Chapter 246-976 WAC
EMERGENCY MEDICAL SERVICES AND TRAUMA CARE SYSTEMS

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WAC

246-976-001 Purpose.
246-976-010 Definitions.

TRAINING

246-976-022 EMS training program requirements, approval, reapproval, discipline.
246-976-023 Initial EMS training course requirements and course approval.
246-976-024 MPD specialized training and pilot projects.
246-976-026 Ongoing training and education programs (OTEP).
246-976-031 EMS instructors, initial approval, and recognition.
246-976-032 EMS instructor reapproval and recognition.
246-976-033 Denial, suspension, modification or revocation of an ESE, SEIC, or SEI recognition.
246-976-041 To apply for training.

CERTIFICATION

246-976-139 Provisional certification.
246-976-141 To obtain initial EMS provider certification following the successful completion of Washington state approved EMS course.
246-976-142 To obtain reciprocal (out-of-state) EMS certification, based on a current out-of-state or national EMS certification approved by the department.
246-976-143 To obtain EMS certification based on possession of a current health care providers credential.
246-976-144 EMS certification.
246-976-161 General education and skill maintenance requirements for EMS provider recertification.
246-976-162 The CME method of recertification.
246-976-163 The OTEP method of recertification.
246-976-171 Recertification, reversion, reissuance, and reinstatement of certification.
246-976-182 Authorized care—Scope of practice.
246-976-191 Disciplinary actions.

LICENSURE AND VERIFICATION

246-976-260 Licenses required.
246-976-261 Emergency services supervisory organizations (ESSO).
246-976-270 Denial, suspension, revocation.
246-976-290 Ground ambulance vehicle standards.
246-976-300 Ground ambulance and aid service—Equipment.
246-976-310 Ground ambulance and aid service—Communications equipment.
246-976-320 Air ambulance services.
246-976-330 Ambulance and aid services—Record requirements.
246-976-340 Ambulance and aid services—Inspections and investigations.
246-976-360 Organ transport service and vehicle license.
246-976-390 Standards for trauma verified prehospital EMS services.
246-976-395 To apply for initial or renewal of verification or to change verification status as a prehospital EMS service.
246-976-400 Verification—Noncompliance with standards.

TRAUMA REGISTRY

246-976-420 Trauma registry—Department responsibilities.
246-976-430 Trauma registry—Provider responsibilities.
246-976-445 EMS data system—Department responsibilities.
246-976-455 EMS data system—EMS service and provider responsibilities.

DESIGNATION OF TRAUMA CARE FACILITIES

246-976-580 Trauma designation process.
246-976-700 Trauma service standards.
246-976-800 Trauma rehabilitation service standards.

SYSTEM ADMINISTRATION

246-976-890 Interhospital transfer guidelines and agreements.
246-976-910 Regional quality assurance and improvement program.
246-976-920 Medical program director.
246-976-930 General responsibilities of the department.
246-976-935 Emergency medical services and trauma care system trust account.
246-976-940 Steering committee.
246-976-960 Regional emergency medical services and trauma care councils.
246-976-970 Local emergency medical services and trauma care councils.
246-976-990 Fees and fines.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

246-976-020 First responder training—Course contents, registration, instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-020, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-021 Training course requirements. [Statutory Authority: RCW 18.71.205, 18.73.081, and 43.70.615. WSR 08-10-091, § 246-976-021, filed 5/6/08, effective 6/6/08. Statutory Au-

thority: RCW 18.71.205, 18.73.081, and 70.168.060. WSR 03-20-107, § 246-976-021, filed 10/1/03, effective 11/1/03. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-021, filed 4/5/00, effective 5/6/00.] Repealed by WSR 11-07-078, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-025 First responder—Continuing medical education. [Statutory Authority: RCW 43.70.040, chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-025, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-030 Emergency medical technician training—Course content, registration, and instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-030, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-035 Emergency medical technician—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-035, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-040 Specialized training. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-040, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-045 Levels of intermediate life support personnel and advanced life support paramedics. [Statutory Authority: Chapter 18.71 RCW. WSR 96-03-052, § 246-976-045, filed 1/12/96, effective 2/12/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-050 Intravenous therapy technician training—Course content, registration, instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-050, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-055 Intravenous therapy technicians—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-055, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-060 Airway technician training—Course content, registration, instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-060, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-065 Airway technician—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-065, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-070 Combined intravenous therapy and airway technician training—Course content, registration, instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-070, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-075 IV therapy/airway technician—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-075, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-076 Intermediate life support training—Course content, registration, instructor qualifications. [Statutory Authority: Chapter 18.71 RCW. WSR 96-17-067, § 246-976-076, filed 8/20/96, effective 9/20/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-077 Intermediate life support technicians—Continuing medical education. [Statutory Authority: Chapter 18.71 RCW. WSR 96-17-067, § 246-976-077, filed 8/20/96, effective 9/20/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-080 Paramedic training—Course content. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-080, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-085 Paramedic—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-085, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-090 Continuing medical education—Units of learning. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-090, filed 12/23/92, effective 1/23/93.] Repealed by WSR 97-20-101, filed 9/29/97, effective 10/30/97. Statutory Authority: RCW 43.70.040.

246-976-110 Senior EMT instructor—Qualifications and responsibilities. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-110, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-115 Course coordinator—Responsibilities. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-115, filed 12/23/92,

effective 1/23/93.] Repealed by WSR 97-20-101, filed 9/29/97, effective 10/30/97. Statutory Authority: RCW 43.70.040.

246-976-120 Disciplinary action—Training personnel. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-120, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-140 Certification and recertification—General requirements. [Statutory Authority: Chapter 18.71 RCW. WSR 96-17-067, § 246-976-140, filed 8/20/96, effective 9/20/96. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-140, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-150 Certification and recertification—First responder. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-150, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-151 Reciprocity, challenges, reinstatement and other actions. [Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-151, filed 4/5/00, effective 5/6/00.] Repealed by WSR 11-07-078, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-160 Certification and recertification—Emergency medical technician. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-160, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-165 Levels of certified intermediate life support personnel and paramedics. [Statutory Authority: Chapter 18.71 RCW. WSR 96-03-052, § 246-976-165, filed 1/12/96, effective 2/12/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-170 Certification and recertification—Intravenous therapy technicians. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-170, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-180 Certification and recertification—Airway technicians. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-180, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-181 Certification and recertification—Intermediate life support technician. [Statutory Authority: Chapter 18.71 RCW. WSR 96-17-067, § 246-976-181, filed 8/20/96, effective 9/20/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-190 Recertification—IV and airway technicians. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-190, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-200 Certification and recertification—Paramedics. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-200, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-210 Certification—Reciprocity, challenges, and reinstatement. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-210, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-220 EMS personnel—Scope of care authorized, prohibited. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-220, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-230 Certification—Reversion, revocation, suspension, modification, or denial. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-230, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-240 Notice of decision and hearing. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-240, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-280 Ground ambulance and aid services—Personnel requirements. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-280, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-350 Ambulance and aid services—Variances from requirements. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-350, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-370 Ambulance and aid services—Prehospital trauma triage procedures. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-370, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-440 Trauma registry—Reports. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-440, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-450 Access and release of trauma registry information. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-450, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-470 Trauma care facilities—Designation process. [Statutory Authority: Chapter 70.168 RCW. WSR 93-20-063, § 246-976-470, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-470, filed 12/23/92, effective 1/23/93.] Repealed by WSR 98-04-038, filed 1/29/98, effective 3/1/98. Statutory Authority: Chapter 70.168 RCW.

246-976-475 On-site review for designation. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-475, filed 12/23/92, effective 1/23/93.] Repealed by WSR 98-04-038, filed 1/29/98, effective 3/1/98. Statutory Authority: Chapter 70.168 RCW.

246-976-480 Denial, revocation, or suspension of designation. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-480, filed 12/23/92, effective 1/23/93.] Repealed by WSR 98-04-038, filed 1/29/98, effective 3/1/98. Statutory Authority: Chapter 70.168 RCW.

246-976-485 Designation of facilities to provide trauma care services. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-485, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-485, filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-490 Suspension or revocation of designation. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-490, filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-500 Designation standards for facilities providing level I trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-500, filed 6/5/02, effective 7/6/02; WSR 98-04-038, § 246-976-500, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-500, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-510 Designation standards for facilities providing level I trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-510, filed 6/5/02, effective 7/6/02; WSR 98-04-038, § 246-976-510, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-510, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-510, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-520 Designation standards for facilities providing level I trauma care service—Outreach, public education, trauma care education, and research. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-520, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-520, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-520, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-530 Trauma service designation—Administration and organization. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-530, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-535 Trauma service designation—Basic resources and capabilities. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-535, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-540 Trauma service designation—Outreach, public education, provider education, and research. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-540, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-550 Designation standards for facilities providing level II trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-550, filed 6/5/02, effective 7/6/02; WSR 98-04-038, § 246-976-550, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-550, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-560 Designation standards for facilities providing level II trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-560, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-560, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-560, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-560, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-560, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-570 Designation standards for facilities providing level II trauma care service—Outreach, public education and trauma care education. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-570, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-570, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-600 Designation standards for facilities providing level III trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-600, filed 6/5/02, effective 7/6/02; WSR 98-04-038, § 246-976-600, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-600, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-600, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-610 Designation standards for facilities providing level III trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-610, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-610, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-610, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-610, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-610, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-615 Designation standards for facilities providing level III trauma care service—Trauma care education. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-615, filed 1/29/98, effective 3/1/98.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-620 Equipment standards for trauma service designation. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-620, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-620, filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-640 Designation standards for facilities providing level IV trauma care services—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-640, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-640, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-650 Designation standards for facilities providing level IV trauma care services—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-650, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-650, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-650, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-650, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-650, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-680 Designation standards for facilities providing level V trauma care services—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-680, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-680, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-680, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-690 Designation standards for facilities providing level V trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-690, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-690, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-720 Designation standards for facilities providing level I pediatric trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-720, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-720, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-720, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-720, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-720, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-730 Designation standards for facilities providing level I pediatric trauma care services—Resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-730, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-730, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-730, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-730, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-730, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-740 Designation standards for facilities providing level I pediatric trauma care service—Outreach, public education, trauma care education, and research. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-740, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-740, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-750 Pediatric trauma service designation—Administration and organization. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-750, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-755 Pediatric trauma service designation—Basic resources and capabilities. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-755, filed 12/10/03, ef-

fective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-760 Pediatric trauma service designation—Outreach, public education, provider education, and research. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-760, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-770 Designation standards for facilities providing level II pediatric trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-770, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-770, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-770, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-770, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-770, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-780 Designation standards for facilities providing level II pediatric trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-780, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-780, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-780, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-780, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-780, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-790 Designation standards for facilities providing level II pediatric trauma care service—Outreach, public education, and trauma care education. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-790, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-790, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-790, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-810 Designation standards for facilities providing level III pediatric trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-810, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-810, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-810, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-810, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-810, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-820 Designation standards for facilities providing level III pediatric trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-820, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-820, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-820, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-820, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-820, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-822 Designation standards for facilities providing level III pediatric trauma care service—Trauma care education. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-822, filed 1/29/98, effective 3/1/98.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-830 Designation standards for facilities providing level I trauma rehabilitation service. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-830, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-830, filed 10/1/93, effective 11/1/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-840 Designation standards for facilities providing level II trauma rehabilitation service. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-840, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-840, filed 10/1/93, effective 11/1/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-850 Designation standards for level III trauma rehabilitation service. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-850, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-850, filed 10/1/93, effective 11/1/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-860 Designation standards for facilities providing level I pediatric trauma rehabilitation service. [Statutory Authority: Chapter 70.168 RCW. WSR 98-19-107, § 246-976-860, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-860, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-860, filed 10/1/93, effective 11/1/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-870 Trauma team activation. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-870, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-870, filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-880 Trauma quality assurance programs for designated trauma care hospitals. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-880, filed 12/23/92, effective 1/23/93.] Repealed by WSR 98-04-038, filed 1/29/98, effective 3/1/98. Statutory Authority: Chapter 70.168 RCW.

246-976-881 Trauma quality improvement programs for designated trauma care services. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-881, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-881, filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-885 Educational requirements—Designated trauma care service personnel. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-885, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-885, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-885, filed 12/23/92, effective 1/23/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-886 Pediatric education requirements (PER) for nonpediatric designated facilities. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-886, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-886, filed 6/5/02, effective 7/6/02.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-887 Pediatric education requirements (PER) for pediatric designated facilities. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-887, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-887, filed 6/5/02, effective 7/6/02.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-950 Licensing and certification committee. [Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-950, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-950, filed 12/23/92, effective 1/23/93.] Repealed by WSR 11-07-078, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

WAC 246-976-001 Purpose. The purpose of these rules is to implement RCW 18.71.200 through 18.71.215, and chapters 18.73 and 70.168 RCW; and those sections of chapter 70.24 RCW relating to EMS personnel and services.

(1) This chapter establishes criteria for:

(a) Training and certification of EMS providers;

(b) Licensure and inspection of ambulance services and aid services;

(c) Verification of prehospital trauma services;

(d) Development and operation of a statewide trauma registry;

(e) The designation process and operating requirements for designated trauma care services;

(f) A statewide emergency medical communication system;

(g) Administration of the statewide EMS/TC system;

(h) Development and operation of a statewide electronic EMS data system.

(2) This chapter does not contain detailed procedures to implement the state EMS/TC system. Requests for procedures, guidelines, or any publications referred to in this chapter must be obtained from the Office of Community Health Systems, Department of Health, Olympia, WA 98504-7853 or on the internet at www.doh.wa.gov.

[Statutory Authority: RCW 43.70.040 and 70.168.090. WSR 24-15-130, § 246-976-001, filed 7/23/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-001, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-001, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-001, filed 12/23/92, effective 1/23/93.]

WAC 246-976-010 Definitions. Definitions in RCW 18.71.200, 18.71.205, 18.73.030, and 70.168.015 and the definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

(2) "Adolescence" means the period of physical and psychological development from the onset of puberty to maturity, approximately 12 to 18 years of age.

(3) "Advanced cardiac life support (ACLS)" means a training course established with national standards recognized by the department that includes the education and clinical interventions used to treat cardiac arrest and other acute cardiac related problems.

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

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

(6) "Advanced life support (ALS)" means the level of care or service that involves invasive emergency medical procedures requiring the advanced medical treatment skills of a paramedic.

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

(8) "Aid service" means an EMS agency licensed by the secretary to operate one or more aid vehicles, consistent with regional and state plans, and the department-approved license application. Aid services respond with aid equipment and certified emergency medical services providers to the scene of an emergency to provide initial care and treatment to ill or injured people.

(9) "Ambulance" or "aid service activation" means the dispatch or other initiation of a response by an ambulance or aid service to provide prehospital care or interfacility ambulance transport.

(10) "Ambulance service" means an EMS agency licensed by the secretary to operate one or more ground or air ambulances, consistent with regional and state plans, and the department-approved license application.

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

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

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

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

(15) "Basic life support (BLS)" means the level of care or service that involves basic emergency medical procedures requiring basic medical treatment skills as defined in chapter 18.73 RCW.

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

(17) "Board-qualified" means physicians who have graduated less than five years previously from a residency program accredited for the

appropriate specialty by the accreditation council for graduate medical education.

(18) "BP" means blood pressure.

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

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

(21) "Continuing medical education method (CME method)" means a method of obtaining education required for the recertification of EMS providers. The CME method requires the successful completion of department-approved knowledge and practical skill certification examinations to recertify.

(22) "County operating procedures (COPs)" means department-approved written operational procedures adopted by the county MPD and the local EMS council. COPs provide county level guidance and operational direction which supports the delivery of patient care and coordination of patient transport and movement within the local emergency care system. COPs must be compatible with and work in coordination with state triage and destination procedures, regional patient care procedures, and patient care protocols.

(23) "CPR" means cardiopulmonary resuscitation.

(24) "Data user" means any individual who may access or possess data for any use, including quality improvement, administrative record keeping, research, surveillance, or evaluation.

(25) "Data use agreement" means a signed agreement with the department for transmitting, receiving, and using records containing individually identifiable or potentially identifiable health information. The agreement specifies, at a minimum what information will be exchanged, the conditions or restrictions under which the information will be used and protected, restrictions on redisclosure of data and restrictions on attempt to locate information associated with a specific individual.

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

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

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

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

(30) "ED" means emergency department.

(31) "Electronic patient care report" means the record of patient care produced in an electronic data system.

(32) "EMS agency" means an EMS service such as an emergency services supervisory organization (ESSO), aid or ambulance service licensed or recognized by the secretary to provide prehospital care or interfacility transport.

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

(34) "Emergency medical services and trauma care (EMS/TC) system" means an organized approach to providing personnel, facilities, and equipment for effective and coordinated medical treatment of patients with a medical emergency or injury requiring immediate medical or sur-

gical intervention to prevent death or disability. The emergency medical services and trauma care system includes prevention activities, prehospital care, hospital care, and rehabilitation.

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

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

(37) "EMS" means emergency medical services.

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

(39) "Emergency services supervisory organization (ESSO)" means an entity that is authorized by the secretary to use first responders to provide medical evaluation and initial treatment to sick or injured people, while in the course of duties with the organization for on-site medical care prior to any necessary activation of emergency medical services. ESSOs include law enforcement agencies, disaster management organizations, search and rescue operations, and diversion centers.

(40) "EMS/TC" means emergency medical services and trauma care.

(41) "Endorsement" means a higher form of recognition that requires successful completion of a department-approved MPD specialized training course. Endorsements are added to an EMS providers primary EMS certification.

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

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

(44) "Initial recognition application procedure (IRAP)" means the application and procedure that a senior EMS instructor (SEI) candidate must complete and submit to the department to apply for initial recognition as an SEI.

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

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

(47) "Intermediate life support (ILS)" means the level of care or service that may involve invasive emergency medical procedures requiring the medical treatment skills of an advanced emergency medical technician (AEMT).

(48) "Venous access" means a fluid or medication administered directly into the venous system.

(49) "Local council" means a local EMS/TC council authorized by RCW 70.168.120(1).

(50) "Medical control" means oral or written direction provided by the MPD or MPD physician delegate to EMS providers who provide medical care to patients of all age groups.

(51) "Medical control agreement" means a department-approved written agreement between two or more MPDs, that provides guidance regarding aspects of medical oversight to support continuity of patient care between counties. MPD agreements must be compatible and work in

coordination with state triage and destination procedures, county operating procedures, patient care procedures, and patient care protocols.

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

(53) "Medical program director delegate (MPD delegate)" means a physician appointed by the MPD and recognized and approved by the department. An MPD delegate may be:

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

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

(54) "Medical program director policy" means a department-approved written policy adopted by the county MPD that establishes expectations, procedures, and guidance related to the administrative activities of providing oversight to EMS providers and are within the roles and responsibilities of the MPD.

(55) "National Emergency Medical Services Information System (NEMSIS)" means the national database used to store EMS data from the U.S. States and Territories and is a national standard for how prehospital and interfacility transport information is collected.

(56) "Ongoing training and evaluation program (OTEP)" means a continuous program of education for the recertification of EMS providers. An OTEP must be approved by the MPD and the department.

(57) "Pediatric advanced life support (PALS)" means a training course established with department recognized national standards for clinical interventions used to treat pediatric cardiac arrest and other acute cardiac related problems.

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

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

(60) "Pediatric education for prehospital providers (PEPP)" means a training course for EMS providers established with department recognized national standards for clinical interventions used to treat pediatric emergencies.

(61) "Physician" means an individual licensed under the provisions of chapters 18.71 or 18.57 RCW.

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

(63) "Postgraduate year" means the classification system for residents who are undergoing postgraduate training. The number indicates the year the resident is in during the resident's postmedical school residency program.

(64) "Practical skills examination" means a test conducted in an initial course, or a test conducted during a recertification period,

to determine competence in each of the practical skills or group of skills specified by the department.

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

(66) "Prehospital patient care protocols" means the department-approved, written orders adopted by the MPD under RCW 18.73.030(16) and 70.168.015(27) which direct the out-of-hospital care of patients. These protocols are related only to delivery and documentation of direct patient treatment. The protocols meet or exceed statewide minimum standards developed by the department in rule as authorized in chapter 70.168 RCW. Protocols must be compatible with and work in coordination with state triage and destination procedures, regional patient care procedures, and county operating procedures.

(67) "Prehospital provider" means EMS provider.

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

(69) "Prehospital trauma life support (PHTLS)" means a training course for EMS providers established with department recognized national standards for clinical interventions used to treat trauma patients.

(70) "Prehospital triage and destination procedure" means the statewide minimum standard and method used by prehospital providers to evaluate patients for time sensitive emergencies, identify the most appropriate destination, and alert the receiving facility of the patient's condition to help inform activation of the trauma, cardiac or stroke system of care from the field.

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

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

(73) "Recertification" means the process of renewing a current EMS certification.

(74) "Recognition application procedure (RAP)" means the application and procedure that must be completed by a department recognized senior EMS instructor (SEI) to apply for renewal of an SEI recognition.

(75) "Regional council" means the regional EMS/TC council established by RCW 70.168.100.

(76) "Regional patient care procedure (PCP)" means department-approved written operating guidelines adopted by the regional emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communication centers, and the emergency medical services county medical program directors. PCPs provide an operational framework and broad overarching guidance for the coordination of patient transport and movement within the regional emergency care system. PCPs identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility, mental health facility, or chemical dependency program to first receive the patient, and the name and location of other trauma care facilities, mental health facilities, or chemical dependency programs to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients are consistent with the transfer procedures in chapter 70.170 RCW. Patient care procedures do not relate to direct patient care and must be compatible

with and work in coordination with state triage and destination procedures.

(77) "Regional plan" means the plan defined in WAC 246-976-960 (1)(b) that has been approved by the department.

(78) "Registered nurse" means an individual licensed under the provisions of chapter 18.79 RCW.

(79) "Reinstatement" means the process of reissuing an EMS certification that is revoked or suspended by the department.

(80) "Reissuance" means the process of reissuing a certification that is expired.

(81) "Reversion" means the process of reverting a current EMS certification to a lower level of EMS certification.

(82) "Rural" means an unincorporated or incorporated area with a total population of less than 10,000 people, or with a population density of less than 1,000 people per square mile.

(83) "Secretary" means the secretary of the department of health.

(84) "Senior EMS instructor (SEI)" means an individual approved and recognized by the department to conduct initial emergency medical responder (EMR) or emergency medical technician (EMT) training courses.

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

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

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

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

(86) "Specialty care transport (SCT)" means the level of care or service needed during an interfacility transport for a patient who is critically injured or ill and whose condition requires care by a physician, registered nurse, or a paramedic who has received special training and approval of the MPD.

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

(88) "Steering committee" means the EMS/TC steering committee created by RCW 70.168.020.

(89) "Substance use disorder professional (SUDP)" means an individual certified in substance use disorder counseling under chapters 18.205 RCW and 246-811 WAC.

(90) "Suburban" means an incorporated or unincorporated area with a population of 10,000 to 29,999 or any area with a population density of between 1,000 and 2,000 people per square mile.

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

(92) "Training program" means an organization that is approved by the department to conduct initial and ongoing EMS training as identified in the approved training program application on file with the department.

(93) "Training program director" means the individual responsible for oversight of a department-approved EMS training program.

(94) "Trauma registry" means the statewide data registry to collect data on incidence, severity, and causes of trauma described in RCW 70.168.090(1).

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

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

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

(98) "Urban" means:

(a) An incorporated area over 30,000; or

(b) An incorporated or unincorporated area of at least 10,000 people and a population density over 2,000 people per square mile.

(99) "Verification" means an EMS agency is capable of providing verified trauma care services and is credentialed under chapters 18.73 and 70.168 RCW.

(100) "Washington EMS information system (WEMSIS)" means the statewide electronic EMS data system responsible for collecting EMS data described in RCW 70.168.090(2).

(101) "WEMSIS data administrator" means an EMS agency representative who is assigned by their agency as the primary contact for WEMSIS data submission management as indicated in the department-approved EMS agency licensing application.

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

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-010, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-010, filed 3/22/11, effective 5/15/11; WSR 05-01-221, § 246-976-010, filed 12/22/04, effective 1/22/05; WSR 00-08-102, § 246-976-010, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapter 18.71 RCW. WSR 96-03-052, § 246-976-010, filed 1/12/96, effective 2/12/96. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-010, filed 12/23/92, effective 1/23/93.]

TRAINING

WAC 246-976-022 EMS training program requirements, approval, reapproval, discipline. (1) To apply for initial department approval as an EMS training program, applicants shall:

(a) Contact the Washington workforce training and education board to determine if the EMS training program is subject to private vocational school requirements;

(b) Submit a completed application on forms provided by the department and provide supplemental information that:

(i) Demonstrates the need for a new or additional training program; and

(ii) Demonstrates how the training program will maintain the resources needed to sustain a quality education program;

(c) Identify the training program organization type as one of the following:

(i) A local EMS and trauma care council or county office responsible for EMS training for the county. This includes organizations es-

tablished by local ordinance and approved by the county medical program director to coordinate and conduct EMS training programs;

(ii) A regional EMS and trauma care council providing EMS training throughout the EMS and trauma care region that it serves;

(iii) An accredited institution of higher education or a private educational business licensed as a private vocational school;

(iv) A state-approved skill center or other bona fide vocational education program approved by the office of superintendent of public instruction; or

(v) An optional organization. If the organizations listed above do not exist or are unable to provide an EMS training program, the local EMS and trauma care council may recommend to the department another entity that is able to provide training. In the absence of a local EMS council, the regional EMS and trauma care council may provide such recommendation;

(d) Identify the training program director for the training program. The training program director must meet the minimum requirements listed in the *EMS Training Program and Instructor Manual (DOH 530-126)*;

(e) Identify additional training program personnel who meet the minimum requirements and would perform roles listed in the *EMS Training Program Instructor Manual (DOH 530-126)*;

(f) Indicate what levels of initial EMS training courses (EMR, EMT, AEMT, paramedic), endorsements and other courses the training program is seeking approval to conduct;

(g) If the training program is conducting a paramedic program, provide proof of accreditation by a national accrediting organization approved by the department;

(h) Provide a list of clinical and field internship sites available to students. Include information that clearly depicts a formal relationship between the training organization and the clinical site;

(i) Provide an operations manual that includes:

(i) Training program policies and procedures that meet the requirements listed in the *EMS Training Program and Instructor Manual (DOH 530-126)*; and

(ii) The training program handbook that is provided to students. The handbook must meet the requirements listed in the *EMS Training Program and Instructor Manual (DOH 530-126)*;

(j) Provide a list of equipment and supplies on hand or accessible for use in the training program;

(k) Provide an example of a certificate or letter of completion meeting the department requirements listed in the *EMS Training Program and Instructor Manual (DOH 530-126)*;

(l) Obtain the recommendation from the county medical program director in each county where the training program will reside; and

(m) Obtain the recommendation from each local EMS and trauma council in each county where the training program will reside. In the absence of a local EMS and trauma care council, the regional EMS and trauma care council may provide such a recommendation.

