preference. "

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

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

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

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

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

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

Current Approved Stroke Centers

Level 1	Harborview Medical Center
	Swedish Cherry Hill
	UW Medical Center- Northwest
	Virginia Mason Medical Center
Level II	MultiCare Auburn Medical Center

EvergreenHealth
Overlake Hospital Medical Center
St. Anne Hospital
Swedish First Hill
Swedish Issaquah
Valley Medical Center

Level III Snoqualmie Valley Hospital
St. Elizabeth Hospital
St. Francis Hospital
Swedish – Ballard
UW Medical Center - Montlake

4. **APPENDICES:** See stroke triage tool on the next page.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
Regional Council	Update facility names	9/12/22	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

2019 King County Prehospital Stroke Triage Procedure

STEP 1: Assess Likelihood of Stroke

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

If any of above, proceed to STEP 2, otherwise, transport per regional/county operating procedures

STEP 2: Perform F.A.S.T. Assessment (positive if any of Face/Arms/Speech abnormal)

- **Face**: Unilateral facial droop
- **Arms**: Unilateral arm drift or weakness
- **Speech**: Abnormal or slurred
- **Time**: Best estimate of Time Last Known Well =_____

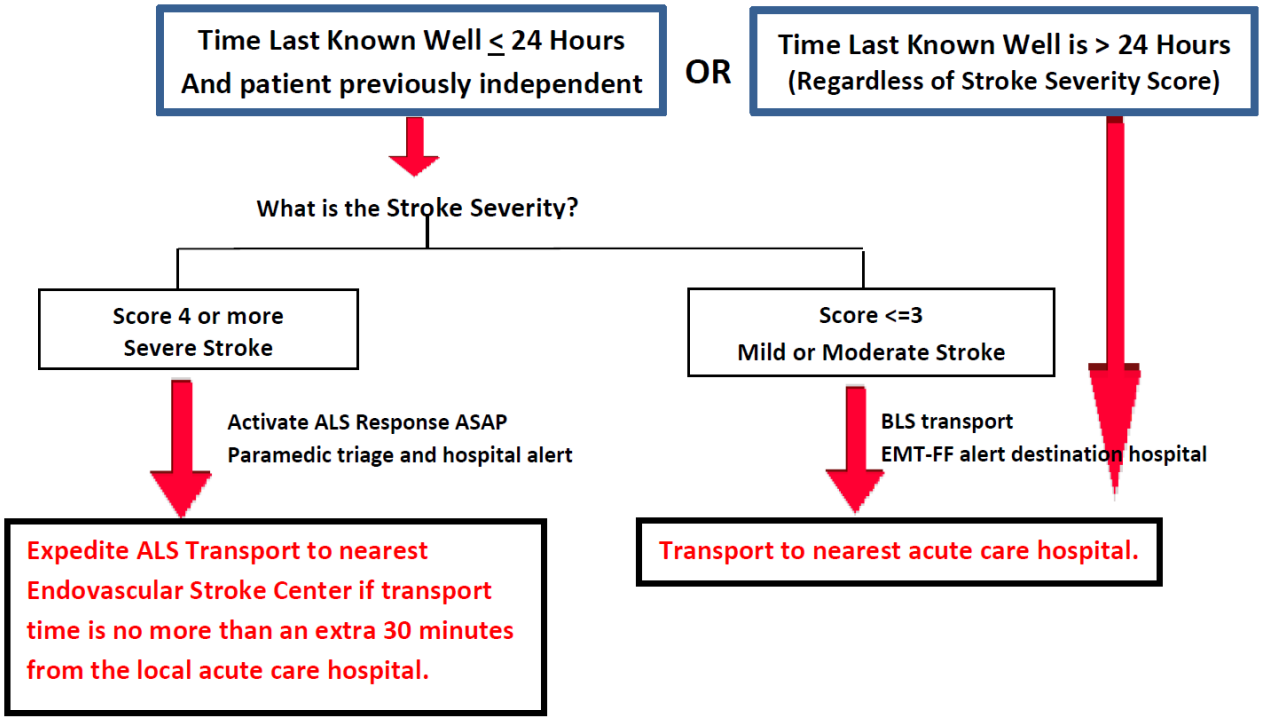
If FAST negative transport per regional operating procedures

STEP 3: If F.A.S.T Positive - Calculate Stroke Severity Score

Facial Droop:	Absent 0	Present 1			
Arm Drift:	Absent 0	Drifts 1	Falls Rapidly 2		
Grip Strength:	Normal 0	Weak 1	No Grip 2		

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

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



Exclude persons with chronic illness that makes them bedbound – for example those with advanced dementia or longstanding medical illness who require substantial assistance for basic life activities. These patients should proceed to local hospital regardless of stroke severity or last known well status.