(2) Approved training programs shall:

(a) Conduct courses in accordance with department requirements;

(b) Collaborate with the course instructor to ensure course applicants meet the course application requirements in WAC 246-976-041;

(c) Maintain clinical and field internship sites to meet course requirements. Students conducting field internship rotations on EMS vehicles may not replace required staff on the vehicle;

(d) Provide the department, MPD, or MPD delegate access to all course related materials upon request;

(e) Conduct examinations over course lessons and other Washington state required topics;

(f) Participate in educational planning conducted by local and regional EMS and trauma care councils;

(g) Coordinate certification examination activities with the department-approved certification examination provider. This includes:

(i) Registering the training program with the examination provider;

(ii) Assisting students in registering with the examination provider and scheduling the cognitive examination. Students who successfully pass the course must be provided an opportunity to take the certification examination;

(iii) Provide verification to the examination provider of cognitive knowledge and psychomotor skills for students successfully completing the EMS course; and

(iv) For BLS, ILS, and ALS level courses, the training program must conduct psychomotor examinations and competence assessments as required by the department;

(h) Maintain student records for a minimum of seven years in a retrievable electronic or paper format;

(i) Monitor and evaluate the quality of instruction for the purposes of quality improvement, including course examination scores for each level taught;

(j) Provide students access to the Washington state EMS student survey;

(k) If identified in subsection (1)(c)(iv) of this section, provide continuous training until the student either graduates from high school or turns 18 years of age, whichever is earlier. Continuous training topics must align with WAC 246-976-161 and the *EMS Training Program and Instructor Manual (DOH 530-126)*;

(l) Maintain an overall pass rate of 75 percent on department-approved state certification examinations;

(m) Submit a report to the department annually that includes:

(i) Attrition rates;

(ii) Annual certification examination rates;

(iii) Postgraduation survey results; and

(n) Seek reapproval of the training program as follows:

(i) For BLS or ILS level courses training programs must be reapproved every three years.

(ii) For ALS level courses, training programs must be renewed every five years.

(iii) If the training program is approved to conduct multiple levels of training, the program is required to renew in accordance with the higher training level requirement.

(3) Training program approval is effective on the date the department issues the certificate. The expiration date is indicated on the approval letter. To apply for reapproval, an EMS training program shall:

(a) Complete the requirements in subsection (1) of this section;

(b) Be in compliance with the requirements in subsection (2) of this section;

(c) Be in good standing with the department, have no violations of the statute and rules, and no pending disciplinary actions; and

(d) Have an overall pass rate of 75 percent on department-approved state certification examinations.

(4) Discipline of EMS training programs.

(a) The secretary may deny, suspend, modify, or revoke the approval of a training program when it finds any of the following:

(i) Violations of chapter 246-976 WAC.

(ii) Pending disciplinary actions.

(iii) Falsification of EMS course documents.

(iv) Failure to maintain EMS course documents as required.

(v) Failure to update training program information with the department as changes occur.

(b) The training program may request a hearing to contest the secretary's decisions regarding denial, suspension, modification, or revocation of training program approval in accordance with the Administrative Procedure Act (APA) (chapter 34.05 RCW) and chapter 246-10 WAC.

[Statutory Authority: RCW 18.73.081, 43.70.040, and 2025 c 98. WSR 26-14-022, s 246-976-022, filed 6/22/26, effective 7/23/26. Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-022, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-022, filed 3/22/11, effective 5/15/11.]

WAC 246-976-023 Initial EMS training course requirements and course approval. (1) EMS training course applications are required for the following initial and refresher courses:

(a) EMR, EMT, AEMT, and paramedic training;

(b) EMS endorsements; and

(c) EMS instructor training.

(2) To conduct an EMS training course an applicant must:

(a) Submit a completed application on forms provided by the department, postmarked or received by the department at least 30 days prior to the course start date identified on the application.

(b) Provide the following supplemental information:

(i) Type of course being taught;

(ii) Training program the course will be affiliated with;

(iii) The course delivery method;

(iv) The location where the course will be held;

(v) The location where clinical and field training will be conducted and how it will be conducted;

(vi) The location where the psychomotor practical skills examination and minimum student competency verifications will be conducted and how these assessments will be conducted;

(vii) A list of instructional personnel participating in course delivery;

(viii) An example of a certificate of completion that meets the criteria in *EMS Training Program and Instructor Manual (DOH 530-126)*;

(ix) A course schedule or agenda that meets the criteria in *EMS Training Program and Instructor Manual (DOH 530-126)*; and

(c) A recommendation from the county medical program director(s) in the county(s) where the course will be held. The county medical program director must sign the course application.

(d) Be approved by the department.

(3) To conduct an EMS training course, training program directors and instructors must:

(a) Have written approval from the department to conduct the course prior to the start of the course. The department will send written approval to the training program director;

(b) Meet requirements for training programs identified in WAC 246-976-022;

(c) Provide adequate personnel that meet requirements identified in WAC 246-976-031;

(d) Verify students meet the requirements identified in WAC 246-976-041;

(e) Conduct or facilitate EMS course practical skill evaluations and psychomotor examinations and reexaminations. Use department-approved EMS evaluators that meet requirements in WAC 246-976-031. Evaluators must be certified to perform the skill being evaluated; and

(f) Submit the EMS Course Completion Verification form (DOH-530-008) within 30 days of the course completion date included on the course approval notification from the department.

(4) Course curriculum must meet all of the following standards:

(a) Current national EMS education standards for the level of training conducted including skills identified in the Washington state approved skills and procedures list (DOH 530-173) required for all Washington state certified EMS providers.

(b) Include education on multicultural health awareness as required in RCW 43.70.615, portable orders for life sustaining treatment (POLST) as provided in RCW 43.70.480, and legal obligations and reporting for vulnerable populations as provided in RCW 74.34.035.

(5) Instructional personnel required for courses is as follows:

(a) If the course being taught is provided by a training program that is recognized by an accreditation organization recognized by the department, then instructional personnel must meet standards of the accrediting organization.

(b) For an emergency medical responder (EMR) course, the course instructor must be a department-approved senior EMS instructor (SEI). An SEI candidate (SEI-C) may instruct under the supervision of a current department-approved SEI for the purposes of demonstrating instructional proficiency to SEI.

(c) For an emergency medical technician (EMT) course, the course instructor must be a department-approved SEI. An SEI candidate (SEI-C) may instruct under the supervision of the SEI for the purposes of demonstrating instructional proficiency to the SEI.

(d) For an advanced emergency medical technician (AEMT) course, the course instructor must be certified at the AEMT or paramedic level and be a department-approved SEI. An SEI candidate (SEI-C) may instruct under the supervision of the SEI for the purposes of demonstrating instructional proficiency to the SEI.

(e) For a paramedic course, the lead instructor must have proof of clinical experience at the paramedic level or above.

(f) For a supraglottic airway (SGA) endorsement course for EMT, the course instructor must have proof of clinical experience and the depth and breadth of knowledge of the subject matter and be approved by the MPD.

(g) For an intravenous (IV) therapy endorsement course for EMT, the course instructor must have proof of clinical experience and the depth and breadth of knowledge of the subject matter and be approved by the MPD.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69,

and 2022 c 136. WSR 24-15-104, § 246-976-023, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-023, filed 3/22/11, effective 5/15/11.]

WAC 246-976-024 MPD specialized training and pilot projects. (1) MPDs may submit a proposal to conduct a pilot project to determine the need for training, skills, techniques, equipment, or medications that are not included in standard course curricula and instructional guidelines. A pilot project allows the MPD to conduct field research to determine:

(a) The effectiveness of the training;

(b) EMS provider knowledge and skills competency; and

(c) EMS provider ability to provide proper patient care after the training.

(2) To request approval of a pilot project, the MPD must submit a proposal on forms provided by the department at least 90 days prior to the start of the pilot project. Proposals must include all the following:

(a) Describe the pilot project and the need that the proposed pilot will address;

(b) Identify the proposed length of the pilot project. Projects may be approved for up to two years;

(c) Identify what training, skills, techniques, equipment, and medications will be included;

(d) Provide research to support that the proposal is an evidence-based practice relevant and appropriate to EMS activities;

(e) Identify the outcome the project is aiming to achieve, level of risk to patients, and the expected clinical outcomes;

(f) Provide information regarding the economic burden of additional hours of training, equipment, and other applicable costs;

(g) Identify the level of certified EMS providers who will be participating in the project and explain how it was determined that the provider level has the breadth and depth of knowledge needed to participate in the project;

(h) Describe how certified EMS providers will be trained and provide the course prerequisites, curriculum/lesson plans, including any student evaluations and examinations;

(i) Identify the instructional personnel required to conduct the pilot training. Instructional personnel must meet the requirements in WAC 246-976-031;

(j) Describe the medical oversight for the project and provide the proposed patient care protocols relevant to the activities being conducted;

(k) Describe the provisions for protecting patient safety;

(l) Describe quality assurance activities to include what data will be collected, the method of data collection, and evaluation; and

(m) Evaluate and determine if a review from an IRB is necessary and supply documentation to support the decision.

(3) The department will:

(a) Review the proposal;

(b) Determine what additional consultation with advisory groups is needed;

(c) Consult with the EMS and trauma care steering committee and any other applicable advisory groups as determined by the department, to determine the need for, and the expected benefits of the proposed activities if implemented statewide; and

(d) Make the final determination to approve or deny the request to conduct the proposed pilot project.

(4) The MPD must report the results of the pilot project to the department, applicable advisory groups, and the EMS and trauma care steering committee.

(5) Upon favorable results of the pilot project and with the recommendation of the EMS and trauma care steering committee, the department will make the final determination to approve or deny the proposed activities to continue in whole or in part and determine if the project will be implemented statewide on a mandatory or optional basis.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-024, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-024, filed 3/22/11, effective 5/15/11.]

WAC 246-976-026 Ongoing training and education programs (OTEP). (1) The purpose of this section is to identify requirements to apply for, conduct, and renew an OTEP program. OTEP is a method of recertification defined in WAC 246-976-010.

(2) To apply for approval of an OTEP, an applicant must:

(a) Be a licensed EMS service, ESSO, a local county or regional EMS office, or an EMS county medical program director (MPD);

(b) Submit a completed application on forms provided by the department, postmarked or received by the department at least 90 days prior to the OTEP start date identified on the application;

(c) Obtain the recommendation for approval from the MPD in each county where the OTEP will be conducted. The MPD(s) must sign the application; and

(d) Provide the following supplemental information:

(i) The levels of training included in the OTEP;

(ii) What skills, endorsements, or specialized training are to be included in the OTEP;

(iii) The name of the EMS services that will be participating in the OTEP;

(iv) A description of how the OTEP program meets the education requirements described in WAC 246-976-161 and how the topics will be covered over a three-year period;

(v) Identify the sources of the instructional material that will be used. All training and education content must meet the requirements in WAC 246-976-163;

(vi) Describe how specialized training or other components required by the MPD will be incorporated into the OTEP;

(vii) Describe how and when the OTEP will be reviewed and updated to remain current with state and national standards;

(viii) Identify the course delivery method for didactic components;

(ix) Describe how the effectiveness of the OTEP is evaluated including what testing mechanisms are in place to evaluate participant competency;

(x) Describe how quality improvement activities are incorporated into the OTEP;

(xi) Describe how OTEP records will be managed and tracked, if the record is electronic or paper, the position within the organiza-

tion responsible for tracking how participants are notified of their progress, completion, and compliance with OTEP, how participants can request and receive copies of their training records during and after affiliation with the EMS service, and how records will be maintained;

(xii) Describe how the EMS service supervisor verifies attendance and completion of OTEP modules and that a participant has met the minimum requirements of the OTEP for recertification; and

(xiii) Provide a description of the remediation plan to include how failed or missed courses can be made up and when a certified EMS provider must recertify using the CME method because they did not meet the minimum standards of the OTEP.

(3) To conduct an OTEP program, the applicant must:

(a) Have approval from the MPD and the department prior to the start of the OTEP. The department will send written approval to the applicant and the MPD;

(b) Develop, implement, and keep updated an OTEP that meets education requirements in WAC 246-976-161;

(c) Provide personnel that meet requirements in WAC 246-976-031;

(d) Provide knowledge and skill evaluations following completion of training to assess the competency of the participant. Practical skill evaluations must be recorded on department-approved practical skill evaluation forms or nationally recognized skill evaluation forms. An MPD may approve an alternative method and documentation standard for skill evaluations;

(e) Provide education at least on a quarterly basis. An EMS service in a rural area who uses volunteers may submit an alternative schedule and request an exception to this requirement from the department;

(f) Maintain training records for a minimum of seven years or in accordance with the records retention requirements of the organization, whichever is greater; and

(g) Provide training records to participants, the department and MPD upon request. This includes skill sheets, rosters, evaluations, quizzes, and training content.

(4) OTEP programs may use a distributed learning model to provide OTEP when the training and content meets requirements in WAC 246-976-161 and each topic includes a cognitive evaluation after the training.

(a) Instruction and demonstration of practical skills may be provided using a distributed learning model.

(b) Evaluation of all practical skills must be provided in person.

(c) To receive credit for the topic, the participant must successfully complete both the didactic and any required skill evaluation for that topic.

(5) OTEP programs must be renewed every five years. To renew an OTEP program:

(a) Submit a completed application on forms provided by the department, postmarked or received by the department at least 90 days prior to the OTEP start date identified on the application; and

(b) Meet all the requirements in this section.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-026, filed 7/22/24, effective 9/30/24.]

WAC 246-976-031 EMS instructors, initial approval, and recognition. (1) EMS instructor types include:

(a) "EMS evaluator (ESE)" means a person approved and recognized by the department that is authorized to conduct continuing medical education and ongoing training and evaluate psychomotor skills during initial, refresher, and continuing medical education and ongoing training. The ESE may provide field training and evaluate newly hired providers who are pending certification and are participating in an EMS service field training program. The ESE may function as a clinical preceptor to mentor and evaluate the clinical performance of students enrolled in initial EMS courses.

(b) "Senior EMS instructor candidate (SEIC)" means an applicant that has met requirements to start the initial recognition process to become a senior EMS instructor (SEI). The applicant is approved and recognized by the department as an SEIC and may conduct EMS training courses under the supervision of a currently approved and recognized SEI and county medical program director. An SEIC may only conduct courses at or below the level for which they hold a current and valid Washington state EMS certification.

(c) "Senior EMS instructor (SEI)" means an applicant that has met the requirements to become approved and recognized by the department as an SEI and may conduct initial EMS training courses and continuing medical education and ongoing training. An SEI may only conduct courses at or below the level for which they hold a current and valid Washington state EMS certification. An SEI is responsible for the overall administration and quality of instruction. The SEI must meet the requirements in this chapter and the department *EMS Training Program and Instructor Manual (DOH 530-126)* to maintain recognition as an SEI.

(d) "Lead instructor" means a person that has specific knowledge, experience, and skills in the field of prehospital emergency care and is approved by the county medical program director to instruct EMS training courses that do not require an SEI.

(e) "Guest instructor" means a person that has specific knowledge, experience, and skills in the field of prehospital emergency care and is approved by the county medical program director to instruct course lessons for initial and refresher EMS courses and continuing medical education and ongoing training under the supervision of an SEI or lead instructor.

(2) To apply for recognition as an EMS evaluator (ESE), an applicant must:

(a) Hold a current and valid Washington state EMS certification;

(b) Have a minimum of three years' experience at or above the level of certification being evaluated;

(c) Be current in continuing medical education and ongoing training requirements for their primary EMS certification;

(d) Submit an application on forms provided by the department;

(e) Provide proof of successful completion of a department-approved initial EMS evaluator course within the past three years; and

(f) Be recommended by the county medical program director. The county medical program director must sign the application.

(3) To apply for recognition as a senior EMS instructor candidate (SEIC), an applicant must:

(a) Be a current Washington state certified EMS provider at or above the level of certification being instructed;

(b) Have a minimum of three years' experience in direct patient care at or above the level of certification being instructed;

(c) Be currently recognized as an EMS evaluator;

(d) Hold current recognition as a health care provider level CPR instructor from a nationally recognized training program recognized by the department for CPR, foreign body airway obstruction (FBAO), and defibrillation;

(e) Provide proof of successful completion of an instructor training course by the U.S. Department of Transportation, National Highway Traffic Safety Administration, an instructor training course from an accredited institution of higher education, or equivalent instructor course approved by the department;

(f) Provide proof of successful completion of a one-hour Washington state EMS instructor orientation provided by the department;

(g) Pass a written evaluation developed and administered by the department on current EMS training and certification regulations including the Washington Administrative Code (WAC), the Uniform Disciplinary Act (UDA), and EMS course administration;

(h) Be affiliated with a department-approved EMS training program that meets the standards in WAC 246-976-022;

(i) Submit an application on forms provided by the department; and

(j) Be recommended by the county medical program director. The county medical program director must sign the application.

(4) If approved for recognition as a senior EMS instructor candidate (SEIC), the department will issue the applicant an initial recognition application procedure packet (IRAP). The IRAP must be successfully completed in accordance with department standards and policies, under the oversight of a currently recognized SEI. The SEIC must demonstrate the knowledge and skills necessary to administer, coordinate, and conduct initial EMS courses to apply for and be considered for approval and recognition as an SEI.

(5) A SEIC recognition will be issued for three years.

(6) An applicant who is an EMS instructor in another state, country, or U.S. military branch may apply to obtain reciprocal recognition as an SEI candidate (SEIC). To become an SEI candidate (SEIC), the applicant must meet the criteria in this section and provide proof of at least three years of instructional experience as an EMS instructor. If approved for recognition as an SEIC, the department will issue the applicant an abridged initial recognition application procedure packet (IRAP) which must be successfully completed in accordance with department standards and policies, under the oversight of a currently recognized SEI to apply for full SEI recognition.

(7) To apply for recognition as a senior EMS instructor (SEI), an applicant must:

(a) Meet all the criteria in subsection (3) of this section and be currently approved and recognized as a senior EMS instructor candidate (SEIC);

(b) Submit the completed initial recognition application procedure packet (IRAP) that was issued by the department; and

(c) Be recommended by the county medical program director. The county medical program director must sign the application.

(8) If approved, SEI recognition is effective on the date the department issues the recognition card. SEI recognition must be renewed every three years. The expiration date is indicated on the certification card.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69,

and 2022 c 136. WSR 24-15-104, § 246-976-031, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-031, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 18.73.081 and 70.168.120. WSR 02-14-053, § 246-976-031, filed 6/27/02, effective 7/28/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-031, filed 4/5/00, effective 5/6/00.]

WAC 246-976-032 EMS instructor reapproval and recognition. (1) To apply for rerecognition as an EMS evaluator (ESE), an applicant must:

(a) Hold a current and valid Washington state EMS certification at or above the level of certification being evaluated;

(b) Submit an application on forms provided by the department;

(c) Be current in continuing medical education and ongoing requirements for their primary EMS certification;

(d) Provide proof of successful completion of a department-approved EMS evaluator refresher course; and

(e) Be recommended by the county medical program director. The county medical program director must sign the application.

(2) An ESE whose recognition has expired for more than three years must complete the initial recognition process.

(3) To apply for rerecognition as a senior EMS instructor candidate (SEIC), an applicant must:

(a) Meet the requirements in WAC 246-976-031;

(b) Be currently approved and recognized as an SEIC;

(c) Submit an application on forms provided by the department; and

(d) Be recommended by the county medical program director. The county medical program director must sign the application.

(4) To apply for rerecognition as a senior EMS instructor (SEI), an applicant must:

(a) Hold a current Washington state certification as an EMS provider at or above the level of certification being instructed;

(b) Be currently approved and recognized as an SEI or have an SEI recognition that is expired less than three years;

(c) Complete the recognition application procedure packet (RAP) on forms issued by the department;

(d) Pass a written evaluation developed and administered by the department on current EMS training and certification regulations including Washington Administrative Code (WAC), the Uniform Disciplinary Act (UDA), and EMS course administration;

(e) Successfully complete a one-hour Washington state EMS instructor orientation;

(f) Attend one department-approved SEI or instructor improvement workshop;

(g) Submit an application on forms provided by the department; and

(h) Be recommended by the county medical program director. The county medical program director must sign the application.

(5) An SEI whose recognition has expired for more than three years must complete the recognition process described in WAC 246-976-031 (3)(m).

(6) SEI recognition is effective on the date the department issues the recognition. SEI recognition must be renewed every three years. The expiration is indicated on the certification card.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-032, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-032, filed 3/22/11, effective 5/15/11.]

WAC 246-976-033 Denial, suspension, modification or revocation of an ESE, SEIC, or SEI recognition. (1) The secretary may deny, suspend, modify or revoke an ESE, SEIC, or SEI's recognition when it finds the ESE, SEIC, or SEI has:

(a) Violated chapter 18.130 RCW, the Uniform Disciplinary Act;

(b) Failed to:

(i) Maintain EMS certification;

(ii) Update the following personal information with the department as changes occur:

(A) Name;

(B) Address;

(C) Home and work phone numbers;

(iii) Maintain knowledge of current EMS training and certification statutes, WAC, the UDA, and course administration;

(iv) Comply with requirements in WAC 246-976-031(1);

(v) Participate in the instructor candidate evaluation process in an objective and professional manner without cost to the individual being reviewed or evaluated;

(vi) Complete all forms and maintain records in accordance with this chapter;

(vii) Demonstrate all skills and procedures based on current standards;

(viii) Follow the requirements of the Americans with Disabilities Act; or

(ix) Maintain security on all department-approved examination materials.

(2) The ESE, SEIC, or SEI may request a hearing to contest the secretary's decisions in regard to denial, suspension, modification or revocation of an ESE, SEIC, or SEI recognition in accordance with the Administrative Procedure Act (APA) (chapter 34.05 RCW), the Uniform Disciplinary Act (chapter 18.130 RCW), and chapter 246-10 WAC.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-033, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-033, filed 3/22/11, effective 5/15/11.]

WAC 246-976-041 To apply for training. (1) An applicant for EMS training must be at least 17 years old at the beginning of the course. Variances will not be allowed for the age requirement except for applicants under subsection (2) of this section.

(2) An applicant who is 16 years of age may enroll in a state-approved skill center or other bona fide vocational education program approved by the office of superintendent of public instruction.

(3) An applicant for training at the intermediate (AEMT) level shall meet all entry requirements of the state approved AEMT program.

(4) An applicant for training at the advanced life support (paramedic) level shall meet all entry requirements of the state approved paramedic training program.

[Statutory Authority: RCW 18.73.081, 43.70.040, and 2025 c 98. WSR 26-14-022, s 246-976-041, filed 6/22/26, effective 7/23/26. Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-041, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-041, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-041, filed 4/5/00, effective 5/6/00.]

CERTIFICATION

WAC 246-976-139 Provisional certification. (1) An individual may apply for a provisional certification to engage in supervised practice as a certified EMS provider for the level they have applied for. Upon completion of any EMS service field training and MPD integration criteria, an applicant may apply for full certification. A provisional certification is valid for up to six months. There is no renewal option for a provisional certification.

(2) To apply for a provisional certification, an applicant must:

(a) Submit a completed application on forms provided by the department;

(b) Be at least 18 years of age and provide their date of birth on the initial certification application. Variances to this age requirement will not be granted;

(c) Successfully complete a background check provided by the department. The background check may include the requirement for fingerprint card and FBI background check. If an applicant has submitted fingerprints and has been informed by the department that their fingerprints were rejected and must be redone, the applicant may request a temporary practice permit in accordance with WAC 246-12-050;

(d) Provide proof of a high school diploma or GED for EMT, AEMT, and paramedic level certifications;

(e) Provide proof of competency and a current and valid certification from another state or national organization recognized by the department;

(f) Provide proof of active membership paid or volunteer with a licensed aid or ambulance service, or an EMS service supervisory organization (ESSO) recognized by the department; and

(g) Be recommended by the county medical program director. The county medical program director must sign the application.

(3) A person holding a provisional certification may apply for full certification upon successful completion of any EMS service field training and MPD integration criteria. To apply for certification, an applicant must:

(a) Submit a completed application on forms provided by the department;

(b) Provide proof of active membership paid or volunteer with a licensed aid or ambulance service, or an EMS service supervisory organization (ESSO) recognized by the department; and

(c) Be recommended by the county medical program director. The county medical program director must sign the application.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-139, filed 7/22/24, effective 9/30/24.]

WAC 246-976-141 To obtain initial EMS provider certification following the successful completion of Washington state approved EMS course. To apply for initial EMS provider certification following the successful completion of a Washington state approved EMS course, an applicant must:

(1) Submit a completed application on forms provided by the department;

(2) Be at least 18 years of age and provide their date of birth on the initial certification application. Variances to this age requirement will not be granted;

(3) Successfully complete a background check provided by the department. The background check may include the requirement for fingerprint card and FBI background check. If an applicant has submitted fingerprints and has been informed by the department that their fingerprints were rejected and must be redone, the applicant may request a temporary practice permit in accordance with WAC 246-12-050;

(4) Provide proof of high school diploma or GED for EMT, AEMT, and paramedic level certifications;

(5) Provide proof of competency, a current and valid certification from another state or national organization recognized by the department;

(6) Provide proof of active membership paid or volunteer with a licensed aid or ambulance service, or an EMS service supervisory organization (ESSO) recognized by the department. Senior EMS instructors or training coordinators teaching at department-approved EMS training programs who are unable to be with approved agencies above may affiliate with department-approved training programs with the approval from the county medical program director; and

(7) Be recommended by the county medical program director. The county medical program director must sign the application.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-141, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-141, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-141, filed 4/5/00, effective 5/6/00.]

WAC 246-976-142 To obtain reciprocal (out-of-state) EMS certification, based on a current out-of-state or national EMS certification approved by the department. To apply for certification, an applicant must:

(1) Submit a completed application on forms provided by the department;

(2) Be at least 18 years of age and provide their date of birth on the initial certification application. Variances to this age requirement will not be granted;

(3) Successfully complete a background check provided by the department. The background check may include the requirement for finger-

print card and FBI background check. If an applicant has submitted fingerprints and has been informed by the department that their fingerprints were rejected and must be redone, the applicant may request a temporary practice permit in accordance with WAC 246-12-050;

(4) Provide proof of a high school diploma or GED for EMT, AEMT, and paramedic level certifications;

(5) Provide proof of competency, a current and valid certification from another state or national organization recognized by the department;

(6) Provide proof of active membership paid or volunteer with a licensed aid or ambulance service, or an EMS service supervisory organization (ESSO) recognized by the department. Senior EMS instructors or training coordinators teaching at department-approved EMS training programs who are unable to be with approved agencies above may affiliate with department-approved training programs with the approval from the county medical program director; and

(7) Be recommended by the county medical program director. The county medical program director must sign the application.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-142, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-142, filed 3/22/11, effective 5/15/11.]

WAC 246-976-143 To obtain EMS certification based on possession of a current health care providers credential. To apply for certification, an applicant shall:

(1) Hold a Washington state license or certification in another health profession;

(2) Provide proof of an education that is substantially equivalent to EMS education requirements for the level of certification being applied for; and

(3) Meet the requirements and follow the procedures outlined in WAC 246-976-142.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-143, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-143, filed 3/22/11, effective 5/15/11.]

WAC 246-976-144 EMS certification. (1) Certification is effective on the date the department issues the certificate. Certifications must be renewed every three years. The expiration date is indicated on the certification card.

(2) The secretary may extend the certification period to accommodate the efficient processing of recertification applications. Requests to extend the certification period must be coordinated through the county medical program director. The expiration date will be indicated on the certification card issued by the department.

(3) An EMS certification is valid only:

(a) In the county or counties where recommended by the MPD and approved by the secretary;

(b) In other counties where department-approved medical program director agreements are in place;

(c) In other counties when accompanying a patient in transit or when encountering an incident and stopping to render aid when returning to a home county. In these cases, 911 should be contacted to engage the local EMS system; or

(d)(i) While responding to other counties for mutual aid purposes, mass care, or other incidents in an episodic manner. In these situations:

(ii) The EMS provider will provide patient care following the prehospital patient care protocols of their supervising MPD.

(4) A certified AEMT or paramedic may function at a lower certification level in counties other than those described in subsection (3)(a) through (d) of this section, with approval of that county's MPD and the department.

(5) EMTs who hold an IV therapy or supraglottic airway training endorsement may use those skills only when following approved county MPD protocols that permit EMTs with such training to perform those skills.

(6) When certified EMS personnel change or add membership with an EMS agency, EMS service supervisory organization (ESSO), or department-approved training program, or their contact information changes, they must notify the department within 30 days of the change. Changes submitted must be made on forms provided by the department.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-144, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-144, filed 3/22/11, effective 5/15/11.]

WAC 246-976-161 General education and skill maintenance requirements for EMS provider recertification. (1) Education and skill maintenance is required to recertify as an EMS provider. There are two methods by which the EMS provider may meet continuing medical education and ongoing training and skill requirements for recertification at the end of each certification period. The continuing medical education and examination (CME) method described in WAC 246-976-162 or the ongoing training and evaluation program (OTEP) method described in WAC 246-976-163.

(2) The EMS provider shall maintain records of successfully completed educational, practical skill evaluation and skill maintenance requirements for a minimum of seven years. The EMS provider shall provide records to their EMS agency, their county medical program director, and the department upon request.

(3) All training and education content must meet current national EMS education standards to include skill evaluations. Department recognized national EMS training courses for topics such as basic and advanced cardiac life support, pediatric advanced life support, advanced medical life support, and prehospital trauma life support may be used. EMS continuing medical education and ongoing training programs approved by national accreditation organizations recognized by the department may also be used. All training and education content must be approved by the MPD.

(4) Education must include information and psychomotor skill maintenance opportunities relevant to the skills and procedures iden-

tified on the Washington State Approved Skills and Procedures for Certified EMS Providers list (DOH 530-173), to all age groups and be appropriate to the level of certification. Topics required for both methods of recertification must include all the following:

(a) Age appropriate patient assessment;

(b) Airway management including the use of airway adjuncts appropriate to the level of certification;

(c) Cardiovascular education that includes recognition, assessment of severity, and care of cardiac and stroke patients, CPR for the health care provider, foreign body airway obstruction, and electrical therapy for the level of certification;

(d) Trauma including spinal motion restriction;

(e) Pharmacology including epinephrine, naloxone, and medications approved by the MPD;

(f) Obstetrics, pediatric, geriatric, bariatric, behavioral, mental health, and chemical dependency;

(g) Patient advocacy concepts including multicultural awareness education as required in RCW 43.70.615, health equity education trainings for health care professionals as required in RCW 43.70.613, portable orders for life sustaining treatment (POLST) as provided in RCW 43.70.480, legal obligations and reporting for vulnerable populations as provided in RCW 70.34.035, and training as required in RCW 43.70.490 for people with disabilities or functional needs;

(h) EMS provider advocacy and wellness concepts including suicide awareness, mental health and physical wellbeing, infectious disease training, and workplace safety;

(i) Law and regulations related to the scope of practice of providers in Washington state and regulatory requirements for an EMS provider to maintain certification;

(j) State, regional, and local policies including state triage tools, regional patient care procedures, county operating procedures, and county MPD patient care protocols and policies;

(k) Disaster preparedness concepts such as the use of incident command system (ICS), multiple patient incidents, mass casualty incidents, disaster triage, all hazard incidents, public health emergencies, and active shooter events;

(l) Documentation standards for patient care including reporting to the Washington state EMS electronic data system as provided in RCW 70.168.090, data quality, evidence-based practice and research; and

(m) Ambulance operations including concepts such as driving an emergency vehicle, stretcher handling, crime scene awareness, safety around air ambulances and landing zones.

(5) If a competency-based education delivery method is not used, the required number of hours for education in each certification period for each level of care is as follows:

(a) EMR – 15 hours;

(b) EMT – 30 hours;

(c) AEMT – 60 hours;

(d) Paramedic – 150 hours.

(6) Skill maintenance is a required component for both OTEP and CME methods of recertification under WAC 246-976-162 and 246-976-163. Skill maintenance activities should include skills identified in the department-approved EMS skills and procedures list (DOH 530-173) appropriate to the level of certification. Skill maintenance should include an educational component. The provider must demonstrate the ability to perform a skill properly to the satisfaction of the MPD or approved MPD delegate. Skill proficiency must include opportunities

for EMS providers to annually practice and demonstrate proficiency in high risk, low frequency skills, and must include:

(a) Airway, respiration, and ventilation:

(i) For EMR include airway management, airway adjuncts, bag valve mask, and oral suctioning for all age groups.

(ii) For EMT and AEMT include content prescribed for EMR and if supraglottic airway is included in the scope of practice for the level of certification or if the EMS provider holds an endorsement for supraglottic airway. "Supraglottic airway" means airway adjuncts not intended for insertion into the trachea. This includes verification of initial placement and continued placement, in a skill lab setting, through procedures identified in county MPD protocols.

(iii) For paramedic include content prescribed for EMR, EMT, AEMT, and paramedics. Paramedics must successfully complete a department-approved MPD airway management education program throughout each three-year certification period.

(iv) Distributive learning may be used to provide the didactic portion of the airway management education and must include a cognitive assessment for each module.

(v) The airway management program must include a minimum of all the following:

(A) Respiratory system anatomy and physiology;

(B) Basic airway management and airway adjuncts;

(C) Recognizing the need for and preparatory steps for advanced airway management including difficult airways; and

(D) Post intubation management including monitoring airway, patient movement considerations, and documentation.

(vi) Paramedics must annually demonstrate psychomotor skills to the satisfaction of the MPD or approved MPD delegate. Psychomotor skills must include:

(A) Appropriate use and placement of oral and nasal airway adjuncts for pediatric and adult patients;

(B) Appropriate use and placement of supraglottic airways for pediatric and adult patients;

(C) Appropriate use and placement of endotracheal tube for pediatric and adult patients. Successful human intubation or successful placement on MPD approved high-fidelity mannequins satisfy the psychomotor requirements with approval from the MPD; and

(D) Appropriate use and placement of surgical airway management techniques for pediatric and adult patients.

(vii) If a paramedic is unable to obtain human intubations or successfully demonstrate competency for advanced airway management and intubation the MPD may conduct a quality improvement review of patient care provided in accordance with department-approved MPD quality improvement plan. The MPD may also require additional education and psychomotor opportunities to demonstrate competency.

(b) Vascular access:

(i) AEMT and EMTs that hold an IV therapy endorsement must:

(A) Demonstrate proficiency of intravenous insertion and infusion on patients to the satisfaction of the MPD or an approved MPD delegate. Skills can be performed while in the course of duty as an EMS provider on sick, injured, or preoperative adult and pediatric patients; and

(B) Demonstrate proficiency of intraosseous insertion and infusion to the satisfaction of the MPD or an approved MPD delegate. Skills can be performed while in the course of duty as an EMS provider on sick, injured, or preoperative adult and pediatric patients.

(ii) Paramedics must:

(A) Complete requirements for AEMT; and

(B) Demonstrate proficiency to the satisfaction of the MPD or approved MPD delegate for advanced level vascular access, infusion, and monitoring of lines such as central venous and external jugular lines and other relevant skills identified in the Washington state approved EMS skills and procedures list (DOH 530-173).

(iii) If an EMS provider is unable to complete any of the skill requirements identified above, upon approval from the MPD, the EMS provider may meet the requirements by performing the skill on artificial training aids.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-161, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-161, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71 and 18.73 RCW. WSR 04-08-103, § 246-976-161, filed 4/6/04, effective 5/7/04. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-161, filed 4/5/00, effective 5/6/00.]

WAC 246-976-162 The CME method of recertification. (1) To complete the CME method of recertification, an EMS provider must complete and document the requirements in WAC 246-976-161 and this section.

(2) The EMS provider must complete requirements appropriate to the level of certification for each certification period and maintain competency in knowledge and skills. The EMS provider must demonstrate competency in knowledge and the ability to perform a skill properly to the satisfaction of the MPD or approved MPD delegate.

(3) An EMS provider who applies for recertification using the CME method must successfully complete department-approved knowledge and any practical skill examinations as identified in WAC 246-976-171.

(4) An EMS provider may transition from the OTEP to the CME method of recertification within their certification period if the provider meets all the following:

(a) Meets all requirements in WAC 246-976-161 by the end of their certification cycle;

(b) Meets all of the requirements in this section by the end of their certification cycle;

(c) Has completed and submitted the department continuing medical education and ongoing training gap tool to the MPD;

(d) Has received an MPD approved education plan to meet any deficiencies; and

(e) Has been approved by the MPD to transition recertification methods.

(5) An EMS provider must transition from OTEP to CME if they are unable to meet the requirements of the OTEP method of recertification.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-162, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-162, filed 3/22/11, effective 5/15/11.]

WAC 246-976-163 The OTEP method of recertification. (1) To recertify using the OTEP method, an EMS provider must complete a county MPD and department-approved OTEP that meets requirements in WAC 246-976-026, 246-976-161, and this section. Due to the competency-based nature of OTEP, fewer class hours may be required to complete the requirements than the recommended hours identified in WAC 246-976-161.

(2) The EMS provider must complete requirements appropriate to the level of certification for each certification period and maintain competency in knowledge and skills. The EMS provider must demonstrate competency in knowledge and the ability to perform a skill properly to the satisfaction of the MPD or approved MPD delegate.

(3) An EMS provider may transition from the CME to the OTEP method of recertification within their certification period if the provider meets all the following:

(a) Has at least one year remaining in their certification cycle;

(b) Meets all requirements in WAC 246-976-161 by the end of their certification cycle;

(c) Meets all of the requirements in this section by the end of their certification cycle;

(d) Has completed and submitted the department continuing medical education and ongoing training gap tool to the MPD;

(e) Has received an MPD approved education plan to meet any deficiencies; and

(f) Has been approved by the MPD to transition recertification methods.

(4) An EMS provider must transition from OTEP to CME if they are unable to meet the requirements of the OTEP method of recertification.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-163, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-163, filed 3/22/11, effective 5/15/11.]

WAC 246-976-171 Recertification, reversion, reissuance, and reinstatement of certification. (1) An EMS provider may not provide care with an expired certification.

(2) To apply for recertification, reversion, reissuance, or reinstatement, an applicant must meet the requirements for the appropriate process described in this section. Applicants must:

(a) Submit a completed application on forms provided by the department;

(b) Successfully complete a background check provided by the department. The background check may include the requirement for fingerprint card and FBI background check. If an applicant has submitted fingerprints and has been informed by the department that their fingerprints were rejected and must be redone, the applicant may request a temporary practice permit in accordance with WAC 246-12-050;

(c) Provide proof of active membership paid or volunteer with a licensed aid or ambulance service, or an EMS service supervisory organization (ESSO) recognized by the department. Senior EMS instructors or training coordinators teaching at department-approved EMS training programs who are unable to be with approved agencies above may affiliate with department-approved training programs with the approval from the county medical program director; and

(d) Be recommended by the county medical program director. The county medical program director must sign the application.

(3)(a) To recertify, applicants must:

(i) Have a current Washington state EMS certification; and

(ii) Successfully complete continuing medical education and ongoing training requirements prescribed in WAC 246-976-161.

(b) For applicants recertifying by the CME method prescribed in WAC 246-976-162:

(i) Provide the county MPD proof of successful completion of education and skill requirements; and

(ii) Provide proof of successful completion of department-approved knowledge examination within the current certification period.

(c) For applicants recertifying by the OTEP method prescribed in WAC 246-976-163:

(i) Successfully complete a department and MPD approved OTEP program; and

(ii) Provide the county MPD proof of successful completion of education and skill requirements.

(4) To revert to a lower level of certification, applicants must:

(a) Have a current Washington state EMS certification at a higher level;

(b) Be current in EMS education and skills for the level they are reverting to; and

(c) Provide the county MPD proof of successful completion of education and skill requirements.

(5) For the department to reissue an expired certification an applicant, if expired less than two years, must:

(a) Provide the county MPD proof of successful completion of education and skill requirements prescribed in WAC 246-976-161;

(b) Complete any additional MPD required education and skills competency checks;

(c) For applicants seeking reissuance by meeting the CME recertification requirements prescribed in WAC 246-976-162:

(i) Provide the county MPD proof of successful completion of education and skill requirements; and

(ii) Provide proof of successful completion of the department-approved knowledge examination within the current certification period;

(d) For applicants seeking reissuance by meeting the OTEP recertification requirements prescribed in WAC 246-976-163:

(i) Successfully complete a department-approved OTEP program; and

(ii) Provide the county MPD proof of successful completion of education and skill requirements.

(6) Regarding a suspended or revoked certification:

(a) A person whose EMS certification is suspended or revoked may petition for reinstatement as provided in RCW 18.130.150.

(b) The petitioner must:

(i) Provide proof of completion of all requirements identified by the departmental disciplinary authority; and

(ii) Meet the appropriate reissuance requirements in this section.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-171, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-171, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71 and 18.73 RCW. WSR 04-08-103, §

246-976-171, filed 4/6/04, effective 5/7/04. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-171, filed 4/5/00, effective 5/6/00.]

WAC 246-976-182 Authorized care—Scope of practice. (1) Certified EMS personnel are only authorized to provide patient care:

(a) When performing:

(i) In a prehospital emergency setting; or

(ii) During interfacility ambulance transport; or

(iii) When participating in a community assistance education and referral (CARES) program authorized under RCW 35.21.930; or

(iv) When providing collaborative medical care in agreement with local, regional, or state public health agencies to control and prevent the spread of communicable diseases; and

(b) When performing for a licensed EMS service or an emergency services supervisory organization (ESSO) recognized by the secretary; and

(c) Within the scope of care that is included in the approved instructional guidelines/curriculum or approved specialized training and is included on the department-approved EMS skills and procedures list (DOH 530-173) for the individual's level of certification; and

(d) When following department-approved county MPD protocols.

(2) If protocols, MPD policies, county operating procedures, or regional patient care procedures do not provide off-line direction for the situation, the certified person in charge of the patient must consult with their online medical control as soon as possible. Medical control can only authorize a certified person to perform within their scope of practice.

(3) All prehospital providers must follow state approved triage procedures, county operating procedures, regional patient care procedures, county MPD policies, and patient care protocols.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-182, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-182, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-182, filed 4/5/00, effective 5/6/00.]

WAC 246-976-191 Disciplinary actions. (1) The secretary is the disciplining authority under RCW 18.130.040 (2)(a).

(2) Modification, suspension, revocation, or denial of certification will be consistent with the requirements of the Administrative Procedure Act (chapter 34.05 RCW), the Uniform Disciplinary Act (chapter 18.130 RCW), and chapter 246-10 WAC.

(3) MPDs may perform counseling regarding the clinical practice of certified individuals.

(4) Before recommending disciplinary action, the MPD must initiate protocol and procedural counseling with the certified individual, consistent with department guidelines.

(5) The MPD may request the secretary to summarily suspend certification of an individual if the MPD believes that continued certification is an immediate and critical threat to public health and safety.

(6) The MPD may recommend denial or renewal of an individual's certification.

(7) As required by RCW 18.130.080, an employing or sponsoring agency is subject to the reporting requirements identified in chapter 246-16 WAC. An employing or sponsoring agency must report to the department the following:

(a) When the certified individual's services have been terminated or restricted based upon a final determination that the individual has either committed an act or acts that may constitute unprofessional conduct; or

(b) That the certified individual may not be able to practice his or her profession with reasonable skill and safety to consumers as a result of a mental or physical condition; or

(c) When a certified individual is disciplined by an employing or sponsoring agency for conduct or circumstances that would be unprofessional conduct under RCW 18.130.180 of the Uniform Disciplinary Act.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-191, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-191, filed 4/5/00, effective 5/6/00.]

LICENSURE AND VERIFICATION

WAC 246-976-260 Licenses required. (1) The secretary licenses ambulance and aid services and vehicles to provide service that is consistent with the state plan and approved regional plans.

(2) The secretary may extend the licensing period to accommodate efficient processing of renewal applications. The expiration date will be indicated on the EMS service license issued by the department.

(3) An aid or ambulance service operating in the state of Washington must:

(a) Be licensed by the department to operate, unless an exception in RCW 18.73.130 applies; and

(b) Comply with all applicable regulations and standards in this chapter and requirements in RCW 48.49.200.

(4) To apply for an initial aid or ambulance service license, an applicant must:

(a) Submit a completed application on forms provided by the department;

(b) Provide proof of the motor vehicle liability coverage required in RCW 46.30.020 (ambulance and aid services only) and professional and general liability coverage;

(c) Provide a map of the proposed response area;

(d) Identify the level(s) of service to be provided to include:

(i) Basic life support (BLS);

(ii) Intermediate life support (ILS);

(iii) Advanced life support (ALS) (paramedic); and

(iv) Specialty care transport (SCT). Identify the scope of care and any specialty services (such as neonatal transport) provided;

(e) Identify the scheduled hours of operation for all levels of service provided; and

(f) Meet the minimum staffing requirements for each level of service provided. Staffing requirements are as follows:

(i) For aid services:

(A) An aid service providing BLS level of care must staff an aid vehicle with at least one emergency medical responder (EMR).

(B) An aid service providing ILS level of care must staff an aid vehicle with at least one advanced emergency medical technician (AEMT).

(C) An aid service providing ALS level of care must staff an aid vehicle with at least one paramedic.

(ii) For ambulance services:

(A) An ambulance service providing BLS level of care must staff an ambulance with a minimum of at least one emergency medical technician (EMT) and one person certified as an emergency medical responder (EMR) or a driver with a certificate of advanced first aid qualification or department-approved equivalent.

(B) An ambulance service providing ILS level of care must staff an ambulance with a minimum of at least one advanced emergency medical technician (AEMT) and one EMT.

(C) An ambulance service providing ALS level of care must staff an ambulance with a minimum of at least one paramedic and one EMT.

(D) A licensed service that provides inter-facility specialty care transport (SCT) must provide a minimum of two certified or licensed health care providers on each transport that have the education, experience, qualifications, and credentials consistent with the patient's needs and scope of care required for the transport and includes:

(I) One paramedic or registered nurse cross trained in prehospital emergency care and certified as an EMT; and

(II) One other person who may be the driver, must be a registered nurse, respiratory therapist, paramedic, advanced EMT, EMT, or other appropriate specialist as appointed by the physician director.

(E) With approval from the department, an ambulance service established by a volunteer or municipal corporation, or association made up of two or more municipalities in a rural area with insufficient personnel may use a driver without any medical or first-aid training as provided in RCW 18.73.150(2).

(g) Provide a current list of certified EMS personnel affiliated with the EMS service;

(h) Provide the number of advanced first-aid trained personnel used in the staffing model by the EMS service;

(i) Provide the number of nonmedically trained drivers used in the staffing model by the EMS service;

(j) Meet the equipment requirements for the level(s) of service provided in WAC 246-976-300;

(k) Provide information about the type of aid or ambulance vehicles that will be used by the service;

(l) Provide supplemental documentation that describes all the following:

(i) The dispatch plan;

(ii) The deployment plan;

(iii) The response plan to include how patient transport will be continued if a vehicle becomes disabled or personnel become unavailable to respond or continue to a call and how patient care will be provided if medical equipment failure occurs; and

(iv) The tiered response and rendezvous plan; and

(m) Be approved by the department.

(5) To renew an aid or ambulance license, applicants must provide a completed application on forms provided by the department at least

30 days before the expiration of the current license and be approved by the department.

(6) Licensed aid and ambulance services must:

(a) Provide initial training and updates to certified EMS personnel on department-approved prehospital triage procedures, regional patient care procedures, county operating procedures, county medical program director policies, and patient care protocols;

(b) In accordance with RCW 43.70.490 provide training to familiarize EMS personnel with techniques, procedures, and protocols for best handling situations in which persons with disabilities are present at the scene of an emergency;

(c) Identify how certified EMS personnel will receive continuing medical education and ongoing training;

(d) Comply with department-approved prehospital triage procedures, regional patient care procedures, county operating procedures, county medical program director policies, and patient care protocols;

(e) Provide service consistent with the state plan, approved regional plans, and the approved application on file with the department; and

(f) Participate in the Washington state EMS electronic data system in accordance with RCW 70.168.090(2).

(7) The department will:

(a) Develop and administer the application and evaluation process;

(b) Notify the regional EMS and trauma care council and county medical program director when the department receives an application for an aid or ambulance service within their area;

(c) Approve applications based on evaluations;

(d) Approve renewal of an aid or ambulance license if the service continues to meet standards; and

(e) Provide written notification to the regional EMS a trauma care council and county medical program director when the license is first issued, when amendments to existing licenses impacting the service provided in the region occur, and when a license has expired.

(8) The department may:

(a) Conduct a site review; and

(b) Grant a provisional license not to exceed 120 days. The secretary may withdraw the provisional license if the service is unable to meet the requirements for licensure within the 120-day period.

[Statutory Authority: RCW 18.73.081, 43.70.040, and 2024 c 218. WSR 25-20-024, s 246-976-260, filed 9/23/25, effective 10/24/25. Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-260, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-260, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-260, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-260, filed 12/23/92, effective 1/23/93.]

WAC 246-976-261 Emergency services supervisory organizations (ESSO). (1) An emergency services supervisory organization (ESSO) is defined in RCW 18.73.030 and is an organization recognized by the secretary to use certified EMS providers.

(2) An ESSO must be one of the following organization types:

(a) Federal, state, county, or municipal law enforcement agency;

(b) Disaster management organizations within Washington state that deploy county emergency management teams during disasters. A letter of endorsement from the appropriate department of emergency management having jurisdiction must be provided with the application for recognition as an ESSO;

(c) Organizations conducting search and rescue (SAR) operations. This includes:

(i) Ski patrol organizations that provide medical, rescue, and hazard prevention services and medical care to sick and injured people in ski area boundaries or sometimes into backcountry settings and remote environments; or

(ii) SAR organizations functioning under chapter 38.52 RCW. A letter of endorsement from the local chief law enforcement officer (usually the county sheriff) must be provided with the application for recognition as an ESSO for search and rescue operations;

(d) Diversion centers. These are organizations that provide short-term placement and shelter to homeless adults with substance use disorders or behavioral health issues. Diversion centers offer services to divert people away from incarceration and toward treatment; or

(e) Businesses with organized industrial safety teams such as refineries, large manufacturing plants, mining operations, or aerospace manufacturing plants.

(3) To become recognized as an ESSO an applicant must:

(a) Be an organization type identified in subsection (2) of this section;

(b) Provide a completed application on forms provided by the department;

(c) Provide an operational plan that meets the requirements identified on the application;

(d) Provide a current list of certified EMS providers;

(e) Request comments and recommendation for recognition as an ESSO from the local EMS and trauma care council and the county medical program director in all counties in which the organization will be conducting activities using certified EMS providers; and

(f) Be approved for recognition by the department.

(4) Recognized ESSOs must:

(a) Ensure that certified emergency medical services providers work under the medical oversight and protocols of a department-approved county medical program director;

(b) Ensure that certified emergency medical services providers work within the scope of practice for their level of certification;

(c) Ensure that certified emergency medical services providers can meet the training requirements to maintain their certification;

(d) Comply with department-approved prehospital triage procedures, regional EMS and trauma care plans, patient care procedures, county operating procedures, MPD policies and patient care protocols; and

(e) Provide the medical equipment listed in WAC 246-976-300 for the level of service the ESSO will provide.

(5) To renew an ESSO recognition, an applicant must:

(a) Be an organization type identified in subsection (2) of this section;

(b) Provide a completed application on forms provided by the department;

(c) Provide an operational plan that meets the requirements identified on the application;

(d) Provide a current list of certified EMS personnel; and

(e) Be approved by the department for renewal.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-261, filed 7/22/24, effective 9/30/24.]

WAC 246-976-270 Denial, suspension, revocation. (1) The secretary may suspend, modify, or revoke an agency's license or verification issued under this chapter. The secretary may deny licensure or verification to an applicant when it finds:

(a) Failure to comply with the requirements of chapters 18.71, 18.73, 70.168 RCW, or RCW 48.49.200, or other applicable laws or rules, or with this chapter;

(b) Failure to comply or ensure compliance with prehospital patient care protocols or regional patient care procedures;

(c) Failure to cooperate with the department in inspections or investigations; or

(d) Failure to consistently meet trauma response times identified by the regional plan and approved by the department for trauma verified services.

(2) The secretary may fine an agency licensed to provide ground ambulance services in an amount not to exceed $1,000 per violation if the insurance commissioner reports to the department that they have cause to believe that a ground ambulance services organization has engaged in a pattern of violations of RCW 48.49.200, and the report is substantiated after investigation.

(3) Modification, suspension, revocation, or denial of licensure or verification, or imposition of a fine, will be consistent with the requirements of the Administrative Procedure Act, chapter 34.05 RCW, and chapter 246-10 WAC. The secretary will not take action against a licensed, nonverified service under this section for providing emergency trauma care consistent with regional patient care procedures when the wait for the arrival of a verified service would place the life of the patient in jeopardy or seriously compromise patient outcome.

[Statutory Authority: RCW 18.73.081, 43.70.040, and 2024 c 218. WSR 25-20-024, s 246-976-270, filed 9/23/25, effective 10/24/25. Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-270, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-270, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-270, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-270, filed 12/23/92, effective 1/23/93.]

WAC 246-976-290 Ground ambulance vehicle standards. (1) All ground ambulance vehicles that are used to transport patients must meet the minimum standards in this chapter. Ambulance vehicles that

meet a national ground ambulance standard recognized by the department are deemed to have met the minimum standards in this section.

(2) Equipment required for the safety and comfort of all occupants must be in good working order.

(3) The body of ambulance vehicles must meet the following standards:

(a) The length of the patient compartment must be at least 112 inches in length, measured from the partition to the inside edge of the rear loading doors;

(b) The width of the patient compartment after cabinet and gurney installation must provide at least nine inches of clear walkway;

(c) The height of the patient compartment must be at least 53 inches at the center of the patient area, measured from floor to ceiling, exclusive of cabinets or equipment;

(d) There must be secondary egress from the vehicle; and

(e) Back doors must open in a manner to increase the width for loading and unloading patients without blocking existing working lights of the vehicle.

(4) The interior of ambulance vehicles must meet the following standards:

(a) A current state ambulance vehicle credential must be prominently displayed in a clear plastic cover positioned high on the partition behind the driver's seat;

(b) The floor at the lowest level permitted by clearances must provide flat and unencumbered access to the work area, with no voids or pockets in the floor to side wall areas where water or moisture can become trapped to cause rusting or unsanitary conditions;

(c) Floor covering applied to the top side of the floor surface must withstand washing with soap and water or disinfectant without damage to the surface. All joints in the floor covering must have minimal void between matching edges, cemented with a suitable waterproof cement to eliminate the possibility of joints loosening or lifting;

(d) The finish of the entire patient compartment must be impervious to soap and water and disinfectants to permit washing and sanitizing;

(e) Interior lighting in the driver compartment must be designed and located so that no glare is reflected from surrounding areas to the driver's eyes or line of vision from the instrument panel, switch panel, or other areas which may require illumination while the vehicle is in motion;

(f) Interior lighting in the patient compartment must be provided adequately throughout the compartment, and provide an intensity of 215 lumen at the level of the patient;

(g) Ambulance vehicles must have one ABC two and one-half pound fire extinguisher. The extinguisher must be accessible, be in good physical condition, and in compliance with servicing requirements; and

(h) Interior equipment must be kept in a secure manner to provide for the safety of all occupants in the vehicle.

(5) Ambulance vehicles must be equipped with manufacturer recommended restraint systems which include:

(a) Seat belts must comply with Federal Motor Vehicle Safety Standards 207, 208, 209, and 210;

(b) Gurney restraints that comply with manufacturer recommendations must be used on patients during transport;

(c) Ambulance vehicles must have manufacturer recommended hardware installed that is in good working order to secure a gurney in the vehicle for transport;

(d) Restraints must be provided in all seat positions in the vehicle, including attendant stations;

(e) Restraints must be provided for patients when equipment such as a backboard or scoop stretcher is used to move a patient from surface to surface. A means to secure this equipment to the gurney or a bench seat must be provided for transport;

(f) Seat belts and related restraints must permit quick attachment and detachment for quick transfer of a patient; and

(g) Appropriate restraints for pediatric patients must be provided and used in a manner and location consistent with all applicable manufacturer recommendations.