5.4 MENTAL HEALTH AND CHEMICAL DEPENDENCY DESTINATION PROCEDURE

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

5.5 PREHOSPITAL TRIAGE AND DESTINATION PROCEDURE - OTHER

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

6 EMS/MEDICAL CONTROL COMMUNICATIONS

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

7 HOSPITAL DIVERSION

Effective Date: 2009

1. PURPOSE: This procedure outlines Central Region's no-divert policy.

2. **SCOPE**: This procedure is appropriate for times of high patient census, and is meant for hospital and prehospital personnel.

3. **GENERAL PROCEDURES:**
Ambulance diversion is defined as an active statement by a hospital, whether verbal or via WATrac ED Status, that patients arriving by ambulance will not be accepted. King County hospitals have unanimously adopted a No Diversion Policy for all medical and surgical patients effective May 31, 2011.

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

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

8 CROSS BORDER TRANSPORT

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

9 INTER-FACILITY TRANSPORT PROCEDURE

Effective Date: 2009

1. PURPOSE: To establish guidelines for the transport of patients between facilities within Central Region.

2. **SCOPE**: This procedure is relevant for hospital emergency department personnel and EMS agencies who may transfer a patient from one facility to another within the region.

3. **GENERAL PROCEDURES:**

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

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

Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

10 PROCEDURES TO HANDLE TYPES AND VOLUMES OF PATIENTS THAT EXCEED REGIONAL RESOURCES

10.1 MCI

Effective Date: 2009

1. PURPOSE: To establish procedures for patient transport in the event of a mass casualty incident.

2. **SCOPE**: This procedure is relevant to EMS and hospital personnel in the region in the event of a mass casualty incident.

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

Large Multiple Casualty Incidents may require the triage of patients to non-designated King County hospitals or to trauma centers in adjacent counties.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

10.2 ALL HAZARDS- MCI AND SEVERE BURNS

Effective Date: 2009

1. PURPOSE: Provides guidance for transport and care of patients in an MCI who may have suffered severe burns and need specialized care.

2. **SCOPE**: This procedure is appropriate for EMS teams in an MCI in which many patients suffer severe burns.

3. **GENERAL PROCEDURES:**

STANDARD: During a mass casualty incident (MCI) with severely burned adult and pediatric patients,

1. All verified ambulance and verified aid services shall respond to an MCI per the King County Fire Chief's MCI Plan
2. All licensed ambulance and licensed aid services shall assist during an MCI per King County Fire Chief's MCI Plan when activated by incident command through dispatch in support of the King County Fire Chief's MCI Plan and/or in support of verified EMS services
3. All EMS certified personnel shall assist during an MCI per King County Fire Chief's MCI Plans when requested by incident command through dispatch in support of the King County Fire Chief's MCI Plan and/or in support of verified EMS services
4. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
5. All EMS agencies working during an MCI event shall operate within the Incident Command System as identified in local protocol and MCI plan.

PURPOSE:

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

PROCEDURES:

1. Incident Command shall follow the King County Fire Chief's MCI Plan and will notify Disaster Medical Control Center (DMCC) when an MCI condition exists, including factors identifying severe burn injuries and number of adult/pediatric patients.
2. Medical program directors agree that protocols being used by responding agencies shall continue to be used throughout transport of patients regardless of county, state or country.
3. EMS personnel may use the "Prehospital Mass Casualty Incident (MCI) general Algorithm during the MCI incident.

A. The “SAMPLE ONLY” algorithm is intended as a boilerplate or skeleton outline only. It is not intended as a state directed requirement.
B. the DRAFT-SAMPLE Algorithm is attached on the next page.

4. APPENDICES:

Prehospital Mass Causality Incident (MCI) General Algorithm

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

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

Prepare transport vehicle to return to service

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

10.3 OTHER

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

A) REGION SPECIFIC PATIENT CARE PROCEDURES: ACTIVATION OF TRAUMA TEAM

Effective Date: 2009

1. PURPOSE: To provide a general guideline for hospital facilities' activation of their trauma team for incoming patients.

2. **SCOPE**: Applies to hospital personnel.

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

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

B) REGION SPECIFIC PATIENT CARE PROCEDURES: ADAPT CLINIC AND URGENT CARE CLINIC TRANSPORTATION POLICY

Effective Date: 2009

1. PURPOSE: To provide guidance about patient transport to urgent care clinics.

2. **SCOPE**: This procedure applies to prehospital personnel.

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

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

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

ADAPT Taxi Voucher Transportation Policy

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

4. **APPENDICES:**

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

C) Region Specific Patient Care Procedures: Paramedic Training and Changes in Service Levels

Effective Date: 2009

1. PURPOSE: To provide information about paramedic training and service levels in the region.

2. **SCOPE**: Applies to prehospital agencies and leadership.