(6) The exterior of ambulance vehicles must meet the following standards:

(a) The ambulance vehicle must be clearly identified as an emergency medical services vehicle;

(b) The ambulance vehicle must display the agency or service identification by reflective emblems and markings on the front, sides, and rear of the vehicle;

(c) The ambulance vehicle must have retro-reflective paint or tape, stripes or markings, or a combination of stripes and markings that are a minimum of six inches in width affixed to the full length of both sides and the rear of the vehicle;

(d) A minimum of 50 percent of the rear of the vehicle surface must be equipped with a retro-reflective pattern on ambulance vehicles built in the year 2020 and thereafter;

(e) Emergency warning lights and audible warning signals must be provided in accordance with national ambulance standards recognized by the department;

(f) Windshield wipers and washers must be dual, multispeed, and functional at all times;

(g) Ambulance vehicles must have exterior mirrors on the left and right side of the vehicle and mounted to provide maximum rear vision from the driver's seated position;

(h) Exterior lights must be fully operational, and include body-mounted floodlights over the patient loading doors to provide loading visibility;

(i) Exterior surfaces must be smooth, with projections kept to a minimum; and

(j) Equipment stored in exterior compartments must be secured in a manner to provide for the safety of all occupants in the vehicle.

(7) Mechanical and electrical components of ambulance vehicles must meet the following standards:

(a) The electrical power generating system must be capable of sustaining all systems and must be appropriately ventilated and sealed according to manufacturer recommendations;

(b) If the electrical system uses fuses instead of circuit breakers, extra fuses must be readily available;

(c) Within the engine compartment of the ambulance vehicle, hoses, belts, and wiring must not have any obvious defects; and

(d) Vehicle brakes, regular and special electrical equipment, heating and cooling units, safety belts, and window glass must be always functional.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-290, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

WSR 11-07-078, § 246-976-290, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-290, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-290, filed 12/23/92, effective 1/23/93.]

WAC 246-976-300 Ground ambulance and aid service—Equipment. (1) Licensed and verified ground ambulance, aid services, and emergency services supervisory organizations (ESSO) must provide equipment listed in Table A of this section on each licensed vehicle or to their on-site EMS providers for the service levels they are approved by the department to provide when they are available for service.

Table A: Equipment

*Means the use of this equipment at this level of service is determined by the MPD. Department-approved and MPD specialized training protocols must be in place.

	BLS		ILS		ALS	
	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO
Airway Adjuncts						
Adjunctive airways, (OPA/NPA) adult and pediatric assorted	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Water-soluble lubricant	1	1	1	1	2	2
Intubation insertion equipment. Enough for all patient sizes with back up equipment including power sources.	N/A	N/A	Assortment	Assortment	Assortment	Assortment
Stylet for endotracheal tubes (adult and pediatric)	N/A	N/A	N/A	N/A	2 each	2 each
Bougie (gum-elastic) for all patient sizes	N/A	N/A	N/A	N/A	1 each	1 each
ET tube holder (adult and pediatric)	N/A	N/A	N/A	N/A	2 each	2 each
End-tidal CO_2 detector	*1	*1	1	1	1	1
Supraglottic airways	*Assortment	*Assortment	Assortment	Assortment	Assortment	Assortment
Cricothyrotomy equipment	N/A	N/A	N/A	N/A	1	1
Chest decompression equipment (to include a nonsafety large bore needle, minimum length of 3.25")	N/A	N/A	N/A	N/A	1	1
McGill forceps (adult and pediatric)	N/A	N/A	1 each	1 each	1 each	N/A
Oxygen saturation monitor	*1	*1	1	1	1	1
Suction						
Portable	1	1	1	1	1	1
Vehicle mounted and powered, providing: Minimum of 30 L/min. & vacuum ≥ 300 mm Hg	1	0	1	0	1	0
Spare canister	1	0	1	0	1	0
Tubing, suction	1	1	1	1	1	1

Table A: Equipment						
*Means the use of this equipment at this level of service is determined by the MPD. Department-approved and MPD specialized training protocols must be in place.						
	BLS		**ILS**		**ALS**	
	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO
Bulb syringe, pediatric	1	1	1	1	1	1
Rigid suction tips	2	1	2	1	2	1
Catheters	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment
Meconium aspirator	N/A	N/A	N/A	N/A	1	1
Oxygen/Delivery Devices						
Oxygen delivery system built in or an alternative system approved by the department	1	0	1	0	1	0
3000 L Oxygen supply, with regulator, 500 PSI minimum, or equivalent liquid oxygen system	1	0	1	0	1	0
300 L Oxygen supply, with regulator, 500 PSI minimum, or equivalent liquid oxygen system	2	1	2	1	2	1
Cannula, nasal, adult	4	2	4	2	4	2
O_2 mask, nonrebreather, adult	4	2	4	2	4	2
O_2 mask, nonrebreather, pediatric	2	1	2	1	2	1
BVM, with O_2 reservoir to provide tidal volume appropriate for each (adult, pediatric, infant)	1 each	1 each	1 each	1 each	1 each	1 each
Nebulizer	*2	*2	2	2	2	2
Continuous Positive Airway Pressure (CPAP)	*2	*2	*2	*2	2	2
Patient Assessment and Care						
Sphygmomanometer (adult large, regular, and pediatric)	1 each	1 each	1 each	1 each	1 each	1 each
Stethoscope, adult	1	1	1	1	1	1
Thermometer	1	0	1	0	1	0
Flashlight, w/spare or rechargeable batteries & bulb	1	1	1	1	1	1
Automated External Defibrillator (AED)	1	1	1	1	0	0
12 lead ECG monitor with defibrillator	0	0	0	0	1	1
Defibrillator pads - multifunction	2 each	2 each	2 each	2 each	2 each	2 each
Tool for estimating pediatric medication and equipment sizes	1	1	1	1	1	1
Glucometer	1	1	1	1	1	1

Table A: Equipment						
*Means the use of this equipment at this level of service is determined by the MPD. Department-approved and MPD specialized training protocols must be in place.						
	BLS		**ILS**		**ALS**	
	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO
Glucose measuring supplies	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Wound Care						
Dressing, sterile	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Dressing, sterile, trauma	2	2	2	2	2	2
Roller gauze bandage	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Medical tape	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Self-adhesive bandage strips	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Cold packs	4	2	4	2	4	2
Hot packs	2	2	2	2	2	2
Occlusive dressings	2	2	2	2	2	2
Trauma shears	1	1	1	1	1	1
Irrigation solution	2	1	2	1	2	1
Commercial tourniquet	2	2	2	2	2	2
Extrication and Splinting						
Collars, rigid. Adult (small, medium, large) or adjustable	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Collars, rigid. Pediatric or functionally equivalent sizes	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Immobilization device, cervical/thoracic, adult	1	0	1	0	1	0
Immobilization device, cervical/thoracic, pediatric	1	1	1	1	1	1
Backboard with straps	1	1	1	1	1	1
Head immobilization equipment	1	1	1	1	1	1
Splint, traction, adult w/ straps	1	0	1	0	1	0
Splint, traction, pediatric, w/straps	1	0	1	0	1	0
Splint, adult (arm and leg)	2 each	1 each	2 each	1 each	2 each	1 each
Splint, pediatric (arm and leg)	1 each	1 each	1 each	1 each	1 each	1 each
IV Access						
Intravenous fluid type per protocols	*4	*2	4	2	4	2
Intravenous drip sets per protocols	*4	*2	4	2	4	2
Intravenous start supplies (venous tourniquet, transparent film dressing, antiseptic swab)	*4	*2	4	2	4	2
Catheters, intravenous (14-24 gauge)	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment

Table A: Equipment						
*Means the use of this equipment at this level of service is determined by the MPD. Department-approved and MPD specialized training protocols must be in place.						
	BLS		**ILS**		**ALS**	
	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO
Intraosseous (Equipment sufficient to perform IO insertion and infusion adult and pediatric)	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment
Pediatric volume control device	*2	*1	2	1	2	1
Pressure infusion device	*1	0	1	0	1	0
Syringes	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment
Needles						
Hypodermic	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment	*Assortment
Medications						
Epinephrine for anaphylaxis adult and pediatric dose	1 each	1 each	1 each	1 each	1 each	1 each
Medications consistent with department-approved MPD protocols	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Storage and handling of pharmaceuticals in ambulances and aid vehicles must be in compliance with the manufacturers' recommendations						
Personal Protection Equipment						
Eye protection	2	2	2	2	2	2
Mask	5	5	5	5	5	5
Exam gloves (assortment of sizes)	Assortment	Assortment	Assortment	Assortment	Assortment	Assortment
Gowns (isolation)	3	3	3	3	3	3
Trauma Emergencies						
Triage identification tags	12	12	12	12	12	12
General						
Gurney, wheeled, collapsible, with a functional restraint system per the manufacturer	1	0	1	0	1	0
Pillows, plastic covered or disposable	1	0	1	0	1	0
Pillowcase, cloth or disposable	2	0	2	0	2	0
Sheets, cloth or disposable	4	2	4	2	4	2
Blankets	2	2	2	2	2	2
Towels, cloth or disposable 12" x 23" minimum	4	2	4	2	4	2
Emesis collection device	5	1	5	1	5	1
Urinal	1	0	1	0	1	0
Bed pan	1	0	1	0	1	0
OB kit	1	1	1	1	1	1
Patient care restraints (commercial)	2 pair	0	2 pair	0	2 pair	0
Garbage bags	2	2	2	2	2	2

Table A: Equipment						
*Means the use of this equipment at this level of service is determined by the MPD. Department-approved and MPD specialized training protocols must be in place.						
	BLS		ILS		ALS	
	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO	Ambulance Vehicle	Aid/ESSO
Safety vest or equivalent gear	2	1	2	1	2	1
Sharps container mounted	1 each	0	1 each	0	1 each	0
Sharps container portable	1 each	1 each	1 each	1 each	1 each	1 each

(2) A licensed service that provides interfacility transport of patients needing specialty level care (SCT) must make available equipment and medications consistent with the scope of practice and care required for the transport type. Equipment must include all the following:

(a) ALS equipment required in Table A of this section;

(b) Multimodality ventilators capable of invasive ventilation appropriate to all age groups transported;

(c) Invasive hemodynamic monitoring; transvenous pacemakers, central venous pressure, and arterial pressure;

(d) Controlled delivery devices for IV infusions;

(e) Medications consistent with scope of practice and care required for the transport type; and

(f) Neonatal and pediatric equipment sufficient for all aspects of prehospital interfacility specialized care if the ambulance service provides transport to this population.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-300, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-300, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-300, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-300, filed 12/23/92, effective 1/23/93.]

WAC 246-976-310 Ground ambulance and aid service—Communications equipment. (1) Licensed ground ambulance and aid services must provide each licensed ambulance and aid vehicle with communication equipment which:

(a) Is consistent with state and regional plans;

(b) Is in good working order;

(c) Allows direct two-way communication with dispatch control point, medical control, and all hospitals in the service area of the vehicle; and

(d) Licensed ground ambulance and aid vehicles capable of transporting patients must also have direct two-way communication from both the driver's and patient's compartment.

(2) If cellular telephones are used, there must also be another method of radio contact with dispatch control point, medical control, and all hospitals in the service area for use when cellular service is unavailable.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-310, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-310, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-310, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-310, filed 12/23/92, effective 1/23/93.]

WAC 246-976-320 Air ambulance services. The purpose of this rule is to ensure the consistent quality of medical care delivered by air ambulance services in the state of Washington.

(1) An air ambulance service operating in the state of Washington must:

(a) Be licensed by the department in compliance with this section unless an exception in RCW 18.73.130 applies;

(b) Comply with all regulations and standards in this chapter pertaining to licensed and verified ambulance services and vehicles, except that WAC 246-976-290 and 246-976-300 are replaced for air ambulance services by subsections (7) and (8) of this section; and

(c) Comply with the standards in this section for all types of transports, including interfacility and prehospital transports.

(2) An air ambulance service applying for initial or renewal licensure must:

(a) Provide a completed application for licensure on forms provided by the department;

(b) Provide copies of the following current and valid documentation issued by the Federal Aviation Administration (FAA):

(i) Air Taxi Registration (OST Form 4507) showing the effective date of FAA registration and exemption under 14 C.F.R. 298;

(ii) Air carrier certificate authorizing common carriage under 14 C.F.R. 135, including Operations Specifications (FAA form 8430-18) authorizing aeromedical helicopter or fixed-wing air ambulance operations as applicable;

(iii) Certificate of Registration (AC form 8050-3) for each air ambulance operated; and

(iv) Standard Airworthiness Certificate (FAA form 8100-2) for each air ambulance operated;

(c) Provide a certificate of insurance establishing current and valid public and passenger liability insurance coverage for the air ambulance service;

(d) Provide a certificate of insurance establishing current and valid professional and general liability insurance coverage for the air ambulance service; and

(e) Provide proof of the air ambulance service's current accreditation status and a copy of the current accreditation report by a nationally recognized and department approved air ambulance accreditation entity that demonstrates that the air ambulance service meets the standards in this section. Failure to produce the accreditation report and supporting documentation to the department may be grounds for denial, suspension, or revocation of an ambulance license.

(3) An air ambulance service requesting initial licensure or renewal of licensure:

(a) That is ineligible to attain accreditation because it lacks a history of operation, must meet the standards in this section and provide proof that the air ambulance service is pursuing accreditation review with an accreditation entity approved by the department. A provisional license may be granted for no longer than two years at which time the service must provide documentation from a department approved accreditation entity that it meets the standards in this section.

(b) That has been unable to obtain accreditation may apply for a waiver of the full accreditation requirement if the air ambulance service meets all components of accreditation that are consistent with the standards in this section other than criteria related to the Federal Aviation Agency or Airline Deregulation Act regulated activities. The applicant must supply a copy of the accreditation report and supporting documentation to the department to show that it meets the standards in this section.

(4) To meet the minimum standards for medical oversight and patient care protocols an air ambulance service must:

(a) Have a physician director. The physician director must be:

(i) The department-certified medical program director (MPD) of the county where the air ambulance service declares its primary base of operation or a physician delegate of that county's MPD, as provided in WAC 246-976-920(4);

(ii) Licensed to practice in the state of Washington and in current good standing; and

(iii) Able to provide proof of educational experience consistent with the mission statement and scope of care provided by the air ambulance service;

(b) Ensure that all medical team members hold current and valid Washington state health care profession licenses;

(c) Ensure that all prehospital personnel used by the air ambulance service per subsection (5) of this section hold current and valid Washington state certifications as defined in WAC 246-976-010 and in accordance with RCW 18.71.200 and 18.71.205. Certified prehospital personnel must comply with department approved, MPD patient care protocols;

(d) Have a quality management program; and

(e) Ensure data related to patient care and transport services is collected and reviewed regularly and protected health care information is handled according to state and federal law and regulations.

(5) An air ambulance service must meet the following minimum standards for staffing of air ambulances:

(a) All medical personnel on each transport must have education, experience, qualifications, and credentials consistent with the mission statement and scope of care provided by the air ambulance service;

(b) Each critical care transport (CCT) is staffed by a medical team of at least two individuals with at least the following qualifications and licensure:

(i) One paramedic or registered nurse trained in prehospital emergency care; and

(ii) One other person who must be a registered nurse, respiratory therapist, paramedic, advanced EMT, EMT, or other appropriate specialist as appointed by the physician director;

(c) Each advanced life support (ALS) transport is staffed by a medical team of at least two individuals with at least the following qualifications and licensure:

(i) One paramedic; and

(ii) One other person, who must be a paramedic, advanced EMT, EMT, or other appropriate specialist as appointed by the physician director; and

(d) Each basic life support (BLS) transport is staffed by a medical team of at least two individuals in accordance with ambulance personnel requirements listed in RCW 18.73.150.

(6) An air ambulance service must meet the following minimum standards for training of air ambulance medical personnel:

(a) Establish and maintain a structured training program. If prehospital personnel are used by the air ambulance service, the training program must also meet requirements as defined in chapter 246-976 WAC;

(b) Create and maintain a file for each medical team member containing documentation of the personnel member's qualifications including, as applicable, licenses, certifications, and training records; and

(c) Ensure that each medical team member completes training in the following subjects before serving on a transport:

(i) Aviation terminology;

(ii) Altitude physiology and stressors of flight;

(iii) Patient loading and unloading;

(iv) Safety in and around the aircraft;

(v) In-flight communications;

(vi) Use, removal, replacement, and storage of the medical equipment installed on the aircraft;

(vii) In-flight emergency procedures;

(viii) Emergency landing and evacuation procedures; and

(ix) Policies and procedures for the air ambulance service, including policies to address altitude limitations.

(7) An air ambulance service must meet the following minimum standards for aircraft configuration and equipment to safely and effectively treat ill and injured patients on air ambulance transports and that include:

(a) A climate control system to prevent temperature extremes that would adversely affect patient care;

(b) Interior lighting that allows for patient care and monitoring without interfering with the pilot's vision;

(c) At least one outlet per patient and electric current which is capable of operating all electrically powered medical equipment unless battery power is available that exceeds the flight time for the transport;

(d) A back-up source of electric current or batteries capable of operating all electrically powered life support equipment for at least a minimum of one hour;

(e) An entry that allows for patient loading and unloading without rotating a patient and stretcher more than thirty degrees about the longitudinal (roll) axis or forty-five degrees about the lateral (pitch) axis and without compromising the operation of monitoring systems, intravenous lines, or manual or mechanical ventilation;

(f) Adequate space that allows each medical team member sufficient access to each patient to begin and maintain treatment modalities, including complete access to the patient's head and upper body for effective airway management;

(g) Adequate placement of stretcher and medical equipment that does not impede rapid egress by personnel or patient from the aircraft; and

(h) A communications system that is capable of air to ground communication with, ground fire and EMS services, public safety vehicles,

hospitals, medical control, and communication centers and that allows the flight crew and medical team members to communicate with each other during the transport.

(8) An air ambulance service must meet the following minimum standards for medical equipment aboard air ambulances:

(a) Maintain and provide a minimum of the following equipment, supplies, and medications consistent with the mission statement and scope of care provided on transports. All equipment, supplies, and medications must be approved for use by the MPD and physician director.

(i) Minimum equipment available for each basic life support (BLS) transport must include:

(A) Oral/nasal pharyngeal airway;

(B) Nonrebreather oxygen mask;

(C) Bag valve mask;

(D) Pulse oximeter;

(E) Oxygen source;

(F) Automated external defibrillator;

(G) Noninvasive vital sign measurement;

(H) Glucometer;

(I) Equipment for control of bleeding to include tourniquets;

(J) Infection control;

(K) Medications consistent with scope of practice and care required for the transport type;

(L) Spinal motion restriction; and

(M) Neonatal and pediatric equipment sufficient for all aspects of prehospital and interfacility specialized care, if the air ambulance service provides transport to this population.

(ii) Minimum equipment available for each advanced life support (ALS) transport must include:

(A) All BLS equipment required in (a)(i) of this subsection; and

(B) Equipment for endotracheal intubation to include alternative airways such as supraglottic airways;

(C) Equipment for needle thoracostomy;

(D) Noninvasive carbon dioxide (CO_2) monitoring with numerical and waveform capability;

(E) Equipment to establish and maintain a peripheral IV;

(F) Equipment to establish and maintain an intraosseous infusion;

(G) Ventilator;

(H) Equipment to provide continuous positive airway pressure (CPAP);

(I) Cardiac monitor capable of performing twelve lead ECG, defibrillation, cardioversion, and external pacing;

(J) Medications consistent with scope of practice and care required for the transport type; and

(K) Neonatal and pediatric equipment sufficient for all aspects of prehospital and interfacility specialized care, if the air ambulance service provides transport to this population.

(iii) Minimum equipment available for each critical care transport (CCT) must include:

(A) All BLS equipment required in (a)(i) of this subsection; and

(B) All ALS equipment required in (a)(ii) of this subsection; and

(C) Multimodality ventilators capable of invasive ventilation appropriate to all age groups transported;

(D) Invasive hemodynamic monitoring, transvenous pacemakers, central venous pressure and arterial pressure;

(E) Medications consistent with scope of practice and care required for the transport type; and

(F) Neonatal and pediatric equipment sufficient for all aspects of prehospital and interfacility specialized care, if the air ambulance service provides transport to this population.

(iv) Ensure that during a transport, the air ambulance has the equipment and supplies necessary to provide an appropriate level of medical care for the patient and to protect the health and safety of the personnel on the transport;

(v) Maintain and provide upon request equipment, supply and medication inventories that document what is included for each type of transport; and

(vi) Ensure the equipment and supplies on an air ambulance are secured, stored, and maintained in a manner that prevents hazards to personnel and patients.

[Statutory Authority: RCW 70.168.050 and Eagle Air Med Corp. v. Colorado Board of Health, 570 F. Supp. 2d 1289. WSR 17-07-059, § 246-976-320, filed 3/13/17, effective 4/13/17. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-320, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 18.73.140. WSR 00-22-124, § 246-976-320, filed 11/1/00, effective 12/2/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-320, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-320, filed 12/23/92, effective 1/23/93.]

WAC 246-976-330 Ambulance and aid services—Record requirements. (1) Each ambulance and aid service must:

(a) Maintain a record of certifications and endorsements of all personnel;

(b) Periodically audit certifications to assure they are current and active;

(c) Maintain a record of nonmedically trained drivers used by the service and relevant records that nonmedically trained drivers meet requirements in RCW 18.73.150;

(d) Report any additions and changes in a certified EMS providers affiliation with the service to include new employees or employee severance within 30 days;

(e) Maintain a record of make, model, and license number of all ambulance and aid vehicles;

(f) Report any additions and changes in ambulance and aid vehicles; and

(g) Maintain and provide a count of ambulance and aid service activations including: Advanced life support service activations, intermediate life support service activations, basic life support service activations, prehospital care, patient transports, interfacility transfers, and canceled activations between January 1st and December 31st of the previous calendar year.

(2) Licensed services must make all patient care records available for inspection and duplication upon request of the county MPD or the department.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69,

and 2022 c 136. WSR 24-15-104, § 246-976-330, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-330, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 70.168.060 and 70.168.090. WSR 02-02-077, § 246-976-330, filed 12/31/01, effective 1/31/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-330, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-330, filed 12/23/92, effective 1/23/93.]

WAC 246-976-340 Ambulance and aid services—Inspections and investigations. (1) The department may conduct periodic, unannounced inspections of licensed ambulances and aid vehicles and services.

(2) If the service is also verified in accordance with WAC 246-976-390, the department will include a review for compliance with verification standards as part of the inspections described in this section.

(3) At the end of an inspection for the purposes of initial, renewal, or amendment of licensure or verification, the department will:

(a) Present the preliminary findings to the EMS service; and

(b) Send a written report to the EMS service summarizing the department's findings and recommendations. The report shall identify any deficiencies found and the steps to take to address the deficiencies.

(4) Licensed services must provide the department full access to the facility, vehicles, and all records and documents relevant to the inspection or investigation which may include patient care reports, training and certification documentation, policies, procedures, protocols, crew schedules, mutual aid agreements, quality improvement materials or other relevant documents.

(5) Licensed services shall make available to the department and provide copies of any printed or written materials relevant to the inspection, verification review, or investigative process in a timely manner.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-340, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-340, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-340, filed 12/23/92, effective 1/23/93.]

WAC 246-976-360 Organ transport service and vehicle license. (1) The secretary licenses organ transport services and vehicles. To become licensed an applicant shall:

(a) Comply with RCW 18.73.290;

(b) Submit a completed application on forms provided by the department; and

(c) Meet the minimum organ transport vehicle standards in subsection (2) of this section.

(2) A licensed organ transport vehicle must meet the following standards:

(a) Essential equipment for driver and passenger safety and comfort must be in good working order;

(b) A paper copy of current state organ transport vehicle license must be made immediately available upon request;

(c) Tires must be in good condition;

(d) Electrical system. All regular and special electrical equipment must be functional at all times:

(i) Interior lighting in the driver compartment must be designed and located so that no glare is reflected from surrounding areas to the driver's eyes or line of vision from the instrument panel, switch panel, or other areas which may require illumination while the vehicle is in motion;

(ii) Exterior lights must be fully operational;

(iii) Emergency warning lights must be provided in accordance with RCW 46.37.190, as administered by the state patrol; and

(iv) Emergency audible warning signals may be used in accordance with RCW 46.37.380;

(e) Windshield wipers and washers must be dual, electric, multispeed, and functional at all times;

(f) Battery system. The battery must be capable of sustaining all systems. It must be located in a ventilated area sealed off from the vehicle interior, and completely accessible for checking and removal;

(g) Vehicle brakes, heating and cooling units, and window glass, must be functional at all times;

(h) Equipment, organs, and tissue donors must be secured in the vehicle to prevent items from sliding, rolling, and vertical movement;

(i) Functioning seat belts that comply with Federal Motor Vehicle Safety Standards 207, 208, 209, and 210. Restraints must be provided in all seat positions in the vehicle;

(j) Mirrors on the left side and right side of the vehicle. The location of mounting must provide maximum rear vision from the driver's seated position;

(k) One 5-B:C fire extinguisher must be secured in a manner that prevents sliding, rolling, and vertical movement; and

(l) Exterior surfaces must be smooth, with appurtenances kept to a minimum.

(3) Drivers of organ transport vehicles must comply with RCW 18.73.290.

(4) Licenses for organ transport services and vehicles must be renewed every two years. To renew a license, an applicant shall submit an application to the department at least 30 days prior to expiration.

[Statutory Authority: RCW 18.73.081, 43.70.040, and 2023 c 290. WSR 24-17-005, § 246-976-360, filed 8/8/24, effective 9/30/24.]

WAC 246-976-390 Standards for trauma verified prehospital EMS services. Verified EMS services must:

(1) Provide initial training and updates to certified EMS personnel on department-approved prehospital triage procedures, regional patient care procedures, county operating procedures, county medical program director policies and patient care protocols;

(2) Identify how certified EMS providers will receive continuing medical education and ongoing training;

(3) Comply with department-approved prehospital triage procedures, regional patient care procedures, county operating procedures, county medical program director policies and patient care protocols;

(4) Participate in the department-approved regional quality improvement program;

(5) Provide service that is consistent with the department-approved application on file for the EMS service, the state plan and approved regional plan; and

(6) Meet the following minimum agency response times as defined by the department and identified in the regional plan. With the advice of the steering committee, the department will consider all available data in reviewing response time standards for verified prehospital trauma services at least biennially.

(a) Aid service response time requirements: Verified aid services must meet the following minimum agency response times as defined by the department and identified in the regional plan:

(i) To urban response areas: Eight minutes or less, 80 percent of the time.

(ii) To suburban response areas: Fifteen minutes or less, 80 percent of the time.

(iii) To rural response areas: Forty-five minutes or less, 80 percent of the time.

(iv) To wilderness response areas: As soon as possible.

(b) Ground ambulance service response time requirements: Verified ground ambulance services must meet the following minimum agency response times for all EMS and trauma responses to response areas identified in their department-approved application on file, as defined by the department and identified in the regional plan:

(i) To urban response areas: Ten minutes or less, 80 percent of the time.

(ii) To suburban response areas: Twenty minutes or less, 80 percent of the time.

(iii) To rural response areas: Forty-five minutes or less, 80 percent of the time.

(iv) To wilderness response areas: As soon as possible.

(c) Verified air ambulance services must meet minimum agency response times as identified in the state plan.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-390, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-390, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 18.73.140. WSR 00-22-124, § 246-976-390, filed 11/1/00, effective 12/2/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-390, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-390, filed 12/23/92, effective 1/23/93.]

WAC 246-976-395 To apply for initial or renewal of verification or to change verification status as a prehospital EMS service. (1) The secretary verifies prehospital EMS services to provide service that is consistent with the state plan and approved regional plans. Verification is a higher form of licensure that requires 24-hour, seven day a week compliance with the standards outlined in chapter 70.168 RCW and this chapter. Verification will expire with the prehospital EMS services' periods of licensure.

(2) An aid or ambulance service operating in the state of Washington must apply for verification when you are:

(a) An agency that responds to 911 emergencies as part of its role in the EMS system;

(b) A new business or legal entity that is formed through consolidation of existing services or a newly formed EMS agency;

(c) An EMS agency that seeks to provide prehospital emergency response in a trauma response area which it previously has not been operating; or

(d) A service that is changing or has changed its type of verification or its verification status.

(3) To apply for initial verification or to change verification status of a verified aid or ambulance service, the applicant must:

(a) Be a licensed aid or ambulance service as specified in WAC 246-976-260 or a licensed air ambulance service as specified in WAC 246-976-320;

(b) Provide a completed application for verification on forms provided by the department;

(c) Identify the level(s) of service to be provided 24/7 to include:

(i) Basic life support (BLS);

(ii) Intermediate life support (ILS);

(iii) Advanced life support (ALS);

(d) Meet the staffing requirements identified in WAC 246-976-260;

(e) Meet the equipment requirements for the level(s) of service provided in WAC 246-976-300;

(f) Provide information about the type of aid or ambulance vehicles that will be used by the service;

(g) Provide documentation that describes:

(i) The dispatch plan;

(ii) The deployment plan;

(iii) The response plan to include how patient transport will be continued if a vehicle or EMS providers become disabled;

(iv) The tiered response and rendezvous plan;

(v) Interagency relations. Mutual aid agreements, memoranda of understanding, or other official documents describing interagency relations and the presence of collaboration and cooperation for coordinated services shall be made available to the department upon request; and

(h) Provide service that is consistent with the department-approved application on file for the EMS service, the state plan, and approved regional plan.

(4) To renew verification, you must provide a completed application and documentation for renewal on forms provided by the department at least 30 days before the expiration of the current license.

(5) The department will:

(a) Develop and administer the application and evaluation process for all levels of service;

(b) Provide a description of the documents an applicant must submit to demonstrate that the service meets the standards identified in chapter 70.168 RCW;

(c) Identify minimum and maximum numbers of verified prehospital services, including level of service for each trauma response area based on:

(i) The approved regional EMS and trauma plans; and

(ii) The Washington state EMS and trauma plan;

(d) Develop guidance for local and regional EMS councils regarding trauma response areas and conducting needs assessments to support identification of minimum and maximum numbers of prehospital services;

(e) Request comments to be considered in the department's review from:

(i) The regional council in which a verification application is received;

(ii) The county medical program director in the area which a verification application is applying to provide service; and

(iii) Other stakeholders or interested parties;

(f) Apply the department's evaluation and decision criteria;

(g) Select verified prehospital services;

(h) Approve an applicant to provide verified prehospital trauma care, based on satisfactory evaluations as described in this section;

(i) Approve renewal of a verified service upon reapplication, if the service continues to meet standards established in this chapter and provides service consistent with the department-approved application on file for the EMS service, the state plan and approved regional plan;

(j) Provide written notification to the applicants on the final decision regarding the license and verification; and

(k) Provide written notification to the regional council and county medical program director when the license and verification is first issued, when amendments to existing licenses and verification impacting service provided in the region occur, and when a license with verification has expired.

(6) The department may:

(a) Conduct a preverification site visit; and

(b) Grant a provisional verification not to exceed 120 days. The secretary may withdraw the provisional verification status if provisions of the service's proposal are not implemented within the 120-day period, or as otherwise provided in chapter 70.168 RCW and this chapter.

(7) The department will evaluate prehospital EMS service applicants for verification on a point system. In the event there are two or more applicants, the secretary will verify the most qualified applicant. The decision to verify will be based on at least the following:

(a) Total evaluation points received on completed applications:

(i) Applicants must receive a minimum of 150 points of the total 200 points possible from the overall evaluation scoring tool to qualify for verification;

(ii) Applicants must receive a minimum of 30 points in the evaluation of its clinical and equipment capabilities section of the evaluation scoring tool to qualify for verification;

(b) Recommendations from the on-site review team, if applicable; and

(c) Comments from the regional council(s).

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

(a) Compliance with the department-approved minimum and maximum number of verified trauma services for the level of verification being sought by the applicant;

(b) How the proposed service will impact care in the region to include discussion on:

(i) Clinical care;

(ii) Response time to prehospital incidents;
(iii) Resource availability;
(iv) Unserved or underserved trauma response areas; and
(v) How the applicant's proposed service will impact existing verified services in the region;
(c) Regional EMS/TC councils will solicit and consider input from local EMS/TC councils where local councils exist.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-395, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-395, filed 3/22/11, effective 5/15/11.]

WAC 246-976-400 Verification—Noncompliance with standards. If the department finds that a verified prehospital trauma care service is out of compliance with verification standards:
(1) The department shall promptly notify in writing: The service, the MPD, and the local and regional EMS/TC councils.
(2) Within thirty days of the department's notification, the service must submit a corrective plan to the department, the MPD, and the local and regional councils outlining proposed action to return to compliance.
(3) If the service is either unable or unwilling to comply with the verification standards, under the provisions of chapter 34.05 RCW, the secretary may suspend or revoke the verification. The department shall promptly notify the local and regional councils and the MPD of any revocation or suspension of verification.
If the MPD, the local council, or regional council receives information that a service is out of compliance with the regional plan, they may forward their recommendations for corrections to the department.
(4) The department will review the plan within thirty days, including consideration of any recommendations from the MPD, local council, and regional council. The department will notify the service whether the plan is accepted or rejected.
(5) The department will monitor the service's progress in fulfilling the terms of the approved plan.
(6) A verified prehospital service that is not in compliance with verification standards will not receive a participation grant.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-400, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-400, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-400, filed 12/23/92, effective 1/23/93.]

TRAUMA REGISTRY

WAC 246-976-420 Trauma registry—Department responsibilities. (1) Purpose: The department maintains a trauma registry, as required by RCW 70.168.060 and 70.168.090. The purpose of this registry is to:

(a) Provide data for trauma surveillance, analysis, and prevention programs;

(b) Monitor and evaluate the outcome of care of trauma patients, in support of statewide and regional quality assurance and system evaluation activities;

(c) Assess compliance with state standards for trauma care;

(d) Provide information for resource planning, system design and management; and

(e) Provide a resource for research and education.

(2) Confidentiality: RCW 70.168.090, 70.41.200, and chapter 42.56 RCW apply to trauma registry data and patient quality assurance proceedings, records, and reports developed pursuant to RCW 70.168.090. Data elements related to the identification of individual patient's, provider's, and facility's care outcomes shall be confidential, shall be exempt from chapter 42.56 RCW, and shall not be subject to discovery by subpoena or admissible as evidence. Patient care quality assurance proceedings, records, and reports developed pursuant to RCW 70.168.090 are confidential, exempt from chapter 42.56 RCW, and are not subject to discovery by subpoena or admissible as evidence.

(a) The department may release confidential information from the trauma registry in compliance with applicable laws and regulations. No other person may release confidential information from the trauma registry without express written permission from the department.

(b) The department may approve requests for trauma registry data reports from qualified agencies or individuals, consistent with applicable statutes and rules. The department may charge reasonable costs associated with customized reports, prepared in response to such requests.

(c) The department has established criteria defining situations in which additional trauma registry information is confidential, in order to protect confidentiality for patients, providers, and facilities.

(d) Subsection (2)(a) through (d) of this section does not limit access to confidential data by approved regional quality assurance and improvement programs established under chapter 70.168 and described in WAC 246-976-910.

(3) Inclusion criteria: The department establishes inclusion criteria to identify those injured patients whom trauma services must report to the trauma registry.

(a) The criteria includes all patients who were discharged with International Classification of Diseases (ICD) diagnosis codes for injuries, drowning, burns, asphyxiation, or electrocution per the department's specifications and one of the following additional criteria:

(i) The trauma service trauma resuscitation team (full or modified) was activated for the patient;

(ii) The patient was dead on arrival at the trauma service;

(iii) The patient was dead at discharge from the trauma service;

(iv) The patient was transferred by ambulance into the trauma service from another facility;

(v) The patient was transferred by ambulance out of the trauma service to another acute care facility;

(vi) The patient was an adult patient (age fifteen or greater) and was admitted to the trauma service and had a length of stay of more than twenty-four hours;

(vii) The patient was a pediatric patient (ages under fifteen years) and was admitted to the trauma service, regardless of length of stay; or

(viii) The patient was an injured patient flown from the scene.

(b) For all licensed rehabilitation services, the criteria includes all patients who received rehabilitative care for acute injury or illness.

(4) Other data: The department and regional quality assurance programs may request data from medical examiners and coroners to be used in support of the trauma registry.

(5) Data submission: The department establishes procedures and format for trauma services to submit data electronically. These will include a mechanism for the reporting agency to check data for validity and completeness before data is sent to the trauma registry.

(6) Data quality: The department establishes mechanisms to evaluate the quality of trauma registry data. These mechanisms will include:

(a) Detailed protocols for quality control, consistent with the department's most current data quality guidelines.

(b) Validity studies to assess the timeliness, completeness and accuracy of case identification and data collection.

(7) Trauma registry reports:

(a) Annually, the department reports:

(i) Summary statistics and trends for demographic and related trauma care information for the state and for each emergency medical service/trauma care (EMS/TC) region;

(ii) Risk adjusted benchmarking and outcome measures, for system-wide evaluation and regional quality improvement programs;

(iii) Trends, patient care outcomes, and other data, for the state and each EMS/TC region, for the purpose of regional evaluation; and

(iv) Aggregate regional data upon request, excluding any confidential or identifying data.

(b) The department will provide reports to trauma services and qualified agencies upon request, according to the confidentiality provisions in subsection (2) of this section.

[Statutory Authority: RCW 70.168.060, 70.168.070, and 70.168.090. WSR 19-07-040, § 246-976-420, filed 3/14/19, effective 4/14/19. Statutory Authority: RCW 70.168.060 and 70.168.090. WSR 14-19-012, § 246-976-420, filed 9/4/14, effective 10/5/14; WSR 09-23-083, § 246-976-420, filed 11/16/09, effective 12/17/09; WSR 02-02-077, § 246-976-420, filed 12/31/01, effective 1/31/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-420, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-420, filed 12/23/92, effective 1/23/93.]

WAC 246-976-430 Trauma registry—Provider responsibilities. (1) A trauma care provider shall protect the confidentiality of data in their possession and as it is transferred to the department.

(2) A verified prehospital agency that transports trauma patients must:

(a) Provide an initial report of patient care to the receiving facility at the time the trauma patient is delivered as described in WAC 246-976-455.

(b) Within 24 hours after the trauma patient is delivered, send a complete patient care report to the receiving facility to include the data shown in Table A.

Table A:
Prehospital Patient Care Report Elements for the Washington Trauma Registry

Data Element	Prehospital-Transport:	Inter-Facility:
Incident Information		
Transporting emergency medical services (EMS) agency number	X	X
Unit en route date/time	X	
Patient care report number	X	X
First EMS agency on scene identification number	X	
Crew member level	X	X
Method of transport	X	X
Incident county	X	
Incident zip code	X	
Incident location type	X	
Patient Information		
Name	X	X
Date of birth, **or** age	X	X
Sex	X	X
Cause of injury	X	
Use of safety equipment	X	
Extrication required	X	
Transportation		
Facility transported from (code)		X
Times		
Unit notified by dispatch date/time	X	X
Unit arrived on scene date/time	X	X
Unit left scene date/time	X	X
Vital Signs		
Date/time of first vital signs taken	X	
First systolic blood pressure	X	
First respiratory rate	X	
First pulse	X	
First oxygen saturation	X	
First Glasgow coma score (GCS) with individual component values (eye, verbal, motor, total, and qualifier)	X	
Treatment		
Procedure performed	X	

(3) A designated trauma service must:

(a) Have a person identified as responsible for trauma registry activities, and who has completed the department trauma registry training course within 18 months of hire. For level I-III trauma serv-

ices the person identified must also complete the abbreviated injury scale (AIS) course within 18 months of hire;

(b) Report data elements for all patients defined in WAC 246-976-420;

(c) Report patients with a discharge date for each calendar quarter in a department-approved format by the end of the following quarter;

(d) Have procedures in place for internal monitoring of data validity, which may include methods to reabstract data for accuracy; and

(e) Correct and resubmit records that fail the department's validity tests as described in WAC 246-976-420(7) within three months of notification of errors.

(4) A designated trauma rehabilitation service must provide data, as identified in subsection (7) of this section, to the trauma registry in a format determined by the department upon request.

(5) A designated trauma service must submit the following data elements for trauma patients:

(a) Record identification data elements must include:

(i) Identification (ID) of reporting facility;

(ii) Date and time of arrival at reporting facility;

(iii) Unique patient identification number assigned to the patient by the reporting facility.

(b) Patient identification data elements must include:

(i) Name;

(ii) Date of birth;

(iii) Sex;

(iv) Race;

(v) Ethnicity;

(vi) Last four digits of the patient's Social Security number;

(vii) Home zip code.

(c) Prehospital data elements must include:

(i) Date and time of incident;

(ii) Incident zip code;

(iii) Mechanism/type of injury;

(iv) External cause codes;

(v) Injury location codes;

(vi) First EMS agency on-scene identification (ID) number;

(vii) Transporting agency ID and unit number;

(viii) Transporting agency patient care report number;

(ix) Cause of injury;

(x) Incident county code;

(xi) Work related;

(xii) Use of safety equipment;

(xiii) Procedures performed.

(d) Prehospital vital signs data elements (from first EMS agency on scene) must include:

(i) Time;

(ii) First systolic blood pressure;

(iii) First respiratory rate;

(iv) First pulse rate;

(v) First oxygen saturation;

(vi) First GCS with individual component values (eye, verbal, motor, total, and qualifiers);

(vii) Intubated at time of first vital sign assessment;

(viii) Pharmacologically paralyzed at time of first vital sign assessment;

(ix) Extrication.

(e) Transportation data elements must include:
(i) Date and time unit dispatched;
(ii) Time unit arrived at scene;
(iii) Time unit left scene;
(iv) Transportation mode;
(v) Transferred in from another facility;
(vi) Transferring facility ID number.
(f) Emergency department (ED) data elements must include:
(i) Readmission;
(ii) Direct admit;
(iii) Time ED physician was called;
(iv) Time ED physician was available for patient care;
(v) Trauma team activated;
(vi) Level of trauma team activation;
(vii) Time of trauma team activation;
(viii) Time trauma surgeon was called;
(ix) Time trauma surgeon was available for patient care;
(x) Vital signs in ED, which must also include:
(A) First systolic blood pressure;
(B) First temperature;
(C) First pulse rate;
(D) First spontaneous respiration rate;
(E) Controlled rate of respiration;
(F) First oxygen saturation measurement;
(G) Lowest systolic blood pressure (SBP);
(H) GCS score with individual component values (eye, verbal, motor, total, and qualifiers);
(I) Whether intubated at time of ED GCS;
(J) Whether pharmacologically paralyzed at time of ED GCS;
(K) Height;
(L) Weight;
(M) Whether mass casualty incident disaster plan implemented.
(xi) Injury scores must include:
(A) Injury severity score;
(B) Revised trauma score on admission;
(C) Pediatric trauma score on admission;
(D) Trauma and injury severity score.
(xii) ED procedures performed;
(xiii) Blood and blood components administered;
(xiv) Date and time of ED discharge;
(xv) ED discharge disposition, including:
(A) If transferred, ID number of receiving hospital;
(B) Was patient admitted to hospital?
(C) If admitted, the admitting service;
(D) Reason for transfer (sending facility).
(g) Diagnostic and consultative data elements must include:
(i) Whether the patient received aspirin in the four days prior to the injury;
(ii) Whether the patient received any oral antiplatelet medication in the four days prior to the injury, such as clopidogrel (Plavix), or other antiplatelet medication, and, if so, include:
(A) Whether the patient received any oral anticoagulation medication in the four days prior to the injury, such as warfarin (Coumadin), dabigatran (Pradaxa), rivaroxaban (Xarelto), or other anticoagulation medication, and, if so, include:
(B) The name of the anticoagulation medication.
(iii) Date and time of head computed tomography scan;

(iv) Date and time of first international normalized ratio (INR) performed at the reporting trauma service;

(v) Results of first INR performed at the reporting trauma service;

(vi) Date and time of first partial thromboplastin time (PTT) performed at the reporting trauma service;

(vii) Results of first PTT performed at the reporting trauma service;

(viii) Whether any attempt was made to reverse anticoagulation at the reporting trauma service;

(ix) Whether any medication (other than Vitamin K) was first used to reverse anticoagulation at the reporting trauma service;

(x) Date and time of the first dose of anticoagulation reversal medication at the reporting trauma service;

(xi) Elapsed time from ED arrival;

(xii) Date of rehabilitation consult;

(xiii) Blood alcohol content;

(xiv) Toxicology results;

(xv) Whether a brief substance abuse assessment, intervention, and referral for treatment done at the reporting trauma service;

(xvi) Comorbid factors/preexisting conditions;

(xvii) Hospital events.

(h) Procedural data elements:

(i) First operation information must include:

(A) Date and time operation started;

(B) Operating room (OR) procedure codes;

(C) OR disposition.

(ii) For later operations information must include:

(A) Date and time of operation;

(B) OR procedure codes;

(C) OR disposition.

(i) Admission data elements must include:

(i) Date and time of admission order;

(ii) Date and time of admission or readmission;

(iii) Date and time of admission for primary stay in critical care unit;

(iv) Date and time of discharge from primary stay in critical care unit;

(v) Length of readmission stay(s) in critical care unit;

(vi) Other in-house procedures performed (not in OR).

(j) Disposition data elements must include:

(i) Date and time of facility discharge;

(ii) Most recent ICD diagnosis codes/discharge codes, including nontrauma diagnosis codes;

(iii) Disability at discharge (feeding/locomotion/expression);

(iv) Total ventilator days;

(v) Discharge disposition location;

(vi) If transferred out, ID of facility the patient was transferred to;

(vii) If transferred to rehabilitation, facility ID;

(viii) Death in facility.

(A) Date and time of death;

(B) Location of death;

(C) Autopsy performed;

(D) Organ donation requested;

(E) Organs donated.

(ix) End-of-life care and documentation;

(A) Whether the patient had an end-of-life care document before injury;

(B) Whether there was any new end-of-life care decision documented during the inpatient stay at the reporting trauma service;

(C) Whether the patient receive a consult for comfort care, hospice care, or palliative care during the inpatient stay at the reporting trauma service;

(D) Whether the patient received any comfort care, in-house hospice care, or palliative care during the inpatient stay (i.e., was acute care withdrawn) at the reporting trauma service;

(k) Financial information must include:

(i) Total billed charges;

(ii) Payer sources (by category);

(iii) Reimbursement received (by payer category).

(6) Designated trauma rehabilitation services must provide the following data upon request by the department for patients identified in WAC 246-976-420(3).

(a) Data submission elements will be based on the current inpatient rehabilitation facility patient assessment instrument (IRF-PAI). All individual data elements included in the IRF-PAI categories below and defined in the data dictionary must be submitted upon request:

(i) Identification information;

(ii) Payer information;

(iii) Medical information;

(iv) Function modifiers (admission and discharge);

(v) Functional measures (admission and discharge);

(vi) Discharge information;

(vii) Therapy information.

(b) In addition to IRF-PAI data elements each rehabilitation service must submit the following information to the department:

(i) Admit from (facility ID);

(ii) Payer source (primary and secondary);

(iii) Total charges;

(iv) Total remitted reimbursement.

[Statutory Authority: RCW 43.70.040 and 70.168.090. WSR 24-15-130, § 246-976-430, filed 7/23/24, effective 9/30/24. Statutory Authority: RCW 70.168.060, 70.168.070, and 70.168.090. WSR 19-07-040, § 246-976-430, filed 3/14/19, effective 4/14/19. Statutory Authority: RCW 70.168.060 and 70.168.090. WSR 14-19-012, § 246-976-430, filed 9/4/14, effective 10/5/14; WSR 09-23-083, § 246-976-430, filed 11/16/09, effective 12/17/09; WSR 02-02-077, § 246-976-430, filed 12/31/01, effective 1/31/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-430, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-430, filed 12/23/92, effective 1/23/93.]

WAC 246-976-445 EMS data system—Department responsibilities. (1) Purpose: The department maintains a statewide electronic emergency medical services data system, as required by RCW 70.168.090. The purpose of this data system is to:

(a) Provide data for EMS activity surveillance, analysis, and quality assurance programs;

(b) Monitor and evaluate the outcome of care provided by EMS services personnel, in support of statewide and regional quality assurance and system evaluation activities;

(c) Assess compliance with state standards for EMS care (chapters 18.71, 18.73, 70.168 RCW and this chapter);

(d) Provide information for resource planning, system design and management; and

(e) Provide a resource for research and education.

(2) Confidentiality: RCW 70.168.090 and chapter 42.56 RCW apply to EMS data, records, and reports developed pursuant to RCW 70.168.090. Data elements related to the identification of individual patient's, provider's, and facility's care outcomes shall be confidential, shall be exempt from chapter 42.56 RCW, and shall not be subject to discovery by subpoena or admissible as evidence. Patient care quality assurance proceedings, records, and reports developed pursuant to RCW 70.168.090 are confidential, exempt from chapter 42.56 RCW, and are not subject to discovery by subpoena or admissible as evidence.

(a) The department may release confidential information from the electronic EMS data system in compliance with applicable laws and regulations. No other person may release confidential information from the data system without express written permission from the department.

(b) The department may approve requests for EMS data system data and reports consistent with applicable statutes and rules.

(c) The department has established criteria defining situations in which EMS data system information is confidential and situations in which data may be shared, in order to protect confidentiality for patients, providers, and facilities.

(d) Subsection (2)(a) through (c) of this section does not limit access to confidential data by approved regional quality assurance and improvement programs and medical program directors established under chapter 70.168 RCW and described in WAC 246-976-910 and 246-976-920.

(3) Data submission: The department establishes and maintains procedures and format for ambulance and aid services to submit data electronically. Reporting mechanisms will meet state requirements for data security, data interoperability, and national reporting standards. These will include a mechanism for the reporting agency to check data for validity and completeness before data is sent to WEMSIS.

(4) Data quality: The department establishes mechanisms to evaluate the quality of EMS data. These mechanisms will include:

(a) Detailed protocols for quality control, consistent with the department's most current data quality guidelines.

(b) Validity studies to assess the timeliness, completeness, and accuracy of case identification and data collection.

(5) Data reports and data sharing: The department may create, release, and provide access to data files and reports in accordance with RCW 70.168.090. The type of information contained in the file, including direct and indirect patient, provider and facility identifiers, determines the permitted release of, or access to, the data file or report.

(a) Annually, the department reports:

(i) Summary statistics and trends for demographic and related EMS care and activity information for the state and for each emergency medical service/trauma care (EMS/TC) region;

(ii) Benchmarking and performance measures, for system-wide evaluation and regional quality improvement programs;

(iii) Trends, patient care outcomes, and other data, for the state and each EMS/TC region, for the purpose of regional evaluation; and

(iv) Aggregate regional data upon request, excluding any confidential or identifying data.

(b) The department will provide reports to EMS services, approved regional quality assurance and improvement programs and medical program directors upon request, according to the confidentiality provisions in subsection (2) of this section and all applicable laws and regulations.

(c) In order to comply with WAC 246-976-920, the department may provide aggregate reports and directly identifiable patient record access to medical program directors for EMS services within their jurisdiction.

(d) In order to comply with RCW 70.168.090, the department will provide reports, patient data and record access related to suspected drug overdoses to government agencies, including local public health agencies, tribal authorities, and other organizations at the discretion of the department, for the purposes of including, but not limited to, identifying individuals to engage substance use disorder peer professionals, patient navigators, outreach workers, and other professionals as appropriate to prevent further overdoses and to induct into treatment and provide other needed supports as may be available. Data for this purpose will be provided upon request and according to the confidentiality provisions in subsection (2) of this section and all applicable laws and regulations.

(e) The department may share confidential data files containing one or more direct patient identifiers with researchers with approval from the Washington state institutional review board (IRB) and a signed confidentiality agreement. The department may also require researchers to enter into a data sharing agreement.

(f) The department may provide a hospital with access to the complete electronic patient care report for activations in which the patient was delivered to their facility.

(g) The department may provide data and reports to other parties not listed in (c) through (f) of this subsection upon request, according to the confidentiality provisions in subsection (2) of this section and all applicable laws and regulations.

(h) When fulfilling a request for data, the department may provide the fewest data elements and patient records necessary for the stated purpose of a requestor's project.

[Statutory Authority: RCW 43.70.040 and 70.168.090. WSR 24-15-130, § 246-976-445, filed 7/23/24, effective 9/30/24.]

WAC 246-976-455 EMS data system—EMS service and provider responsibilities. (1) Licensed EMS services and certified EMS providers shall protect the confidentiality of data in their possession and as it is transferred to the receiving facility or the department.

(2) The certified EMS provider in charge of patient care shall provide the following information to the receiving facility staff:

(a) At the time of arrival at the receiving facility, a minimum of a brief written or electronic patient report including agency name, EMS personnel, and:

(i) Date and time of the medical emergency;

(ii) Time of onset of symptoms;

(iii) Patient vital signs including serial vital signs where applicable;

(iv) Patient assessment findings;

(v) Procedures and therapies provided by EMS personnel;

(vi) Any changes in patient condition while in the care of the EMS personnel;

(vii) Mechanism of injury or type of illness.

(b) Within 24 hours of arrival, a complete written or electronic patient care report that includes at a minimum:

(i) Names and certification levels of all personnel providing patient care;

(ii) Date and time of medical emergency;

(iii) Age of patient;

(iv) Applicable components of system response time;

(v) Patient vital signs, including serial vital signs if applicable;

(vi) Patient assessment findings;

(vii) Procedures performed and therapies provided to the patient; this includes the times each procedure or therapy was provided;

(viii) Patient response to procedures and therapies while in the care of the EMS provider;

(ix) Mechanism of injury or type of illness;

(x) Patient destination.

(c) For trauma patients, all other data points identified in WAC 246-976-430 for inclusion in the trauma registry must be submitted to the receiving facility within 10 days of transporting the patient to the trauma center.

(3) A licensed EMS service must:

(a) Within 48 hours after the initial dispatch, send a complete electronic patient care report to the department for all activations that meet inclusion criteria in subsection (4) of this section.

The electronic patient care reports must:

(i) Be sent in a secure format determined by the department; and

(ii) Include all data elements specified in subsection (5) of this section.

(b) Submit any and all updates or modifications to previously submitted electronic patient care reports to the department within 48 hours of the update.

(c) EMS services who are unable to submit or update electronic patient care reports within 48 hours should notify the department within 30 days from when the delay began. The service must work with the department to submit a modified submission plan in a format determined by the department.

(d) Identify one or more EMS service WEMSIS administrator(s) responsible for EMS data activities. An EMS service WEMSIS administrator must:

(i) Complete the department EMS data system training course within 18 months of being assigned to this role;

(ii) Adhere to WEMSIS data confidentiality restrictions determined by the department; and

(iii) Act as the primary contact for the department regarding WEMSIS related communications including those pertaining to data submission, data validity, data quality, account access, and reporting;

(iv) Adhere to processes and protocols for WEMSIS data use and access as determined by the department.