3. **GENERAL PROCEDURES:**
In order to maintain the highest quality care for prehospital emergencies it shall be required that:

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

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

DOH GUIDANCE DOCUMENTS

State of Washington
Prehospital Trauma Triage (Destination) Procedure

Purpose

The Trauma Triage Procedure was developed by the Centers for Disease Control in partnership with the American College of Surgeons, Committee on Trauma. The guidelines have been adopted by the Department of Health (DOH) based on the recommendation of the State EMS and Trauma Steering Committee.

The procedure is described in the attached algorithm. The guidelines represent the current best practice for the triage of trauma patients. The algorithm allows EMS and Trauma Responders to quickly and accurately determine if the patient is a major trauma patient. Major trauma patients must be taken to the highest appropriate level trauma facility in the defined system within 30 minutes transport time (Air or Ground).

The "defined system" is the trauma system that exists within an EMS and Trauma Care Region.

Explanation of Procedure

Any certified EMS and Trauma responder can identify a major trauma patient and activate the trauma system. This may include asking for Advanced Life Support response or air medical evacuation.

Step (1) Assess the patient's vital signs and level of consciousness using the Glasgow Coma Scale. Step 1 findings require activation of the trauma system. They also require rapid transport to the highest, most appropriate trauma center within 30 minutes transport time (ground or air). If unable to manage the patient's airway, consider meeting up with an ALS unit or transporting to the nearest facility capable of definitive airway management.

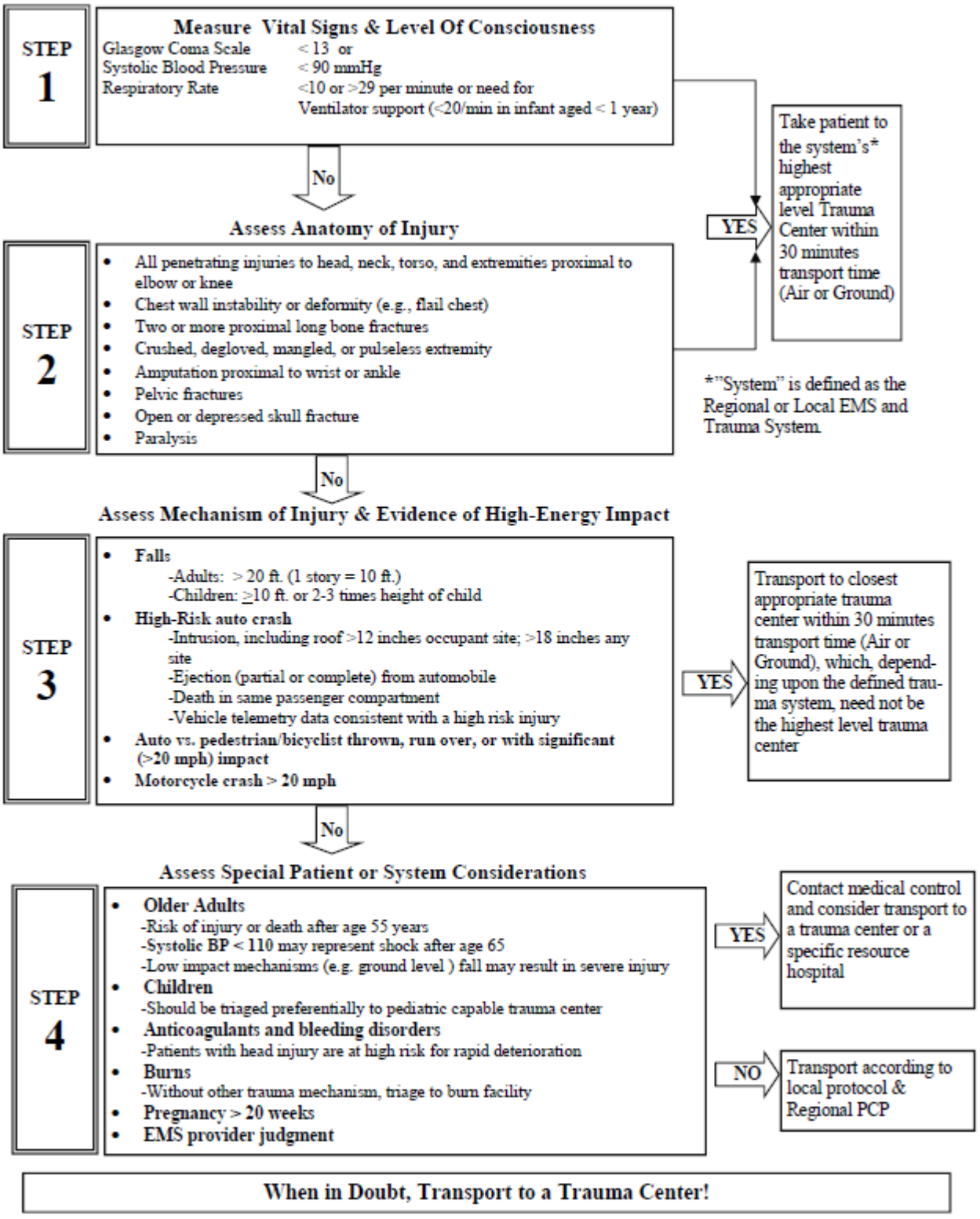
Step (2) Assess the anatomy of injury. Step 2 findings require activation of the trauma system. They also require rapid transport to the highest, most appropriate trauma center within 30 minutes transport time (ground or air). The presence of the specific anatomical injuries even with normal vital signs, lack of pain or normal levels of consciousness still require calling medical control and activating the trauma system.

Step (3) Assess biomechanics of the injury and address other risk factors. The conditions identified are reasons for the provider to transport to a trauma center. The destination trauma center need not be the highest level trauma center. Medical control should be contacted as soon as possible.

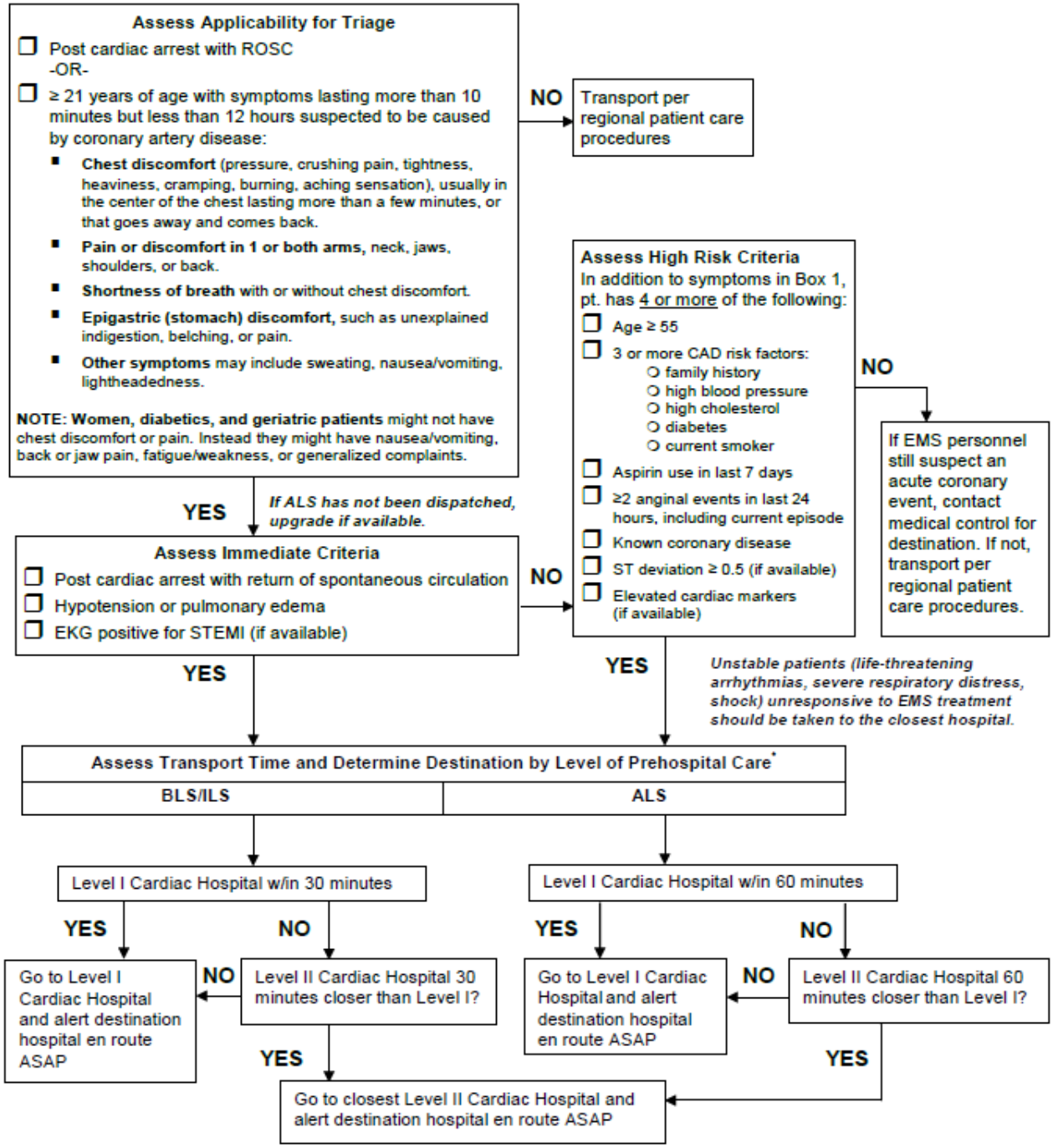
Step (4) has been added to assess special patients or system considerations. Risk factors coupled with "Provider Judgment" are reasons for the provider to contact Medical Control and discuss appropriate transport for these patients. In some cases, the decision may be to transport to the nearest trauma center.