(e) Notify the department within 30 days of any change or addition of EMS service WEMSIS administrators or a change to an administrator's contact information. Changes submitted must be made on forms provided by the department.

(f) Have procedures in place for internal monitoring of data validity, which may include methods to reabstract data for accuracy.

(g) Correct and resubmit patient care records that fail the department's validity tests as described in WAC 246-976-445 within 30 days of notification of errors.

(h) Make all patient care records available for inspection and review upon request of the county MPD or the department. Records provided shall be in electronic format where capabilities allow and will be provided in the most secure method available.

(i) By January 31st each year, submit or update EMS service demographic information for the previous calendar year in a format determined by the department. Demographic information should include:

(i) EMS dispatch volume;

(ii) EMS patient transport volume;

(iii) EMS patient contact volume;

(iv) EMS interfacility transport volume;

(v) EMS interfacility transport volume by ALS;

(vi) EMS interfacility transport volume by ILS;

(vii) EMS interfacility transport volume by BLS;

(viii) EMS interfacility transport volume by first response;

(ix) EMS interfacility transport volume by second response;

(x) EMS ground transport volume;

(xi) EMS air transport volume;

(xii) EMS critical care transport volume.

(4) Inclusion criteria: Ambulance and aid services must submit electronic patient care reports for all activations to which they are dispatched. Criteria includes 911 and interfacility activations where treatment or transport occurred, patient refusal of treatment or transport, and canceled activations. All activations which cross Washington borders and involve a Washington licensed ambulance or aid service must be included if the service is dispatched to a location in Washington state or if a patient is transported to a facility in Washington state.

(5) A licensed ambulance or aid service must submit data elements in adherence with the National Emergency Medical Services Information System (NEMSIS) national EMS data standards and requirements except where they differ from the reporting requirements specified in subsection (6) of this section.

(6) In addition to adhering to the NEMSIS EMS data standards, all licensed ambulance or aid services must submit the following data elements for all records where applicable:

Patient last name;

Patient first name;

Middle initial or name;

Patient Social Security number;

Gender;

Race;

Age;

Age units;

Patient date of birth;

Patient driver's license;

Patient home address;

Alternate home residence;

Patient phone number;
Recent exposure to infectious disease;
Recent travel;
Recent local travel;
Recent international travel;
Recent state travel;
Recent city travel;
Temperature;
Respiratory effort;
Chest/lungs assessment;
Ending travel date;
Beginning travel date;
Personal protective equipment used;
Airway device placement confirmed method;
Cardiac arrest during EMS event;
Cardiac arrest etiology;
Cardiac arrest, resuscitation attempted by EMS;
Cardiac arrest, witnessed by;
Cardiac arrest, who first initiated CPR;
Patient evaluation/care;
Crew disposition;
Transport disposition;
Reason for refusal/release;
Destination/transferred to, name;
Destination/transferred to, code;
Destination street address;
Destination zip code;
EMS transport method;
Final patient acuity;
Type of destination;
Destination team prearrival activation;
Mental status assessment;
Medication allergies;
Medical/surgical history;
Trauma triage criteria;
Cause of injury code;
Use of safety equipment;
Extrication required;
Hospital disposition;
Procedure performed date/time;
Procedure performed prior to EMS care;
Procedure performed;
Procedure number of attempts;
Procedure successful;
Symptom onset date/time;
Symptom, primary;
Symptoms, other associated;
Provider's primary impression;
Provider's secondary impression;
Last known well date/time;
PSAP call date/time;
Dispatch notified date/time;
Unit arrived on scene date/time;
Unit arrived at patient date/time;
Unit left scene date/time;
Patient arrived at destination date/time;
Destination patient transfer of care date/time.

Vital signs:
Date/time of first vital signs taken;
First systolic blood pressure;
First respiratory rate;
First pulse;
First oxygen saturation;
First Glasgow coma score (GCS) with individual component values (eye, verbal, motor, total, and qualifier);
Vital sign, taken date/time;
Vital sign, obtained prior to EMS care;
Vital sign, cardiac rhythm/ECG;
Vital sign, ECG type;
Vital sign, blood glucose level;
Vital sign, stroke scale score;
Vital sign, stroke scale type;
Vital sign, stroke scale value/severity score - LAMS;
Type of scene delay;
First EMS unit on scene;
Incident zip code;
Incident county;
Scene GPS location;
Incident location type;
Facility transported from (code);
Other EMS or public safety agencies at scene;
Type of other service at scene;
Medication administered;
Medication administered route;
Date/time medication administered;
Medication administered prior to this unit's EMS care;
Medication response;
Role/type of person administering medication;
Alcohol/drug use indicators;
Respiratory rate;
Total Glasgow coma score;
Eye assessment;
ACS risk score.
Incident information:
Emergency medical services (EMS) agency number;
Unit enroute date/time;
Patient care report number;
First EMS agency on scene identification number;
Crew member level;
Method of transport;
Incident location type;
Patient information.
Outcome (if known):
Emergency department disposition;
Hospital disposition;
External report ID/number type;
External report ID/number;
Emergency department diagnosis;
Hospital diagnosis.

[Statutory Authority: RCW 43.70.040 and 70.168.090. WSR 24-15-130, § 246-976-455, filed 7/23/24, effective 9/30/24.]

DESIGNATION OF TRAUMA CARE FACILITIES

WAC 246-976-580 Trauma designation process. The department designates health care facilities to provide adult and pediatric acute care trauma services ("trauma services") and adult and pediatric trauma rehabilitation services ("trauma rehabilitation services") as part of the statewide emergency medical services and trauma care (EMS&TC) system. This section describes the designation process.

(1) The department must:

(a) Provide written notification to all licensed hospitals and to other health care facilities that a new designation period is beginning. The written notification and the EMS&TC regional plans are posted on the department's website;

(b) Provide a trauma designation application schedule outlining the steps and timeline requirements for a facility to apply for trauma service designation. The schedule must provide each facility at least ninety days to complete an application for trauma designation. The application schedule is posted on the department's website;

(c) Provide an application for each level, type and combination of designation. Designation applications are released region by region, according to the established schedule;

(d) Conduct a site review for any hospital applying for level I, II, or III adult and pediatric trauma service designation to determine compliance with required standards;

(e) Initiate a three-year contract with successful applicants to authorize participation in the trauma system.

(2) To apply for trauma service designation the health care facility must do the following according to the application schedule:

(a) Request an application;

(b) Submit a letter of intent to apply for trauma service designation indicating what level they are applying for;

(c) Submit a completed application(s);

(d) For health care facilities applying for level I, II, III adult and pediatric trauma service designation, the facility must complete a site review arranged and conducted by the department according to the following process:

(i) The department will contract with trauma surgeons and trauma nurses to conduct the site review. The review team members must:

(A) Work outside the state of Washington, for level I and II site reviews;

(B) Work outside the applicant's EMS&TC region, for level III site reviews;

(C) Maintain the confidentiality of all documents examined, in accordance with RCW 70.41.200 and 70.168.070. This includes, but is not limited to, all trauma patient data, staff discussions, patient, provider, and facility care outcomes, and any reports resulting from the site review;

(D) Present their preliminary findings to the health care facility at the end of the site review visit;

(ii) The department will provide the applicant the names of review team members prior to the site review. Any objections must be sent to the department within ten days of receiving the department's notification of review team members;

(iii) A site review fee, as established in WAC 246-976-990, is charged and must be paid by the health care facility to the department prior to the site review. A standard fee schedule is posted on the department's website. For facilities applying for more than one type of designation or for joint designation, fee rates can be obtained by contacting the department;

(iv) The applicant must provide the department and the site review team full access to the facility, facility staff, and all records and documents concerning trauma care including trauma patient data, education, training and credentialing documentation, standards of care, policies, procedures, protocols, call schedules, medical records, quality improvement materials, receiving facility patient feedback, and other relevant documents;

(e) For health care facilities applying for level IV or V trauma service designation, level I or II trauma rehabilitation service designation or level I pediatric trauma rehabilitation service designation, the department may, at its discretion, conduct a site review as part of the application process to determine compliance with required standards. If a site review is conducted, the process will be the same as identified in (d) of this subsection, except a site review fee will not be charged.

(3) The department will designate the health care facilities it considers most qualified to provide trauma care services including when there is competition for trauma service designation within a region. There is competition for designation within a region when the number of applications for a level and type of designation is more than the maximum number of trauma services identified in the approved EMS&TC regional plan. The department will evaluate, at a minimum, the following in making its decisions:

(a) The quality of the health care facility's performance based on:

(i) The submitted application, attachments, and any other information the department requests from the facility to verify compliance, or the ability to comply with trauma standards;

(ii) Recommendations from the site review team;

(iii) Trauma patient outcomes during the previous designation period, if applicable;

(iv) Compliance with the contract during the previous designation period, if applicable;

(b) The health care facility's conformity with the EMS&TC regional and state plans, based on:

(i) The impact of the facility's designation on the effectiveness of the trauma system;

(ii) Patient volumes for the area;

(iii) The number, level, and distribution of trauma services identified in the state and approved regional plans;

(iv) The facility's ability to comply with state and regional EMS&TC plan goals.

(4) After trauma service designation decisions are made in a region, the department will:

(a) Notify each applicant in writing of the department's designation decision;

(b) Send each applicant a written report summarizing the department's findings, recommendations and additional requirements to maintain designation. If a site review was conducted as part of the application process, the review team findings and recommendations are also included in the written report. Reports are sent:

(i) Within sixty days of announcing designation decisions for level IV and V trauma services and trauma rehabilitation services;

(ii) Within one hundred twenty days of the site review for level I, II and III adult and pediatric trauma services and any other facility that received a site review as part of the application process;

(c) Notify the EMS&TC regional council of designation decisions within the region and all subsequent changes in designation status;

(d) Initiate a trauma designation contract with successful applicants. The contract will include:

(i) Authority from the department to participate in the state trauma system, receive trauma patients from EMS agencies, and provide trauma care services for a three-year period;

(ii) The contractual and financial requirements and responsibilities of the department and the trauma service;

(iii) A provision to allow the department to monitor compliance with trauma service standards;

(iv) A provision to allow the department to have full access to trauma patient data, the facility, equipment, staff and their credentials, education, training documentation, and all trauma care documents such as: Standards of care, policies, procedures, protocols, call schedules, medical records, quality improvement documents, receiving facility patient feedback, and other relevant documents;

(v) The requirement to maintain confidentiality of information relating to individual patient's, provider's and facility's care outcomes under RCW 70.41.200 and 70.168.070;

(e) Notify the designated trauma service and other interested parties in the region of the next trauma designation application process at least one hundred fifty days before the contract expires.

(5) Designated trauma services may ask the department to conduct a site review for technical assistance at any time during the designation period. The department has the right to require reimbursement for the costs of conducting the site review.

(6) The department will not approve an application for trauma service designation if the applicant:

(a) Is not the most qualified, when there is competition for designation; or

(b) Does not meet the trauma care standards for the level applied for; or

(c) Does not meet the requirements of the approved EMS&TC regional plan; or

(d) Has made a false statement about a material fact in its designation application; or

(e) Refuses to permit the department to examine any part of the facility that relates to the delivery of trauma care services, including, but not limited to, records, documentation, or files.

(7) If the department denies an application, the department will send the facility a written notice to explain the reasons for denial and to explain the facility's right to appeal the department's decision in accordance with chapters 34.05 RCW and 246-10 WAC.

(8) To ensure adequate trauma care in the state, the department may:

(a) Provisionally designate health care facilities that are not able to meet all the requirements of this chapter. The provisional designation will not be for more than two years. A department-approved plan of correction must be prepared by the health care facility specifying steps necessary to bring the facility into compliance and an expected date of compliance. The department may conduct a site review to

verify compliance with required standards. If a site review is conducted, the department has the right to require reimbursement for the cost of conducting the site review;

(b) Consider additional applications at any time, regardless of the established schedule, if necessary to attain the numbers and levels of trauma services identified in the approved EMS&TC regional and state plan;

(c) Consider applications from hospitals located and licensed in adjacent states. The department will evaluate an out-of-state application in the same manner as all other applications. However, if the out-of-state applicant is designated as a trauma service in an adjacent state with an established trauma system whose standards meet or exceed Washington's standards and there is no competition for designation at that level, then the department may use the administrative findings, conclusions, and decisions of the adjacent state's designation evaluation to make the decision to designate. Additional information may be requested by the department to make a final decision.

(9) The department may suspend or revoke a trauma designation if the facility or any owner, officer, director, or managing employee:

(a) Is substantially out of compliance with trauma care standards WAC 246-976-700 through 246-976-800 or chapter 70.168 RCW and has refused or is unwilling to comply after a reasonable period of time;

(b) Makes a false statement of a material fact in the designation application, or in any document required or requested by the department, or in a matter under investigation;

(c) Prevents, interferes with, or attempts to impede in any way, the work of a department representative in the lawful enforcement of chapter 246-976 WAC, 34.05 RCW, 246-10 WAC, or 70.168 RCW;

(d) Uses false, fraudulent, or misleading advertising, or makes any public claims regarding the facility's ability to care for non-trauma patients based on its trauma designation status;

(e) Misrepresents or is fraudulent in any aspect of conducting business.

(10) The Administrative Procedure Act, chapter 34.05 RCW, and chapter 246-10 WAC govern the suspension and revocation process. The department will use the following process to suspend or revoke a facility's trauma designation:

(a) The department will send the facility a written notice to explain the reasons it intends to suspend or revoke the designation and to explain the facility's right to a hearing to contest the department's intended action under WAC 246-10-201 through 246-10-205;

(b) The notice will be sent at least twenty-eight days before the department takes action, unless it is a summary suspension, as provided for in the Administrative Procedure Act, chapter 34.05 RCW and WAC 246-10-301 through 246-10-306;

(c) If a facility requests a hearing within twenty-eight days of the date the notice was mailed, a hearing before a health law judge will be scheduled. If the department does not receive the facility's request for a hearing within twenty-eight days of the date the notice was mailed, the facility will be considered in default under WAC 246-10-204;

(d) For nonsummary suspensions, in addition to its request for a hearing, the facility may submit a plan within twenty-eight days of receiving the notice of the department's intent to suspend, describing how it will correct deficiencies:

(i) The department will approve or disapprove the plan within thirty days of receipt;

(ii) If the department approves the plan, the facility must begin to implement it within thirty days;

(iii) The facility must notify the department when the problems are corrected;

(iv) If, prior to sixty days before the scheduled hearing, the facility is able to successfully demonstrate to the department that it is meeting the requirements of chapters 246-976 WAC and 70.168 RCW, which may require a site review at the facility's expense, the department will withdraw its notice of intent to suspend designation;

(e) The department will notify the regional EMS&TC council of the actions it has taken.

(11) A facility may seek judicial review of the department's final decision under the Administrative Procedure Act, RCW 34.05.510 through 34.05.598.

(12) A newly designated or upgraded trauma service must meet education requirements for all applicable personnel according to the following schedule:

(a) At the time of the new designation, twenty-five percent of all personnel must meet the education and training requirements in WAC 246-976-700 through 246-976-800;

(b) At the end of the first year of designation, fifty percent of all personnel must meet the education and training requirements in WAC 246-976-700 through 246-976-800;

(c) At the end of the second year of designation, seventy-five percent of all personnel must meet the education and training requirements defined in WAC 246-976-700 through 246-976-800;

(d) At the end of the third year of designation, and all subsequent designation periods, ninety percent of all personnel must meet the education and training requirements defined in WAC 246-976-700 through 246-976-800.

(13) All currently designated trauma services must have a written education plan with a process for tracking and assuring that new physicians and staff meet all trauma education requirements within the first eighteen months of employment.

[Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 18-24-082, § 246-976-580, filed 12/3/18, effective 1/3/19. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070. WSR 09-23-085, § 246-976-580, filed 11/16/09, effective 12/17/09.]

WAC 246-976-700 Trauma service standards.

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(1) A written trauma scope of service outlining the trauma care resources and capabilities available twenty-four hours every day for:	X	X	X	X	X	X	X	X
(a) Adult and pediatric trauma patient care;	X	X	X	X	X			
(b) Pediatric trauma patient care.						X	X	X
(2) A trauma medical director responsible for the organization and direction of the trauma service who:	X	X	X	X	X	X	X	X
(a) Is currently certified in advanced trauma life support (ATLS);	X	X	X			X	X	X
(b) Is a board-certified general surgeon;	X	X						
(c) Is a board-certified general surgeon **or** general surgeon trained in advanced cardiac life support (ACLS);			X					

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(d) Is a board-certified general surgeon, emergency physician, a general surgeon ACLS trained with current certification in advanced trauma life support (ATLS) or a physician ACLS trained and current certification in ATLS;				X				
(e) Is a board-certified general surgeon, emergency physician, a physician ACLS trained with current certification in ATLS, or a physician assistant or advanced registered nurse practitioner ACLS trained who is currently certified in ATLS;					X			
(f) Is a board-certified pediatric surgeon or a board-certified general surgeon with special competence in the care of pediatric patients;						X	X	
(g) Is a board-certified general surgeon with special competence in the care of pediatric patients or a general surgeon ACLS trained and with special competence in the care of pediatric patients;								X
(h) Must complete thirty-six hours in three years of verifiable, external, trauma-related continuing medical education (CME);	X	X				X	X	
(i) Meets the pediatric education requirement (PER) as defined in subsection (27) of this section;	X	X	X	X	X	X	X	X
(j) Must have responsibility and authority for determining each general surgeon's ability to participate on the trauma call panel based on an annual review, conducted in conjunction with medical staffing and with authority through the trauma quality improvement program and hospital policy;	X	X	X			X	X	X
(k) Is a member of and actively participates in a regional or national trauma organizations.	X	X				X	X	
(3) A trauma program manager or trauma service coordinator responsible for the overall operation of trauma service who:	X	X	X	X	X	X	X	X
(a) Is a registered nurse;	X	X	X	X	X	X	X	X
(b) Has taken ACLS;	X	X	X	X	X	X	X	X
(c) Has successfully completed a trauma nursing core course (TNCC) or a department approved equivalent course, and successfully completes thirty-six hours of trauma-related education every three years in either external continuing education or in an internal education process conducted by the trauma program. The trauma education must include, but is not limited to, the following topics:	X	X	X	X	X	X	X	X
(i) Mechanism of injury;	X	X	X	X	X	X	X	X
(ii) Shock and fluid resuscitation;	X	X	X	X	X	X	X	X
(iii) Initial assessment;	X	X	X	X	X	X	X	X
(iv) Stabilization and transport.	X	X	X	X	X	X	X	X
(d) Has taken pediatric advanced life support (PALS) or emergency nursing pediatric course (ENPC), and thereafter meets the PER contact hours as defined in subsection (27) of this section;	X	X	X	X	X			
(e) Has current PALS or ENPC certification;						X	X	X
(f) Has attended a trauma program manager orientation course provided by the department or a department approved equivalent, within the first eighteen months in the role;	X	X	X	X	X	X	X	X
(g) Is responsible for the overall supervision of the trauma registry and the quality of data submitted to the registry.	X	X	X	X	X	X	X	X
(4) A multidisciplinary trauma quality improvement program that must:	X	X	X	X	X	X	X	X
(a) Be led by the multidisciplinary trauma service committee:	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(i) The trauma medical director serves as chair of the multidisciplinary trauma service committee;	X	X	X	X	X	X	X	X
(ii) The trauma medical director must attend a minimum of fifty percent of the peer review committee meetings;	X	X	X	X	X	X	X	X
(iii) The trauma medical director and trauma program manager must have the authority and be empowered by the hospital governing body to lead the program to ensure compliance with trauma service standards.	X	X	X	X	X	X	X	X
(b) Demonstrate a continuous quality improvement process supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement;	X	X	X	X	X	X	X	X
(c) Have membership representation and participation that reflects the facility's trauma scope of service;	X	X	X	X	X	X	X	X
(d) Have an organizational structure that facilitates the process of quality improvement with a reporting relationship to the hospital's administrative team and medical executive committee that ensures adequate evaluation of all aspects of trauma care;	X	X	X	X	X	X	X	X
(e) Have authority to establish trauma care standards and implement patient care policies, procedures, guidelines, and protocols throughout the hospital and the trauma service must use clinical practice guidelines, protocols, and algorithms derived from evidence-based validated resources;	X	X	X	X	X	X	X	X
(f) Have a current trauma quality improvement plan that outlines the trauma service's quality improvement process;	X	X	X	X	X	X	X	X
(g) Have a process to monitor and track compliance with the trauma care standards using audit filters and benchmarks;	X	X	X	X	X	X	X	X
(h) Have a process to evaluate the care provided to trauma patients and to resolve identified prehospital, physician, nursing, or system issues;	X	X	X	X	X	X	X	X
(i) Have a process in which outcome measures are documented within the trauma quality improvement program's written plan which must be reviewed and updated at least annually. Outcome measures will include, at a minimum:	X	X	X	X	X	X	X	X
(i) Mortality (with and without opportunities for improvement);								
(ii) Trauma surgeon response time (level I-III);								
(iii) Undertriage rate;								
(iv) Emergency department length of stay greater than three hours for patients transferred out;								
(v) Missed injuries;								
(vi) Complications.								
(j) Have a process for correcting problems or deficiencies;	X	X	X	X	X	X	X	X
(k) Have a process for problem resolution, outcome improvements, and assurance of safety. This process must be readily identifiable through methods of monitoring, reevaluation, benchmarking, and documentation;	X	X	X	X	X	X	X	X
(l) Have a process to continuously evaluate compliance with full and modified (if used) trauma team activation criteria as follows:	X	X	X	X	X	X	X	X
(i) The attending surgeon's arrival within fifteen minutes for level II and thirty minutes for level III services for patients with appropriate activation criteria must be monitored by the hospital's trauma quality improvement program;	X	X	X			X	X	X
(ii) All trauma team activations must be categorized by the level of response activation and quantified by number and percentage;	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(iii) Trauma surgeon response time to full activations and for back-up call response must be determined and monitored. Variances should be documented and reviewed for reason for delay, opportunities for improvement, and corrective actions; and	X	X	X			X	X	X
(iv) Rates of undertriage must be monitored and reviewed quarterly.	X	X	X	X	X	X	X	X
(m) Have assurance from other hospital quality improvement committees, including peer review if conducted separately from the multidisciplinary trauma service committee, that resolution was achieved on trauma-related issues. The following requirements must also be satisfied:	X	X	X	X	X	X	X	X
(i) Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion;	X	X	X	X	X	X	X	X
(ii) A process must be in place to ensure that the trauma program manager receives feedback from peer review for trauma-related issues;	X	X	X	X	X	X	X	X
(iii) All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review;	X	X	X	X	X	X	X	X
(iv) This effort must involve the participation and leadership of the trauma medical director and any departments, such as: General surgery, emergency medicine, orthopedics, neurosurgery, anesthesia, critical care, lab and radiology; and	X	X	X	X	X	X	X	X
(v) The multidisciplinary trauma peer review committee must systematically review significant complications and process variances associated with unanticipated outcomes and determine opportunities for improvement.	X	X	X	X	X	X	X	X
(n) Have a process to ensure the confidentiality of patient and provider information, in accordance with RCW 70.41.200 and 70.168.090;	X	X	X	X	X	X	X	X
(o) Have a process to communicate with and provide feedback to referring trauma services and trauma care providers;	X	X	X	X	X	X	X	X
(p) Be able to integrate trauma quality improvement into the hospital's quality improvement program for level III, IV, V trauma services or level III pediatric trauma services with a total annual trauma volume of less than one hundred patients; however, trauma care must be formally addressed in accordance with the quality improvement requirements in this subsection. In that case, the trauma medical director is not required to serve as chair;			X	X	X			X
(q) Have a pediatric-specific trauma quality improvement program for a trauma service admitting at least one hundred pediatric trauma patients annually. For a trauma service admitting less than one hundred pediatric trauma patients annually, or that is transferring trauma patients, the trauma service must review each case for timeliness and appropriateness of care;	X	X	X	X	X	X	X	X
(r) Be a multidisciplinary trauma quality improvement program that transcends normal department hierarchies and includes:	X	X	X	X	X	X	X	X
Identified medical staff representatives or their designees from departments of general surgery, emergency medicine, orthopedics, neurosurgery, anesthesiology, critical care, and radiology who must participate actively in the multidisciplinary trauma quality improvement program with at least fifty percent attendance at peer review committee meetings.	X	X	X			X	X	X
(s) Use risk-adjusted data for benchmarking and performance improvement:	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(i) The risk-adjusted benchmarking system to measure performance must be the American College of Surgeons Trauma Quality Improvement Program (TQIP);	X	X				X	X	
(ii) Data must be collected in compliance with the National Trauma Data Standard (NTDS) and submitted to the National Trauma Data Bank® (NTDB®) every year in a timely fashion so that data can be aggregated and analyzed at the national level;	X	X				X	X	
(iii) Use risk-adjusted data provided by the state for the purposes of benchmarking and performance improvement.			X	X	X			X
(5) Written trauma service standards of care to ensure appropriate care throughout the facility for:	X	X	X	X	X	X	X	X
(a) Adult and pediatric trauma patients;	X	X	X	X	X			
(b) Pediatric trauma patients.						X	X	X
(6) Participation in the regional quality improvement program as defined in WAC 246-976-910.	X	X	X	X	X	X	X	X
(7) Participation in the Washington state trauma registry as defined in WAC 246-976-430.	X	X	X	X	X	X	X	X
(8) Written transfer-in guidelines consistent with the facility's designation level and trauma scope of service. The guidelines must identify the type, severity and complexity of injuries the facility can safely accept, admit, and provide with definitive care.	X	X	X	X	X	X	X	X
(9) Written transfer-out guidelines consistent with the facility's designation level and trauma scope of service. The guidelines must identify the type, severity and complexity of injuries that exceed the resources and capabilities of the trauma service.	X	X	X	X	X	X	X	X
(a) Collaborative treatment and transfer guidelines reflecting facilities' capabilities must be developed and regularly reviewed, with input from higher-level trauma services that receive these patients;			X	X	X			
(b) The decision to transfer an injured patient to a specialty care facility in an acute situation must be based solely on the needs of the patient and not on the requirements of the patient's specific provider network, health maintenance organization, a preferred provider organization, or the patient's ability to pay;	X	X	X	X	X	X	X	X
(c) Acute transfers out must be subjected to individual case review to determine the rationale for transfer, appropriateness of care, and opportunities for improvement. Follow-up from the center to which the patient was transferred should be obtained as part of the case review; and	X	X	X	X	X	X	X	X
(d) Trauma patients must not be admitted or transferred by a primary care physician without the knowledge and consent of the trauma service. The quality improvement program should monitor adherence to this guideline.	X	X	X			X	X	X
(10) Written interfacility transfer agreements with all trauma services that receive the facility's trauma patients. Agreements must include a process to identify medical control during the interfacility transfer, and address the responsibilities of the trauma service, the receiving hospital, and the verified prehospital transport agency. All trauma patients must be transported by a trauma verified prehospital transport agency.	X	X	X	X	X	X	X	X
(11) An air medical transport plan addressing the receipt or transfer of trauma patients with a heli-stop, landing zone, or airport located close enough to permit the facility to receive or transfer trauma patients by fixed-wing or rotary-wing aircraft.	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(12) A written diversion protocol for the emergency department to divert trauma patients from the field to another trauma service when resources are temporarily unavailable. The process must include:	X	X	X	X	X	X	X	X
(a) Trauma service and patient criteria used to decide when diversion is necessary;	X	X	X	X	X	X	X	X
(b) How the divert status will be communicated to the nearby trauma services and prehospital agencies;	X	X	X	X	X	X	X	X
(c) How the diversion will be coordinated with the appropriate prehospital agency;	X	X	X	X	X	X	X	X
(d) A method of documenting/tracking when the trauma service is on trauma divert, including the date, time, duration, reason, and decision maker;	X	X	X	X	X	X	X	X
(e) Assurance that the decision to divert patients from the emergency department is communicated to the trauma surgeon on-call;	X	X	X			X	X	X
(f) Involvement of the trauma surgeon in the decision regarding diversion each time the center goes on bypass;	X	X				X	X	
(g) Routine monitoring, documenting and reporting of trauma center diversion hours, including the reason for initiating the diversion policy. Trauma center diversion must not exceed five percent of the time.	X	X	X			X	X	X
(13) A trauma team activation protocol consistent with the facility's trauma scope of service. The protocol must:	X	X	X	X	X	X	X	X
(a) Define the physiologic, anatomic, and mechanism of injury criteria used to activate the full and modified (if used) trauma teams;	X	X	X	X	X	X	X	X
(b) Identify members of the full and modified (if used) trauma teams consistent with the provider requirements of this chapter;	X	X	X	X	X	X	X	X
(c) Define the process to activate the trauma team. The process must:	X	X	X	X	X	X	X	X
(i) Consistently apply the trauma service's established criteria;	X	X	X	X	X	X	X	X
(ii) Use information obtained from prehospital providers or an emergency department assessment for patients not delivered by a prehospital agency;	X	X	X	X	X	X	X	X
(iii) Be applied regardless of time post injury or previous care, whether delivered by prehospital or other means and whether transported from the scene or transferred from another facility;	X	X	X	X	X	X	X	X
(iv) Include a method to upgrade a modified activation to a full activation when newly acquired information warrants additional capabilities and resources;	X	X	X	X	X	X	X	X
(v) Include the mandatory presence of a general surgeon for full trauma team activations. The general surgeon assumes leadership and overall care using professional judgment regarding the need for surgery or transfer;	X	X	X			X	X	X
(vi) Include the mandatory presence of a general surgeon if general surgery services are included in the facility's trauma scope of service. The general surgeon assumes leadership and overall care using professional judgment regarding the need for surgery or transfer;				X				
(vii) For trauma team activations in pediatric designated trauma services (within five minutes for level I, twenty minutes for level II or thirty minutes for level III), one of the following pediatric physician specialists must respond:						X	X	X
(A) A pediatric surgeon;								
(B) A pediatric emergency medicine physician;								

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(C) A pediatric intensivist;								
(D) A pediatrician;								
(E) A postgraduate year two or higher pediatric resident.								
(viii) Require multisystem injured patients to be admitted to or evaluated by an identifiable surgical service staffed by credentialed trauma providers.	X	X	X					
(14) Emergency care services available twenty-four hours every day with:	X	X	X	X	X	X	X	X
(a) An emergency department (except for level V clinics);	X	X	X	X	X	X	X	X
(b) The ability to resuscitate and stabilize adult and pediatric trauma patients in a designated resuscitation area;	X	X	X	X	X			
(c) The ability to resuscitate and stabilize pediatric trauma patients in a designated resuscitation area;						X	X	X
(d) A medical director, who:	X	X	X			X	X	X
(i) Is board-certified in emergency medicine, board-certified in general surgery, or is board-certified in another relevant specialty practicing emergency medicine as their primary practice;	X	X	X					
(ii) Is board-certified in pediatric emergency medicine, board-certified in emergency medicine with special competence in the care of pediatric patients, board-certified in general surgery with special competence in the care of pediatric patients, or board-certified in a relevant specialty practicing emergency medicine as their primary practice with special competence in the care of pediatric patients.						X	X	X
(e) Emergency physicians who:	X	X	X	X	X	X	X	X
(i) Are board-certified in emergency medicine or board-certified in a relevant specialty practicing emergency medicine as their primary practice. This requirement can be met by a postgraduate year two or higher emergency medicine or general surgery resident working under the direct supervision of the attending emergency physician. The resident must be available within five minutes of notification of the patient's arrival to provide leadership and care until arrival of the general surgeon;	X	X						
(ii) Are board-certified in pediatric emergency medicine, are board-certified in emergency medicine with special competence in the care of pediatric patients, **or** are board-certified in a relevant specialty practicing emergency medicine as their primary practice with special competence in the care of pediatric patients. This requirement can be met by a postgraduate year two or higher emergency medicine or general surgery resident with special competence in the care of pediatric trauma patients and working under the direct supervision of the attending emergency physician. The resident must be available within five minutes of notification of the patient's arrival to provide leadership and care until arrival of the general surgeon;						X	X	
(iii) Are board-certified in emergency medicine or another relevant specialty practicing emergency medicine as their primary practice **or** physicians practicing emergency medicine as their primary practice with current certification in ACLS and ATLS;			X					
(iv) Are board-certified in pediatric emergency medicine, are board-certified in emergency medicine or surgery, with special competence in the care of pediatric patients, are board-certified in a relevant specialty practicing emergency medicine as their primary practice, with special competence in the care of pediatric patients, **or** are physicians with current certification in ATLS who are practicing emergency medicine as their primary practice with special competence in the care of pediatric patients;								X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(v) Are board-certified in emergency medicine or another relevant specialty and practicing emergency medicine as their primary practice **or** physicians with current certification in ACLS and ATLS. A physician assistant (PA) or advanced registered nurse practitioner (ARNP) current in ACLS and ATLS may initiate evaluation and treatment upon the patient's arrival in the emergency department until the arrival of the physician;				X				
(vi) Are board-certified or qualified in emergency medicine, surgery, or other relevant specialty and practicing emergency medicine as their primary practice **or** are physicians with current certification in ACLS and ATLS, **or** are PAs or ARNPs with current certification in ACLS and ATLS;					X			
(vii) Are available within five minutes of notification of the patient's arrival in the emergency department;	X	X	X			X	X	X
(viii) Are on-call and available within twenty minutes of notification of the patient's arrival in the emergency department;				X	X			
(ix) Are currently certified in ACLS and ATLS. This requirement applies to all emergency physicians and residents who care for trauma patients in the emergency department except this requirement does not apply to physicians who are board-certified in emergency medicine **or** board-certified in another relevant specialty and practicing emergency medicine as their primary practice;	X	X	X	X	X			
(x) Are currently certified in ATLS. This requirement applies to all emergency physicians and residents who care for pediatric patients in the emergency department except this requirement does not apply to physicians who are board-certified in pediatric emergency medicine, board-certified in emergency medicine, **or** board-certified in another relevant specialty and practicing emergency medicine as their primary practice;						X	X	X
(xi) Meet the PER as defined in subsection (27) of this section;	X	X	X	X	X	X	X	X
(xii) If the liaison or designee from emergency medicine, must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(xiii) If they are emergency physicians who participate on the trauma team, they must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(xiv) Nonboard-certified emergency physicians and advanced practitioners who participate in the initial care or evaluation of trauma activated patients in the emergency department must have current ATLS certification;	X	X	X	X	X	X	X	X
(xv) Must be able to provide initial resuscitative care to known trauma activated patients;	X	X	X			X	X	X
(xvi) Have completed appropriate orientation, credentialing, initial ED management/evaluation processes, and skill maintenance for advanced practitioners who participate in the initial assessment of trauma patients.	X	X	X	X	X	X	X	X
(f) Emergency care registered nurses (RNs) who:	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(i) Are in the emergency department and available within five minutes of notification of patient's arrival;	X	X	X			X	X	X
(ii) Are in-house and available within five minutes of notification of the patient's arrival;				X	X			
(iii) Have current certification in ACLS;	X	X	X	X	X			
(iv) Have successfully completed TNCC or a department approved equivalent course;	X	X	X	X	X	X	X	X
(v) Have completed twelve hours of trauma related education every designation period. The trauma education must include, but is not limited to, the following topics:	X	X	X	X		X	X	X
(A) Mechanism of injury;								
(B) Shock and fluid resuscitation;								
(C) Initial assessment;								
(D) Stabilization and transport.								
(vi) Meet the PER as defined in subsection (27) of this section.	X	X	X	X	X	X	X	X
(g) Standard emergency equipment for the resuscitation and life support of adult and pediatric trauma patients, including:	X	X	X	X	X	X	X	X
(i) Immobilization devices:	X	X	X	X	X	X	X	X
(A) Back board;	X	X	X	X	X	X	X	X
(B) Cervical injury;	X	X	X	X	X	X	X	X
(C) Long-bone.	X	X	X	X	X	X	X	X
(ii)(A) Infusion control device:	X	X	X	X	X	X	X	X
(B) Rapid infusion capability.	X	X	X			X	X	X
(iii) Intraosseous devices;	X	X	X	X	X	X	X	X
(iv) Sterile surgical sets:	X	X	X	X	X	X	X	X
(A) Thoracostomy with closed drainage devices;	X	X	X	X	X	X	X	X
(B) Emergency transcutaneous airway;	X	X	X	X	X	X	X	X
(C) Bedside ultrasound;	X	X	X	X		X	X	X
(D) Thoracotomy;	X	X	X			X	X	X
(v) Thermal control equipment:	X	X	X	X	X	X	X	X
(A) Blood and fluid warming;	X	X	X	X	X	X	X	X
(B) Thermometer capable of detecting hypothermia;	X	X	X	X	X	X	X	X
(C) Patient warming and cooling.	X	X	X	X	X	X	X	X
(vi) Other equipment:	X	X	X	X	X	X	X	X
(A) Medication chart, tape, or other system to assure ready access to information on proper doses-per-kilogram for resuscitation drugs and equipment sizes for pediatric patients;	X	X	X	X	X	X	X	X
(B) Pediatric emergency airway equipment readily available or transported in-house with the pediatric patient for evaluation, treatment or diagnostics, including bag-valve masks, face masks, and oral/nasal airways.	X	X	X	X	X	X	X	X
(15) Respiratory therapy services, with a respiratory care practitioner available within five minutes of notification of patient's arrival.	X	X	X			X	X	X
(16) Diagnostic imaging services (except for level V clinics) with:	X	X	X	X	X	X	X	X
(a) A radiologist in person or by teleradiology, who is:	X	X	X			X	X	X
(i) On-call and available within twenty minutes of the trauma team leader's request;	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(ii) On-call and available within thirty minutes of the trauma team leader's request;			X					X
(iii) Board certified or eligible for certification by an appropriate radiology board according to current requirements for licensed radiologists who take trauma call.	X	X				X	X	
(b) Personnel able to perform routine radiological capabilities who are:	X	X	X	X	X	X	X	X
(i) Available within five minutes of notification of the patient's arrival;	X	X				X	X	
(ii) On-call and available within twenty minutes of notification of the patient's arrival.			X	X	X			X
(c) A technologist able to perform computerized tomography who is:	X	X	X			X	X	X
(i) Available within five minutes of the trauma team leader's request;	X					X		
(ii) On-call and available within twenty minutes of the trauma team leader's request.		X	X				X	X
(d) A radiologic peer review process that reviews routine interpretations of images for accuracy. Determinations related to trauma patients must be communicated to the trauma program quality committee;	X	X	X			X	X	X
(e) Angiography with a technologist on-call and available within thirty minutes of the trauma team leader's request;	X	X				X	X	
(f) Magnetic resonance imaging with a technologist on-call and available within sixty minutes of the trauma team leader's request;	X	X				X	X	
(g) Sonography with a technologist on-call and available within thirty minutes of the trauma team leader's request;	X	X				X	X	
(h) Interventional radiology services on-call and available within thirty minutes of the trauma team leader's request;	X	X				X	X	
(i) Radiologists who are involved, at a minimum, in protocol development and trend analysis that relate to diagnostic imaging;	X	X	X			X	X	X
(j) Facilities that have a mechanism in place to view radiographic imaging from referring hospitals that are within their catchment area.	X	X				X	X	
(17) Clinical laboratory services (except for level V clinics), with:	X	X	X	X	X	X	X	X
(a) Lab services available within five minutes of notification of the patient's arrival;	X	X	X			X	X	X
(b) Lab services on-call and available within twenty minutes of notification of the patient's arrival;				X	X			
(c) Blood gases and pH determination;	X	X	X	X		X	X	X
(d) Coagulation studies;	X	X	X	X	X	X	X	X
(e) Drug or toxicology measurements;	X	X	X	X	X	X	X	X
(f) Microbiology;	X	X	X	X	X	X	X	X
(g) Serum alcohol determination;	X	X	X	X	X	X	X	X
(h) Serum and urine osmolality;	X	X				X	X	
(i) Standard analysis of blood, urine, and other body fluids.	X	X	X	X	X	X	X	X
(18) Blood and blood-component services (except for level V clinics) with:	X	X	X	X	X	X	X	X
(a) Ability to obtain blood typing and crossmatching;	X	X	X	X	X	X	X	X
(b) Autotransfusion;	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(c) Blood and blood components available from in-house or through community services, to meet patient needs;	X	X	X	X	X	X	X	X
(d) Blood storage capability;	X	X	X	X		X	X	X
(e) Noncrossmatched blood available on patient arrival in the emergency department;	X	X	X	X	X	X	X	X
(f) Policies and procedures for massive transfusion.	X	X	X	X		X	X	X
(19) General surgery services with:	X	X	X			X	X	X
(a) Surgeons who meet the following requirements:	X	X	X			X	X	X
(i) Are board-certified in general surgery and available within fifteen minutes of notification of the patient's arrival when the full trauma team is activated. This requirement can be met by a postgraduate year four or higher surgery resident. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the general surgeon. In this case the general surgeon must be available within fifteen minutes of notification of patient's arrival;	X							
(ii) Are board-certified in pediatric surgery or board-certified in general surgery with special competence in the care of pediatric patients and are available within fifteen minutes of notification of the patient's arrival when the full trauma team is activated. This requirement can be met by a post graduate year four or higher pediatric surgery resident or a general surgery resident with special competence in the care of pediatric patients. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the pediatric or general surgeon. In this case the pediatric or general surgeon must be available within fifteen minutes of notification of patient's arrival;						X		
(iii) Are board-certified in general surgery. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is fifteen minutes or more. Otherwise the surgeon must be in the emergency department within fifteen minutes of notification of patient's arrival. This requirement can be met by a postgraduate year four or higher surgery resident. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the general surgeon;		X						
(iv) Are board-certified in pediatric surgery **or** board-certified in general surgery with special competence in the care of pediatric patients. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is fifteen minutes or more. Otherwise the surgeon must be in the emergency department within fifteen minutes of notification of patient's arrival. This requirement can be met by a postgraduate year four or higher pediatric surgery resident or a general surgical resident with special competence in the care of pediatric patients. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the pediatric or general surgeon;							X	
(v) Are board-certified or trained in ACLS and currently certified in ATLS. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is thirty minutes or more. Otherwise the surgeon must be in the emergency department within thirty minutes of notification of patient's arrival;			X					

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(vi) Are board-certified or board-qualified with special competence in the care of pediatric patients. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is thirty minutes or more. Otherwise the surgeon must be in the emergency department within thirty minutes of notification of patient's arrival;								X
(vii) Are trained in ACLS and currently certified in ATLS. This requirement applies to all surgeons and residents caring for trauma patients except this requirement does not apply to surgeons who are board certified in general surgery;	X	X	X					
(viii) Are currently certified in ATLS. This requirement applies to all surgeons and residents caring for pediatric trauma patients except this requirement does not apply to surgeons who are board certified in pediatric or general surgery;						X	X	X
(ix) Meet the PER as defined in subsection (27) of this section;	X	X	X			X	X	X
(x) Have privileges in general surgery;	X	X	X					
(xi) Maintain at least eighty percent attendance at activations with a mechanism for documenting this attendance record, as required for full trauma activations. The expectation is for one hundred percent attendance at activations;	X	X	X			X	X	X
(xii) The attending surgeon is expected to be present in the operating room for all operations. A mechanism for documenting this presence is required;	X	X	X			X	X	X
(xiii) A surgeon from the trauma call panel must participate in the hospital's disaster planning process;	X	X	X			X	X	X
(xiv) Each member of the group of general surgeons must attend at least fifty percent of the peer review committee meetings;	X	X				X	X	
(xv) If at least fifty percent of the general surgeons did not attend the peer review committee meetings, then the trauma service must be able to demonstrate that there is a formal process for communicating information from the committee meetings to the group of general surgeons.			X					X
(b) A published schedule for first call with a written plan for surgery coverage if the surgeon on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma service's total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma service's trauma quality improvement program. In addition:	X	X	X			X	X	X
(i) Surgical commitment is required for a properly functioning trauma center;	X	X	X			X	X	X
(ii) The trauma surgeon on call must be dedicated to a single trauma center while on duty;	X	X				X	X	
(iii) The liaison from general surgery must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(iv) Other general surgeons who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal.	X	X				X	X	
(c) General surgery services that meet all level III general surgery service standards if the facility's trauma scope of service includes general surgery services twenty-four hours every day **or** transfer trauma patients who need general surgery services to a designated trauma service with general surgery services available.				X				
(20) Neurosurgery services with neurosurgeons who meet the following requirements:	X	X				X	X	
(a) Are board-certified, and available within five minutes of the trauma team leader's request;	X					X		
This requirement can be met by a postgraduate year four or higher neurosurgery resident. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the neurosurgeon. In this case the neurosurgeon must be available within thirty minutes of the trauma team leader's request.	X					X		
(b) Are board-certified or board-qualified and on-call and available within thirty minutes of the trauma team leader's request;		X					X	
(c) Are board-certified or board-qualified and on-call and available within thirty minutes of the trauma team leader's request if the facility's trauma scope of service includes neurosurgery services twenty-four hours every day **or** transfer trauma patients who need neurosurgery services to a designated trauma service with neurosurgery services available;			X	X				X
(d) The liaison from neurosurgery must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(e) Other neurosurgeons who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(f) The facility must have a predefined and thoroughly developed neurotrauma diversion plan that is implemented when the neurosurgeon on call becomes encumbered. A neurotrauma diversion plan must include the following:	X	X				X	X	
(i) Emergency medical services notification of neurosurgery advisory status/divert;	X	X				X	X	
(ii) A thorough review of each instance by the quality improvement program; and	X	X				X	X	
(iii) Monitoring of the efficacy of the process by the quality improvement program.	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(g) A published schedule for first call with a written plan for neurosurgery coverage is required, for when the neurosurgeon on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma services total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma services trauma quality improvement program;	X	X				X	X	
(h) If one neurosurgeon covers two trauma services within the same limited geographic area, there must be a contingency plan.	X	X				X	X	
(21) Surgical services on-call and available within thirty minutes of the trauma team leader's request for:	X	X	X			X	X	X
(a) Cardiac surgery;	X					X		
(b) Microsurgery;	X					X		
(c) Obstetric surgery **or** for level III trauma services, a plan to manage the pregnant trauma patient;	X	X	X			X	X	X
(d) Orthopedic surgery including the following:	X	X	X			X	X	X
(i) Orthopedic team members must have dedicated call at their institution or have an effective backup call system;	X	X				X	X	
(ii) If the on-call orthopedic surgeon is unable to respond promptly, a backup consultant on-call surgeon must be available;	X	X				X	X	
(iii) If the orthopedic surgeon is not dedicated to a single facility while on call, then a published backup schedule is required;			X					X
(iv) A published schedule for first call with a written plan for orthopedic surgery coverage is required for when the orthopedic surgeon on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma services total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma services trauma quality;	X	X	X			X	X	X
(v) The liaison from orthopedic surgery must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(vi) Other orthopedic surgeons who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal.	X	X				X	X	
(e) Orthopedic surgery services on-call and available within thirty minutes of the trauma team leader's request if the facility's trauma scope of service includes orthopedic surgery services twenty-four hours every day or transfer trauma patients who need orthopedic surgery services to a designated trauma service with orthopedic surgery services available;				X				
(f) Thoracic surgery;	X	X				X	X	
(g) Urologic surgery;	X	X				X	X	
(h) Vascular surgery.	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(22) Surgical services on-call for patient consultation or management at the trauma team leader's request for:	X	X				X	X	
(a) Cranial facial surgery;	X	X				X	X	
(b) Gynecologic surgery;	X	X				X	X	
(c) Ophthalmic surgery;	X	X				X	X	
(d) Plastic surgery.	X	X				X	X	
(23) Anesthesiology services with board-certified anesthesiologists or certified registered nurse anesthetists (CRNAs) who meet the following requirements:	X	X	X			X	X	X
(a) Are available within five minutes of the trauma team leader's request;	X					X		
(b) Are on-call and available within twenty minutes of the trauma team leader's request;		X					X	
(c) Are on-call and available within thirty minutes of the trauma team leader's request;			X					X
(d) Are ACLS trained except this requirement does not apply to physicians board-certified in anesthesiology;	X	X	X			X	X	X
(e) Are highly experienced and committed to the care of injured patients; who organize and supervise the anesthetic care of injured patients; and who serve as the designated liaison to the trauma program;	X	X				X	X	
(f) When anesthesiology senior residents or CRNAs are used to fulfill availability requirements, the attending anesthesiologist on call must be advised, available within thirty minutes at all times, and present for all operations;	X	X				X	X	
(g) A published schedule for first call, with a written plan for anesthesia coverage is required for when the anesthesia provider on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma services total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma services trauma quality improvement program;	X	X	X			X	X	X
(h) Meet the PER as defined in subsection (27) of this section;	X	X	X			X	X	X
(i) Meet all level III anesthesiology service standards if the facility's trauma scope of service includes surgery services twenty-four hours every day **or** transfer trauma patients who need surgery services to a designated trauma service with surgery services available.				X				
(24) Operating room services with:	X	X	X			X	X	X
(a) Hospital staff responsible for opening and preparing the operating room available within five minutes of notification;	X	X	X			X	X	X
(b) Operating room staff on-call and available within fifteen minutes of notification;	X	X				X	X	
(c) Operating room staff on-call and available within thirty minutes of notification;			X					X
(d) A written plan to mobilize additional surgical team members for trauma patient surgery;	X	X	X			X	X	X
(e) Delays in operating room availability routinely monitored. Any case that is associated with a significant delay or adverse outcome must be reviewed for reasons for delay and opportunity for improvement;	X	X	X			X	X	X
(f) Standard surgery instruments and equipment needed to perform operations on adult and pediatric patients, including:	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(i) Blood recovery and transfusion;	X	X	X			X	X	X
(ii) Bronchoscopy equipment;	X	X	X			X	X	X
(iii) Cardiopulmonary bypass;	X	X				X	X	
(iv) Craniotomy set;	X	X				X	X	
(v) Endoscopy equipment;	X	X	X			X	X	X
(vi) Rapid infusion capability;	X	X	X			X	X	X
(vii) Thermal control equipment:	X	X	X			X	X	X
(A) Blood and fluid warming;	X	X	X			X	X	X
(B) Patient warming and cooling.	X	X	X			X	X	X
(g) Operating room services that meet all level III operating room service standards if the facility's trauma scope of care includes surgery services twenty-four hours every day **or** transfer trauma patients who need surgery services to a designated trauma service with surgery services available.				X				
(25) Post anesthesia care (PACU) services with:	X	X	X			X	X	X
(a) At least one registered nurse available twenty-four hours every day;	X					X		
(b) At least one registered nurse on-call and available twenty-four hours every day;		X	X				X	X
(c) Registered nurses who are ACLS trained;	X	X	X			X	X	X
(d) PACU equipment to monitor and resuscitate patients, including:	X	X	X			X	X	X
(i) Pulse oximetry;								
(ii) End-tidal carbon dioxide detection;								
(iii) Arterial pressure monitoring;								
(iv) Patient rewarming.								
(e) Post anesthesia care services that meet all level III post anesthesia care service standards if the facility's trauma scope of care includes general surgery services twenty-four hours every day **or** transfer trauma patients who need surgery services to a designated trauma service with surgery services available.				X				
(26) Critical care services with:	X	X	X			X	X	
(a) A critical care medical director who is:	X	X	X			X	X	
(i) Board-certified in:	X							
(A) Surgery and critical care;	X							
(B) Pediatric critical care.						X		
(ii) Board-certified in critical care **or** board-certified in surgery, internal medicine, or anesthesiology with special competence in critical care;		X	X					
(iii) Board-certified in critical care with special competence in pediatric critical care **or** is board-certified in surgery, internal medicine, or anesthesiology with special competence in pediatric critical care;							X	
(iv) Responsible for coordinating with the attending physician for trauma patient care.	X	X	X			X	X	
(b) Physician coverage of critically ill trauma patients in the intensive care unit (ICU) by appropriately trained physicians who meet the following requirements:	X	X	X			X	X	X
(i) Must be available in-house within fifteen minutes, twenty-four hours per day;	X					X		