Regional Patient Care Procedures (PCP's) and Local County Operating Procedures (COPS) provide additional detail about the appropriate hospital destination. PCP's and COP's are intended to further define how the system operates. The Prehospital Trauma Triage procedure and the Regional Patient Care Procedures work in a "hand in glove" fashion to address trauma patient care needs.

Washington State Trauma Triage Destination Procedures



State of Washington
Prehospital Cardiac Triage Destination Procedure



State of Washington
Prehospital Cardiac Triage Destination Procedure

Why triage cardiac patients?

The faster a patient having a heart attack or who's been resuscitated gets treatment, the less likely he or she will die or be permanently disabled. Patients with unstable angina and non-ST elevation acute coronary syndromes (UA/NSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure?

A. **Assess applicability for triage** – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the "Assess Immediate Criteria" box. **NOTE**: Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.

B. **Assess immediate criteria** – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to "Assess Transport Time and Determine Destination" box. If the patient does not meet immediate criteria, or you can't do an ECG, go to the "Assess High Risk Criteria" box.

C. **Assess high risk criteria** – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:

- ☐ 3 or more CAD (coronary artery disease) risk factors:
  - Age ≥ 55: epidemiological data for WA show that incidence of heart attack increases at this age
  - Family history: father or brother with heart disease before 55, or mother or sister before 65
  - High blood pressure: ≥140/90, or patient/family report, or patient on blood pressure medication
  - High cholesterol: patient/family report or patient on cholesterol medication
  - Diabetes: patient/family report
  - Current smoker: patient/family report.
- ☐ Aspirin use in last 7 days: any aspirin use in last 7 days.
- ☐ ≥2 anginal events in last 24 hours: 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
- ☐ Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery.
- ☐ ST deviation ≥ 0.5 mm (if available): ST depression ≥ 0.5 mm is significant; transient ST elevation ≥ 0.5 mm for < 20 minutes is treated as ST-segment depression and is high risk; ST elevation >1 mm for more than 20 minutes places these patients in the STEMI treatment category.
- ☐ Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.

D. **Determine destination** – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For BLS, this is generally within 30 minutes transport time, and for ALS, generally 60 minutes transport time. See below for further guidance. Regional patient care procedures and county operating procedures may provide additional guidance.

E. **Inform the hospital en route so staff can activate the cath lab and call in staff if necessary.**

What if a Level I Cardiac Hospital is just a little farther down the road than a Level II?

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

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

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

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

What if there are two or more Level I or II facilities to choose from?

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

DOH 346-050 April 2011

State of Washington
Prehospital Stroke Triage Destination Procedure

STEP 1: Assess Likelihood of Stroke

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

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

STEP 2: Perform F.A.S.T. Assessment *(positive if any of Face/Arms/Speech abnormal)*

- **Face**: Unilateral facial droop
- **Arms**: Unilateral arm drift or weakness
- **Speech**: Abnormal or slurred
- **Time**: Best estimate of Time Last Known Well =_____

If FAST negative, transport per regional/county operating procedures

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

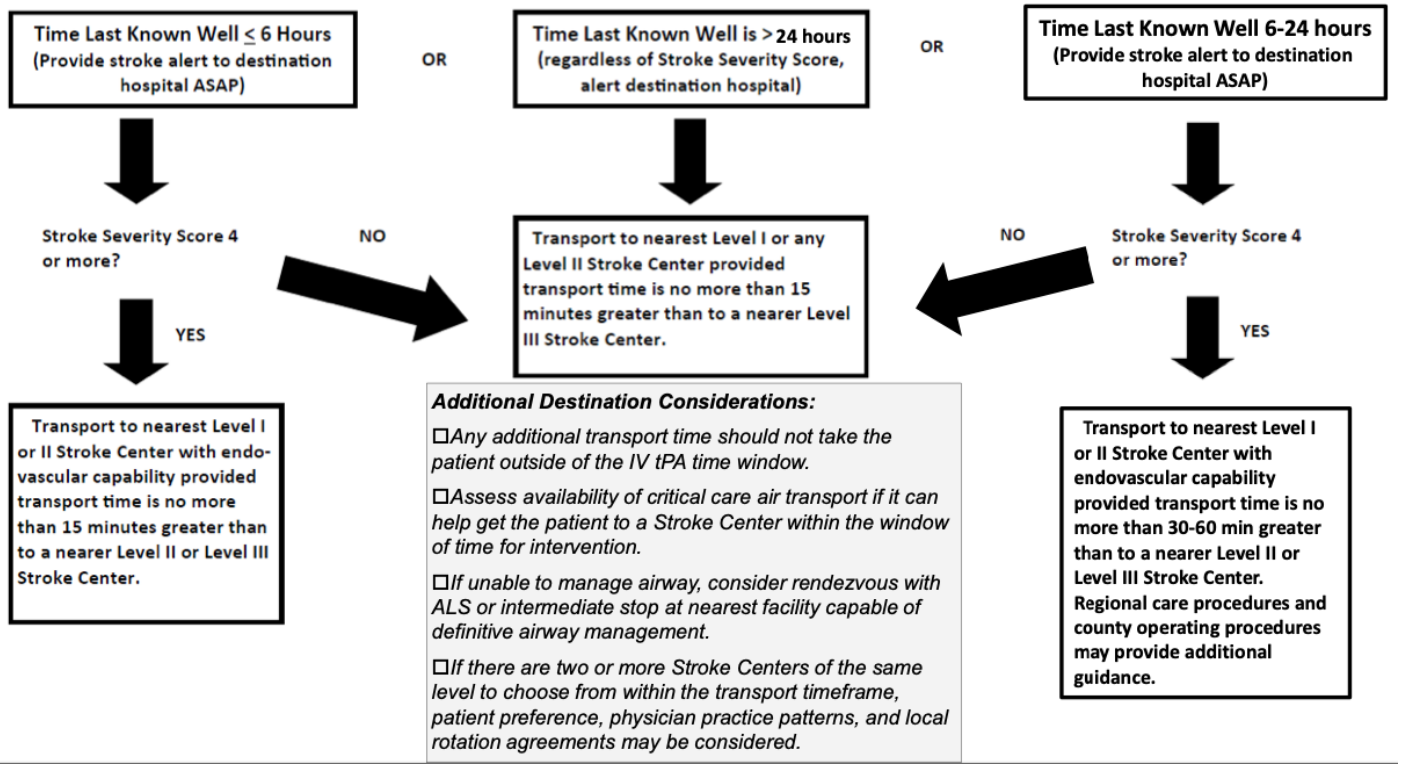
Facial Droop:	Absent	0	Present	1		
Arm Drift:	Absent	0	Drifts	1	Falls Rapidly	2
Grip Strength:	Normal	0	Weak	1	No Grip	2

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

STEP 4: Determine Destination: Time Last Known Well + Stroke Severity Score - *See Back Page*

DOH 530-182 February 2019

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



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

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

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

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

FAST stroke screen to identify a patient with a high probability of stroke.

Stroke Severity Score to determine if a patient meets criteria for "severe" stroke.

Time since Last Known Well (LKW) which helps determine eligibility for tPA and thrombectomy.

STEPS to determine destination:

Do a FAST Stroke Screen Assessment: (**F**acial droop, **A**rm drift, **S**peech changes, **T**ime since LKW) is a simple way to tell if someone might be having a stroke. If FAST is negative, stroke is less likely, and standard destination procedures apply. If FAST is positive (face or arms or speech is abnormal), it's likely the patient is having a stroke and the EMS provider moves on to assessing stroke severity.

Assess severity: The stroke severity assessment scores the FAST stroke screen. Patients get points for deficits:

Facial droop gets 1 point if present, 0 points if absent;

Arm drift (have patient hold arms up in air) gets 2 points if an arm falls rapidly, 1 point if slowly drifts down and 0 points if the arms stay steady;

Grip strength gets 2 points if no real effort can be made, 1 point if grip is clearly there but weak, and 0 points if grips seem of full strength.

Add up the points: A score $\geq$ 4 is interpreted as "severe."

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

Determine Destination:

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

Time since LKW is > 24 hours (regardless of severity score): These patients should be taken to nearest Level I or II stroke center provided it is no more than 15 minutes greater than to a nearer Level III stroke center.

Time since LKW 6-24 hours but NOT "Severe": These patients should be taken directly to the nearest Level I or Level II stroke center provided it is no more than 15 extra minutes travel compared to a nearer Level 3 stroke center.

Time since LKW 6-24 hours AND "Severe": Transport to nearest Level I or II Stroke Center with endovascular capability provided transport time is no more than 30-60 min greater than to a nearer Level II or Level III Stroke Center. Regional care procedures and county operating procedures may provide additional guidance.

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

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

Washington State Department of Health
Guideline for Implementing SHB 1721
July 2016

Background

In 2015 the Washington State Legislature passed legislation (SHB 1721) allowing emergency medical services ambulance and aid services to transport patients from the field to mental health or chemical dependency services. Participation is voluntary.

The Legislation

SHB 1721 section one calls for the Department of Health (department) in consultation, with the Department of Social and Health Services, to convene a workgroup comprising members of the steering committee and representatives of ambulance services, firefighters, mental health providers, and chemical dependency treatment programs. The workgroup was to establish alternative facility guidelines for developing protocols, procedures, and applicable training appropriate to the level of emergency medical service provider.

The guidelines shall consider when to transport to a mental health facility or chemical dependency treatment program to include:

- The presence of a medical emergency that requires immediate medical care;
- The severity of the mental health or substance use disorder needs of the patient;
- The training of emergency medical service personnel to respond to a patient experiencing emergency mental health or substance abuse disorders; and
- The risk the patient presents to the patient's self, the public, and the emergency medical service personnel.

By July 1, 2016, the department shall make the guidelines available to all regional emergency medical services and trauma care councils for incorporation into the patient care procedures of regional emergency medical services and trauma care plans.

Please forward questions about this document to:

Department of Health
Office of Community Health Systems
EMS and Trauma Section
P.O. Box 47853
Olympia, WA 98504
360-236-2841
HSQA.EMS@doh.wa.gov

What this means for regional EMS and trauma care councils
Regional EMS and trauma care councils shall develop a patient care procedure (PCP) that provides guidance to medical program directors and EMS agencies to operationalize transport of patients to a mental health or chemical dependency treatment facility. The PCP must:

- Direct participating facilities and agencies to adhere to the Washington State Department of Health Guideline for the Implementing SHB 1721 (guideline);
- Identify health care representatives and interested parties to be included in collaborative workgroups for designing and monitoring programs;
- Direct facilities that participate in the program to work with the medical program director (MPD) and EMS entities to reach consensus on criteria that all facilities and EMS entities participating in the program will follow for accepting patients.
- Include a statement that the facility participation is voluntary;
- Direct the local EMS council and MPD to establish a quality assurance process to monitor programs;
- Direct the local EMS council and MPD to develop and establish a county operating procedure (COP) inclusive of the standards recommended by the guideline and PCP, to include dispatch criteria, response parameters and other local nuances to operationalize the program;
- Direct the EMS MPD to establish a patient care protocol (protocol) inclusive of the standards and screening criteria recommended by the guideline and PCP;
- Direct the MPD to develop and implement department-approved education for emergency medical service personnel in accordance with the training requirements of the guideline. Educational programs must be approved by the department.

What this means for Local EMS and Trauma Care Councils
Local EMS and trauma care councils must collaborate with the MPD to develop a COP inclusive of the standards in the guideline. The COP must be consistent with state standards and the PCP.

The COP must include:

- A list of approved mental health and chemical dependency facilities participating in the program;
- Destination determination criteria including considerations for transports that may take the EMS service out of its county of origin;
- A list of options for methods of transport and any pertinent timelines for transport to occur;
- Guidance to EMS providers on when to contact law enforcement, and any procedures that must be considered during EMS and law enforcement interactions;
- Guidance to EMS providers on when to contact the designated mental health professional (DMHP) and any procedures to be considered during an involuntary hold.

Washington State Department of Health

What this means for medical program directors
MPDs must develop a patient care protocol inclusive of the standards and screening criteria in the guideline and PCP. The protocol must be consistent with state standards, PCP, and COP. The protocol should assist EMS providers in:

- Determining medical emergency that requires immediate care;
- Assessing the risk the patient presents to the patient's self, the public, and the emergency medical service personnel;
- Determining the severity of mental health or substance use disorder.

MPDs must develop and implement department-approved education for emergency medical service personnel who will respond and transport patients to mental health and chemical dependency facilities. Training must include content that meets the outlined criteria in **Appendix C** of this document.

Washington State Department of Health

Appendix A

EMS Screening Criteria for Transport to Mental Health Services

Inclusion criteria:

Facility:

Reference:

RCW 71.05.020 - Definitions
RCW 71.05.153 - Emergent detention of persons with mental disorders – Procedure

Mental health services authorized to receive patients include; crisis stabilization units, evaluation and treatment facilities and triage facilities.

Mental health services who have elected to operate as an involuntary facility may receive patients referred by a peace officer or a patient in involuntary status by a DMHP.

Patient:

- Voluntary with a mental health chief complaint willing to go to an alternative destination.
- Patients with a mental health chief complaint referred by a peace officer.
- Patients with a mental health chief complaint detained under the Involuntary Treatment Act (ITA) by a DMHP. The proper documents must be completed and signed by a DMHP for reimbursement.
- Patients with mental health complaints must have a clear history of mental health problems. No new onset mental health problems.
- The patient's current condition cannot be explained by another medical issue and traumatic injury is not suspected.
- The EMS agency was dispatched via 911.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- Suicidal patients may accept voluntary care, or may be detained by a peace officer or DMHP.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

Exclusion criteria:

Facility:

- Lack of bed availability
- Intake staff identifies concerns that exceed the ability of the facility to provide adequate care to the patient that requires local hospital emergency department -physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over last 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being utilized that the patient cannot manage.
- New onset of mental health problems. Mental health problem is not clearly indicated in patient history.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.
- Any evidence for acute medical or traumatic problem.

Procedure:

- Scene safety and crisis de-escalation.
- Consider contacting law enforcement to assist EMS with on-scene mitigation of suicidal patients who are not voluntary, and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and illicit drug use.
- Assess for inclusion and exclusion criteria.
- For patients who meet screening criteria, contact receiving center to determine resource availability. MPDs should consider identifying and including a list of available secondary resources other than the emergency room that can be used if a primary resource is unavailable.
- Contact medical control for approval.
- Secure a safe method of transportation identified and approved by the MPD in COPs or protocols.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- At time of patient care transfer, the completed inclusion/exclusion checklist should be provided to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

Washington State Department of Health

Appendix B

EMS Screening Guideline for Transport to Chemical Dependency Services

Inclusion criteria:

Facility:

RCW 70.96A chemical dependency centers, and treatment centers, include sobering centers, and acute and subacute detox centers.

- Facility is identified as a crisis stabilization unit, evaluation and treatment facility, or triage facility that provides chemical dependency treatment services and mental health services.

Patient:

- Voluntary patients with a chemical dependency chief complaint willing to go to an alternative destination.
- Patients with a chemical dependency chief complaint referred by a peace officer.
- Patients with a mental health and/or chemical dependency chief complaint detained under the Involuntary Treatment Act (ITA) by a designated chemical dependency specialist (DCDS). The proper documents must be completed and signed by a DCDS for reimbursement.
- The patient's current condition cannot be not explained by another medical issue.
- The EMS agency was dispatched via 911 or police request.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

Exclusion criteria:

Facility:

- Lack of bed availability.
- Intake staff identifies concerns that require local hospital emergency department - physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose.
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy.
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over past 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being used.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.
- Any evidence for acute medical or traumatic problem.

Procedure:

- Scene safety and crisis de-escalation.
- Contact law enforcement for suicidal patients who are not voluntary, and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and drug use.
- Assess for inclusion and exclusion criteria.

- For patients who meet screening criteria, contact receiving center for resource availability.
- Contact medical control for approval.
- Secure safe method of transportation.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- At time of patient care transfer, provide the completed inclusion-exclusion checklist to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

Washington State Department of Health

Appendix C

Education: The following is the minimum suggested content for department-approved MPD specialized training that shall be provided to EMS providers participating in transport programs authorized by SHB 1721 legislation and operating within the parameters of the guideline. Education programs must be approved by the department. Education must be provided on initial implementation and in an ongoing manner. MPDs may add content to the minimum recommended standards.

I. Review of the Regulatory Framework
- A. SHB 1721 Legislation and Department of Health Guideline
- B. Regional Patient Care Procedure
- C. County Operating Procedure
- D. Patient Care Protocol

II. Define Terms
- A. Receiving centers
  1. Mental Health Centers
  2. Chemical Dependency Centers
- B. Mental Health Professionals
  1. Emergency Social Worker
  2. Designated Mental Health Professional (DMHP)
- C. Involuntary referral
  1. Peace Officer
  2. DMHP
  3. Detainment Laws
  4. Mandatory reporting

III. Behavioral Health Emergencies and Crisis Response
- A. Crisis Intervention
  1. Crisis recognition and assessment
  2. Securing physical safety
     a. Withdraw from contact until scene safe
     b. Contain situation
     c. Call for adequate help
     d. Call for Law Enforcement
  3. Mitigation
  4. Destination decision making/Implementing an action plan
- B. Principles of crisis intervention
  1. Simplicity
  2. Brevity
  3. Innovation
  4. Practicality
  5. Proximity

6. Immediacy
7. Expectancy

C. SAFER-R
1. Stabilize the Situation
2. Acknowledge that something distressing has occurred
3. Facilitate the person's understanding of the situation
4. Encourage the person to make an acceptable plan of action
5. Recovery is evident

D. History/Assessment Tools
1. SAMPLE
2. OPQRST
3. SEA-3
4. MSE

F. Recognition of Increasing Rage/Risk of Violence
1. Bulging neck veins
2. Reddened face
3. Gritted Teeth
4. Muscle tension around jaw
5. Threatening Gestures
6. Threatening Posture
7. Display of a weapon
8. Clenched Fists
9. Wild or staring eyes

G. Suicide
1. Risk factors
2. Overt and covert clues
3. SADPERSONS Suicide assessment scale
4. Steps to bring a suicidal person to safety
   a. Secure the environment
   b. Develop trust and rapport
   c. Engage in a thorough risk assessment
   d. Develop a greater understanding of the person and issues that led up to the current situation
   e. Explore alternatives to suicide
   f. Select the best option for available alternatives
   g. Develop an action plan
   h. Implement the action plan
   i. Refer to appropriate facility

H. Dementia and Delirium
1. Definitions
2. Distinctions
3. Effect and association with emergent medical disorders
   a. Trauma
   b. Infection