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(ii) Must be available within fifteen minutes, twenty-four hours per day;		X					X	
(iii) Must be available within thirty minutes with a formal plan in place for emergency coverage.			X					X
(c) For all levels of trauma service, the quality improvement program must ensure timely and appropriate ICU coverage is provided;	X	X	X			X	X	X
(d) The timely response of credentialed providers to the ICU must be continuously monitored as part of the quality improvement program;	X	X	X			X	X	X
(e) A designated ICU physician liaison or designee to the trauma service. This liaison must attend at least fifty percent of the multidisciplinary peer review meetings with documentation by the trauma quality improvement program;	X	X	X			X	X	X
(f) The physician liaison or designee from the ICU must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(g) Other ICU physicians who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(h) Critical care registered nurses who:	X	X	X			X	X	
(i) Are ACLS trained;	X	X	X					
(ii) Have special competence in pediatric critical care;						X	X	
(iii) Have completed a minimum of six contact hours of trauma specific education every three-year designation period;	X	X				X	X	
(iv) Have completed a minimum of three contact hours of trauma specific education every three-year designation period.			X					
(i) A physician directed code team;	X	X	X			X	X	
(j) Pediatric patient isolation capacity;						X	X	
(k) General surgery consults for critical care trauma patients **or** if intensivists are the primary admitting nonsurgical physician caring for trauma patients, the intensivists must complete a minimum of twelve hours of external or internal trauma critical care specific CME every three-year designation period;	X	X	X			X	X	X
(l) Standard critical care equipment for adult and pediatric trauma patients, including:	X	X	X			X	X	
(i) Cardiac devices:	X	X	X			X	X	
(A) Cardiac pacing capabilities;	X	X	X			X	X	
(B) Cardiac monitor with at least two pressure monitoring modules (cardiac output and hard copy recording), with the capability to continuously monitor heart rate, respiratory rate, and temperature.	X	X	X			X	X	
(ii) Intracranial pressure monitoring devices;	X	X				X	X	
(iii) Intravenous supplies:	X	X	X			X	X	
(A) Infusion control device;	X	X	X			X	X	
(B) Rapid infusion capability.	X	X	X			X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(iv) Sterile surgical sets:	X	X	X			X	X	
(A) Thoracostomy;	X	X	X			X	X	
(B) Emergency surgical airway;	X	X	X			X	X	
(C) Bedside ultrasound;	X	X	X			X	X	
(D) Thoracotomy.	X	X	X			X	X	
(v) Thermal control equipment:	X	X	X			X	X	
(A) Blood and fluid warming;	X	X	X			X	X	
(B) Devices for assuring warmth during transport;	X	X	X			X	X	
(C) Expanded scale thermometer capable of detecting hypothermia;	X	X	X			X	X	
(D) Patient warming and cooling.	X	X	X			X	X	
(m) A written policy to transfer all pediatric trauma patients who need critical care services to a pediatric designated trauma service with critical care services available;	X	X	X					
(n) Surgical collaboration to set and implement policies and administrative decisions impacting trauma patients admitted to the ICU;	X	X	X			X	X	X
(o) Critical care services that meet all level III critical care service standards, if the facility's trauma scope of service includes critical care services for trauma patients twenty-four hours every day **or** transfer trauma patients who need critical care services to a designated trauma service with critical care services available;				X				
(p) Critical care services that meet all level II pediatric critical care service standards if the facility's trauma scope of care includes pediatric critical care services for trauma patients twenty-four hours every day **or** transfer pediatric trauma patients who need critical care services to a designated pediatric trauma service, with pediatric critical care services available.								X
(27) Pediatric education requirement (PER):	X	X	X	X	X	X	X	X
(a) The pediatric trauma medical director and the liaisons from neurosurgery, orthopedic surgery, emergency medicine, and critical care medicine must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;						X	X	
(b) PER must be met by the following providers who are directly involved in the initial resuscitation and stabilization of pediatric trauma patients:	X	X	X	X	X	X	X	X
(i) Emergency department physicians;	X	X	X	X	X	X	X	X
(ii) Emergency department registered nurses;	X	X	X	X	X	X	X	X
(iii) Physician assistants or ARNPs who participate in the initial care or evaluation of trauma activated patients in the emergency department;	X	X	X	X	X	X	X	X
(iv) Emergency medicine or surgical residents who initiate care prior to the arrival of the emergency physician;	X	X				X	X	
(v) General surgeons;	X	X	X			X	X	X
(vi) Surgical residents who initiate care prior to the arrival of the general surgeon;	X	X				X	X	
(vii) Anesthesiologists and CRNAs;	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(viii) General surgeons, anesthesiologists, and CRNAs if the facility's trauma scope of service includes general surgery services twenty-four hours every day;				X				
(ix) Intensivists involved in the resuscitation, stabilization and in-patient care of pediatric trauma patients.						X	X	X
(c) PER must be met by completing pediatric specific contact hours as defined below:	X	X	X	X	X	X	X	X
(i) Five contact hours per provider during each three-year designation period;	X	X	X	X	X			
(ii) Seven contact hours per provider during each three-year designation period;						X	X	X
(iii) Contact hours should include, but are not limited to, the following topics:	X	X	X	X	X	X	X	X
(A) Initial stabilization and transfer of pediatric trauma;	X	X	X	X	X	X	X	X
(B) Assessment and management of pediatric airway and breathing;	X	X	X	X	X	X	X	X
(C) Assessment and management of pediatric shock, including vascular access;	X	X	X	X	X	X	X	X
(D) Assessment and management of pediatric head injuries;	X	X	X	X	X	X	X	X
(E) Assessment and management of pediatric blunt abdominal trauma.	X	X	X	X	X	X	X	X
(iv) Contact hours may be accomplished through one or more, but not limited to, the following methods:	X	X	X	X	X	X	X	X
(A) Review and discussion of individual pediatric trauma cases within the trauma quality improvement program;	X	X	X	X	X	X	X	X
(B) Staff meetings;	X	X	X	X	X	X	X	X
(C) Classes, formal or informal;	X	X	X	X	X	X	X	X
(D) Web-based learning;	X	X	X	X	X	X	X	X
(E) Certification in ATLS, PALS, APLS, ENPC, or other department approved equivalents;	X	X	X	X	X	X	X	X
(F) Other methods of learning which appropriately communicates the required topics listed in this section.	X	X	X	X	X	X	X	X
(28) Acute dialysis services or must transfer trauma patients needing dialysis.	X	X	X	X	X	X	X	X
(29) A burn center, in accordance with the American Burn Association, to care for burn patients or must transfer burn patients to a burn center, in accordance with the American Burn Association transfer guidelines.	X	X	X	X	X	X	X	X
(30) Services on-call for consultation or patient management:	X	X	X			X	X	X
(a) Cardiology;	X	X				X	X	
(b) Gastroenterology;	X	X				X	X	
(c) Hematology;	X	X				X	X	
(d) Infectious disease specialists;	X	X				X	X	
(e) Internal medicine;	X	X	X					
(f) Nephrology;	X	X				X	X	
(g) Neurology;	X	X				X	X	
(h) Pediatric neurology;						X	X	
(i) Pathology;	X	X	X			X	X	X
(j) Pediatrician;	X	X				X	X	X
(k) Pulmonology;	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(l) Psychiatry **or** a plan for management of the psychiatric trauma patient.	X	X				X	X	
(31) Ancillary services available for trauma patient care:	X	X	X	X	X	X	X	X
(a) Adult protective services;	X	X	X	X	X			
(b) Child protective services;	X	X	X	X	X	X	X	X
(c) Chemical dependency services;	X	X	X			X	X	X
(d) Nutritionist services;	X	X	X	X		X	X	X
(e) Occupational therapy services;	X	X	X			X	X	X
(f) Pastoral or spiritual care;	X	X	X	X	X	X	X	X
(g) Pediatric therapeutic recreation/child life specialist;						X	X	
(h) Pharmacy services, with an in-house pharmacist;	X					X		
(i) Pharmacy services;		X	X	X	X		X	X
(j) Physical therapy services;	X	X	X	X		X	X	X
(k) Psychological services;	X	X	X			X	X	X
(l) Social services;	X	X	X	X		X	X	X
(m) Speech therapy services.	X	X	X			X	X	X
(32) A trauma care outreach program, including:	X	X				X	X	
(a) Telephone consultations with physicians of the community and outlying areas;	X	X				X	X	
(b) On-site consultations with physicians of the community and outlying areas.	X	X				X	X	
(33) Injury prevention, including:	X	X	X	X	X	X	X	X
(a) A public injury prevention education program to include:	X	X	X			X	X	X
(i) An employee in a leadership position that has injury prevention as part of their job description;	X	X	X	X	X	X	X	X
(ii) Registry data used to identify injury prevention priorities that are appropriate for local implementation;	X	X	X	X	X	X	X	X
(iii) Trauma centers that have an organized and effective approach to injury prevention and prioritize those efforts based on local trauma registry and epidemiologic data.	X	X	X	X	X	X	X	X
(b) Participation in community or regional injury prevention activities that include partnerships with other community organizations;	X	X	X	X	X	X	X	X
(c) A written plan for drug and alcohol screening and brief intervention and referral for treatment;	X	X	X	X	X	X	X	X
(d) Screening and brief intervention for drug and alcohol use. All patients who have screened positive must receive an intervention by appropriately trained staff and this intervention must be documented.	X	X	X	X	X	X	X	X
(34) A formal trauma education training program for:	X	X				X	X	
(a) Allied health care professional;	X	X				X	X	
(b) Community physicians;	X	X				X	X	
(c) Nurses;	X	X				X	X	
(d) Prehospital personnel;	X	X				X	X	
(e) Staff physicians.	X	X				X	X	
(35) Provisions to allow for initial and maintenance training of invasive manipulative skills for prehospital personnel.	X	X	X	X		X	X	X
(36) Residency programs that must:	X					X		

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(a) Be accredited by the Accreditation Council of Graduate Medical Education;	X					X		
(b) Be committed to training physicians in trauma management.	X					X		
(37) A trauma research program conducting research applicable to the adult and pediatric trauma patient population, including:	X					X		
(a) At a minimum, a trauma research program that publishes twenty peer-reviewed articles in journals included in Index Medicus or PubMed within a three-year period;	X					X		
(b) These publications must result from work related to the trauma center or the trauma system in which the trauma center participates;	X					X		
(c) Of the twenty articles, at least one must be authored or co-authored by members of the general surgery trauma team;	X					X		
(d) At least one article each from three of the following disciplines is required: Basic sciences, neurosurgery, emergency medicine, orthopedics, radiology, anesthesia, vascular surgery, plastics/maxillofacial surgery, critical care, cardiothoracic surgery, rehabilitation, and nursing;	X					X		
(e) In combined level I adult and pediatric centers, half of the required research must be pediatric research;	X					X		
(f) The administration of a level I trauma center must demonstrate support for the research program by including the provision of basic laboratory space, sophisticated research equipment, advanced information systems, biostatical support, salary support for basic and translational scientists, or seed grants for less experienced faculty.	X					X		
(38) For joint trauma service designation (when two or more hospitals apply to share a single trauma designation):	X	X	X			X	X	X
(a) A single, joint multidisciplinary trauma quality improvement program in accordance with the trauma quality improvement standards defined in subsection (4) of this section;	X	X	X			X	X	X
(b) A set of common policies and procedures adhered to by all hospitals and providers in the joint trauma service;	X	X	X			X	X	X
(c) A predetermined, published hospital rotation schedule for trauma care.	X	X	X			X	X	X
(39) Trauma centers must meet the disaster-related requirements of the facility's accrediting agency.	X	X	X	X	X	X	X	X
(40) Organ procurement activities, including:	X	X	X			X	X	X
(a) An established relationship with a recognized organ procurement organization (OPO);	X	X	X			X	X	X
(b) A written policy in place for notification of the regional OPO;	X	X	X			X	X	X
(c) The trauma center must review its organ donation rate annually;	X	X	X			X	X	X
(d) Written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death.	X	X	X			X	X	X

[Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 18-24-082, § 246-976-700, filed 12/3/18, effective 1/3/19. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070. WSR 09-23-085, § 246-976-700, filed 11/16/09, effective 12/17/09.]

WAC 246-976-800 Trauma rehabilitation service standards.

WAC 246-976-800 Trauma Rehabilitation Service Standards	Levels			
A designated trauma rehabilitation service must:	**I**	**II**	**III**	**I Pediatric**
(1) Be a licensed hospital as defined in chapter 246-320 WAC.	X			X
(2) Treat adult and adolescent trauma patients in inpatient and outpatient settings regardless of disability or level of severity or complexity.	X			
(3) Treat pediatric and adolescent trauma patients in inpatient and outpatient settings regardless of disability or level of severity or complexity.				X
(4) Treat adult and adolescent trauma patients in inpatient and outpatient settings with disabilities or level of severity or complexity within the facility's capability and as specified in the facility's admission criteria.		X		
(5) For adolescent patients (approximately twelve to eighteen years of age), the service must consider whether physical development, educational goals, preinjury learning or developmental status, social or family needs, and other factors indicate treatment in an adult or pediatric rehabilitation service.	X	X		X
(6) Have and retain full accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) for inpatient medical rehabilitation programs.	X	X		
(7) Have and retain full accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) for pediatric inpatient medical rehabilitation programs.				X
(8) House patients on a designated rehabilitation nursing unit.	X	X		
(9) House patients in a designated pediatric rehabilitation area, providing an environment appropriate to the age and developmental status of the patient.				X
(10) Provide a peer group for persons with similar disabilities.	X	X		X
(11) Have a medical director who: (a) Is a physiatrist; (b) Is responsible for the organization and direction of the trauma rehabilitation service; and (c) Participates in the trauma rehabilitation service's quality improvement program.	X	X		X
(12) Have a physiatrist in-house or on-call twenty-four hours every day and responsible for the day-to-day clinical management and the treatment plan of trauma patients.	X	X		X
(13) Provide rehabilitation nursing personnel twenty-four hours every day, with:	X	X		X
(a) Management and supervision by a registered nurse;	X	X		X
(b) The initial care plan and weekly update reviewed and approved by a certified rehabilitation registered nurse (CRRN);	X	X		X
(c) An orientation and training program for all levels of rehabilitation nursing personnel;	X	X		X
(d) A minimum of six clinical nursing care hours, per patient day, for each trauma patient;	X	X		X
(e) At least one CRRN on duty, each day and evening shift, when a trauma patient is present;	X			X
(f) At least one CRRN on duty, one shift each day, when a trauma patient is present.		X		
(14) Provide the following trauma rehabilitation services with providers who are licensed, registered, certified, or degreed and are available to provide treatment as defined in the patient's rehabilitation plan:	X	X		X
(a) Occupational therapy;	X	X		X
(b) Physical therapy;	X	X		X
(c) Speech/language pathology;	X	X		X
(d) Social services;	X	X		X
(e) Nutritional counseling;	X	X		X
(f) Clinical psychological services, including testing and counseling;	X	X		X
(g) Neuropsychological services.	X	X		X
(15) Provide the following health personnel and consultative services in-house or on-call twenty-four hours every day:	X	X		X
(a) A pharmacist with immediate access to pharmaceuticals and patient medical records and pharmacy databases;	X	X		X

WAC 246-976-800 Trauma Rehabilitation Service Standards	Levels			
A designated trauma rehabilitation service must:	**I**	**II**	**III**	**I Pediatric**
(b) Respiratory care practitioners;	X	X		X
(c) Pastoral or spiritual care;	X	X		X
(d) A radiologist;	X	X		X
(e) A pediatrician.				X
(16) Provide the following services in-house or through affiliation or consultative arrangements with providers who are licensed, registered, certified, or degreed:	X	X		X
(a) Anesthesiology (anesthesiologist or CRNA);	X	X		X
(b) Audiology;	X	X		X
(c) Communication augmentation;	X	X		X
(d) Dentistry;	X	X		X
(e) Diagnostic imaging, including: (i) Computerized tomography; (ii) Magnetic resonance imaging; (iii) Nuclear medicine; and (iv) Radiology;	X	X		X
(f) Driver evaluation and training;	X	X		
(g) Educational program appropriate to the disability and developmental level of the pediatric or adolescent patient, to include educational screening, instruction, and discharge planning coordinated with the receiving school district;	X	X		X
(h) Electrophysiologic testing, including: (i) Electroencephalography; (ii) Electromyography; and (iii) Evoked potentials;	X	X		X
(i) Laboratory services;	X	X		X
(j) Orthotics;	X	X		X
(k) Prosthetics;	X	X		X
(l) Pediatric therapeutic recreation specialist or child life specialist;				X
(m) Rehabilitation engineering for device development and adaptations;	X	X		X
(n) Substance abuse counseling;	X	X		X
(o) Therapeutic recreation;	X	X		X
(p) Vocational rehabilitation;	X	X		
(q) Urodynamic testing.	X	X		X
(17) Have providers with documented special competence in pediatric rehabilitation care. This requirement applies to all pediatric trauma rehabilitation providers.				X
(18) Serve as a regional referral center for patients in their geographical area needing only level II or III rehabilitation care.	X			
(19) Have an outreach program regarding trauma rehabilitation care, consisting of telephone and on-site consultations with physicians and other health care professionals in the community and outlying areas.	X	X		X
(20) Have a formal program of continuing trauma rehabilitation care education, both in-house and outreach, provided for nurses and allied health care professionals.	X	X		X
(21) Have an ongoing structured program to conduct clinical studies, applied research, or analysis in rehabilitation of trauma patients, and report results within a peer review process.	X			X
(22) Have a quality improvement program that reflects and demonstrates a process for continuous quality improvement in the delivery of trauma rehabilitation care, with: (a) An organizational structure and plan that facilitates the process of quality improvement and identifies the authority to change policies, procedures, and protocols that address the care of the trauma patient;	X	X		X

WAC 246-976-800 Trauma Rehabilitation Service Standards	Levels			
A designated trauma rehabilitation service must:	**I**	**II**	**III**	**I Pediatric**
(b) Representation and participation by the interdisciplinary trauma rehabilitation team; (c) A process for communicating and coordinating with referring trauma care providers as needed; (d) Development of outcome standards; (e) A process for monitoring compliance with or adherence to the outcome standards; (f) A process of internal peer review to evaluate specific cases or problems; (g) A process for implementing corrective action to address problems or deficiencies; (h) A process to analyze and evaluate the effect of corrective action; and (i) A process to ensure that confidentiality of patient and provider information is maintained according to the standards of RCW 70.41.200 and 70.168.090.				
(23) Participate in the regional trauma quality improvement program as defined in WAC 246-976-910.	X	X	X	X
(24) Participate in the Washington state trauma registry as defined in WAC 246-976-430.	X	X	X	X
(25) Provide a community based program of coordinated and integrated outpatient trauma rehabilitation services, evaluation, and treatment to persons with trauma-related functional limitations who do not need or no longer require comprehensive inpatient rehabilitation. Services may be provided in, but not limited to, the following settings: (a) Freestanding outpatient rehabilitation centers; (b) Organized outpatient rehabilitation programs in acute hospital settings; (c) Day hospital programs; (d) Other community settings.			X	
(26) Treat patients according to admission criteria based on diagnosis and severity.			X	
(27) Be directed by a physician with training and experience necessary to provide rehabilitative physician services, acquired through one of the following: (a) Formal residency in physical medicine and rehabilitation; or (b) A fellowship in rehabilitation for a minimum of one year; or (c) A minimum of two years' experience in providing rehabilitation services for patients typically seen in CARF-accredited inpatient rehabilitation programs.			X	
(28) Provide the following trauma rehabilitation services with providers who are licensed, registered, or certified according to the frequency as defined in the rehabilitation plan: (a) Occupational therapy; (b) Physical therapy; (c) Social services; (d) Speech/language pathology.			X	
(29) Provide or assist the patient to obtain the following as defined in the rehabilitation plan: (a) Audiology; (b) Dentistry; (c) Driver evaluation and training; (d) Education; (e) Nursing; (f) Nutrition counseling; (g) Orthotics; (h) Pastoral or spiritual care; (i) Prosthetics; (j) Psychology; (k) Rehabilitation engineering for device development and adaptations; (l) Respiratory therapy;			X	

WAC 246-976-800 Trauma Rehabilitation Service Standards	Levels			
A designated trauma rehabilitation service must:	**I**	**II**	**III**	**I Pediatric**
(m) Substance abuse counseling; (n) Therapeutic recreation; (o) Vocational rehabilitation.				
(30) Have a quality improvement program that reflects and demonstrates a process for continuous quality improvement in the delivery of trauma care, with: (a) A process to identify and monitor trauma rehabilitation care and outcome standards and indicators; (b) An interdisciplinary team, to include the trauma rehabilitation service physician director; (c) A process to ensure confidentiality of patient and provider information in accordance with RCW 70.41.200 and 70.168.090.			X	

[Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070. WSR 09-23-085, § 246-976-800, filed 11/16/09, effective 12/17/09.]

SYSTEM ADMINISTRATION

WAC 246-976-890 Interhospital transfer guidelines and agreements. Designated trauma services must:

(1) Have written guidelines consistent with their written scope of trauma service to identify and transfer patients with special care needs exceeding the capabilities of the trauma service;

(2) Have written transfer agreements with other designated trauma services. The agreements must address the responsibility of the transferring hospital, the receiving hospital, and the prehospital transport agency, including a mechanism to assign medical control during interhospital transfer;

(3) Have written guidelines, consistent with their written scope of trauma service, to identify trauma patients who are transferred in from other facilities, whether admitted through the emergency department or directly into other hospital services;

(4) Use verified prehospital trauma services for interfacility transfer of trauma patients.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-890, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-890, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-890, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-890, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-890, filed 12/23/92, effective 1/23/93.]

WAC 246-976-910 Regional quality assurance and improvement program. (1) The department will:

(a) Develop guidelines for a regional EMS/TC system quality assurance and improvement program including:

(i) Purpose and principles of the program;

(ii) Establishing and maintaining the program;

(iii) Process;

(iv) Membership of the quality assurance and improvement program committee;

(v) Authority and responsibilities of the quality assurance and improvement program committee;

(b) Review and approve written regional quality assurance and improvement plans;

(c) Provide trauma registry and EMS data to regional quality assurance and improvement programs in the following formats:

(i) Quarterly standard reports;

(ii) Ad hoc reports as requested according to department guidelines.

(2) Levels I, II, and III, and Level I, II and III pediatric trauma care services must:

(a) Establish, coordinate and participate in regional EMS/TC systems quality assurance and improvement programs;

(b) Ensure participation in the regional quality assurance and improvement program of:

(i) Their trauma service director or codirector; and

(ii) The RN who coordinates the trauma service;

(c) Ensure maintenance and continuation of the regional quality assurance and improvement program.

(3) The regional quality assurance and improvement program committee must include:

(a) At least one member of each designated facility's medical staff;

(b) The RN coordinator of each designated trauma service;

(c) An EMS provider.

(4) The regional quality assurance program must invite the MPD and all other health care providers and facilities providing trauma care in the region, to participate in the regional trauma quality assurance program.

(5) The regional quality assurance and improvement program may invite:

(a) One or more regional EMS/TC council members;

(b) A trauma care provider who does not work or reside in the region.

(6) The regional quality assurance and improvement program must include a written plan for implementation including:

(a) Operational policies and procedures that detail committee actions and processes;

(b) Audit filters for adult and pediatric patients;

(c) Monitoring compliance with the requirements of chapter 70.168 RCW and this chapter;

(d) Policies and procedures for notifying the department and the regional EMS/TC council of identified regional or statewide trauma system issues, and any recommendations;

(e) Policies regarding confidentiality of:

(i) Information related to provider's and facility's clinical care, and patient outcomes, in accordance with chapter 70.168 RCW;

(ii) Quality assurance and improvement committee minutes, records, and reports in accordance with RCW 70.168.090(4), including a requirement that each attendee of a regional quality assurance and improvement committee meeting is informed in writing of the confidentiality requirement. Information identifying individual patients may not be publicly disclosed without the patient's consent.

[Statutory Authority: RCW 43.70.040 and 70.168.090. WSR 24-15-130, § 246-976-910, filed 7/23/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-910, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-910, filed 12/23/92, effective 1/23/93.]

WAC 246-976-920 Medical program director. (1) Qualifications - Applicants for certification as a county medical program director (MPD) must:

(a) Hold and maintain a current and valid license to practice medicine and surgery under chapter 18.71 RCW or osteopathic medicine and surgery under chapter 18.57 RCW; and

(b) Be qualified and knowledgeable in the administration and management of emergency medical care and services; and

(c) Complete a medical director training course approved by the department within the first two years of initial certification as an MPD unless an EMS fellowship has already been completed or a board certification in EMS is held; and

(d) Be recommended for certification by the local medical community and local emergency medical services and trauma care council (EMS/TC).

(2) MPD certification process. In certifying the MPD, the department will:

(a) Notify the local EMS/TC of a vacancy for an MPD and work with the local EMS/TC council and medical community to identify physicians interested in serving as the MPD;

(b) Receive a letter of interest and curriculum vitae from MPD candidates;

(c) Perform required background checks identified in RCW 18.130.064;

(d) Work with and provide technical assistance to local EMS/TC councils on evaluating MPD candidates;

(e) Obtain letters of recommendation from the local EMS/TC council and local medical community; and

(f) Make final determination to certify the MPD.

(3) Medical control and direction. The certified MPD must:

(a) Provide medical control and direction of EMS certified personnel in their medical duties. This is done by oral or written communication; and

(b) Develop and adopt written prehospital patient care protocols for specialized training and to direct EMS certified personnel in patient care. Protocols must:

(i) Meet the minimum standards of the department;

(ii) Not conflict with county operating procedures or regional patient care procedures;

(iii) Not exceed the authorized care of the certified prehospital personnel as described in WAC 246-976-182;

(iv) Be relevant and meet current nationally recognized and state approved EMS practices;

(v) Be approved by the department. The department may consult with MPDs and other technical advisory groups for input prior to approval of protocols;

(vi) Develop and keep updated a mechanism to familiarize and assess competency of EMS providers with the protocols, county operating procedures, and MPD policies; and

(vii) With approval from the department, may enter into medical control agreements with other MPDs to clarify medical oversight for EMS providers to support the continuity of patient care.

(4) MPD policies. The MPD must:

(a) Establish policies as directed by the department to include a policy for storing, dispensing, and administering controlled substances. Policies must be in accordance with state and federal regulations and guidelines;

(b) Work within the parameters of department policies, regional EMS and trauma care plans, and patient care procedures;

(c) Participate with local and regional EMS/TC councils to develop and revise:

(i) Regional EMS and trauma care plans;

(ii) Regional patient care procedures;

(iii) County operating procedures when applicable. COPs must not conflict with regional patient care procedures or other state standards; and

(iv) Recommendations for improvements in medical control communications and EMS system coordination; and

(d) MPDs must work within the parameters of the approved regional patient care procedures and the regional plan.

(5) MPD oversight of training and education. The MPD:

(a) Must provide oversight of instructors and supervise training of all EMS providers. MPDs may conduct these activities remotely;

(b) Must recommend to the department approval of individuals applying for recognition as senior EMS instructors candidates, senior EMS instructors, EMS evaluators, and locally approve all guest instructors for any EMS education and training;

(c) Must recommend to the department approval of training programs, courses, ongoing education and training plans (OTEP), and content for continuing medical education (CME) and ongoing training;

(d) May develop or approve an intensive airway management program and approve providers to take the program if live intubations cannot be obtained;

(e) May approve providers to perform IV and IO starts on artificial training aids; and

(f) May develop an evaluation form for a procedure or skill if one is not provided by the department.

(6) Certification of EMS providers. The MPD:

(a) Must recommend to the secretary certification, recertification, reciprocity, challenge, reinstatement, reissuance of expired certification or denial of certification of EMS personnel and sign applications; and

(b) May develop an integration process to evaluate and determine competency of an applicant's knowledge and skills in accordance with department policies. The MPD may:

(i) Use examinations to determine competency on department-approved MPD protocols prior to making a recommendation;

(ii) Use examinations to determine knowledge and abilities for personnel prior to recommending applicants for certification or recertification;

(iii) Prescribe additional required refresher training for expired providers;

(iv) Request, review and evaluate an EMS providers training records, skills, and documentation of prehospital medical care provided by the person, to determine proficiency and competency in the application of prehospital care prior to making a recommendation;

(v) Prescribe and review clinical and field evaluations; and

(vi) An MPD integration process must be approved by the department and may not take more than 90 days to complete unless unusual or extenuating circumstances exist;

(c) An MPD may recommend denial of certification to the secretary for any applicant the MPD can document is unable to function as an EMS provider, regardless of successful completion of training, evaluation, or examinations;

(d) An MPD must recommend certified providers to be approved or denied endorsements for specialized skills; and

(e) An MPD may approve a certified advanced emergency medical technician or a paramedic to function at a lower level of certification.

(7) Quality improvement and assurance activities. The MPD:

(a) Must adopt an MPD quality improvement plan that describes how quality improvement activities are conducted by the MPD. The plan must meet the minimum standards of the department;

(b) May access patient care records and reports in the statewide electronic EMS data system for EMS services under their oversight;

(c) May audit the medical care performance of EMS providers in accordance with the MPD quality improvement plan. The audit may include a review of documentation of patient care, training, and skills maintenance of EMS personnel;

(d) May perform counseling and assign remediation regarding the clinical practice of EMS providers;

(e) May recommend to the secretary disciplinary action to be taken against EMS personnel, which may include modification, suspension, or revocation of certification; and

(f) Must participate in regional quality improvement activities.

(8) Oversight of licensed, verified, or recognized EMS services. The MPD:

(a) Must review and make a recommendation to the department for applications for services applying for recognition as an emergency services supervisory organization (ESSO);

(b) Must approve equipment and medications used to provide medical care by EMS personnel; and

(c) May make recommendations for corrections for EMS services that are out of compliance with the regional plan to the department in accordance with WAC 246-976-400.

(9) Delegation of duties. In accordance with department policies and procedures, the MPD may appoint a qualified physician to be an MPD delegate as defined in WAC 246-976-010. The MPD:

(a) May delegate duties to other physicians, except for duties described in subsections (3)(b), (4)(c)(i), (5) (b) and (c), (6)(a), (d), and (e), (7)(e), and (8)(a) of this section.

(i) The MPD must notify the department in writing of the names and duties of individuals so delegated, within 14 days of appointment; and

(ii) The MPD may recommend to the secretary removal of a delegate's authority.

(b) The MPD may delegate duties relating to training, evaluation, or examination of certified or recognized EMS personnel, to qualified nonphysicians.

(10) The secretary may withdraw the certification of an MPD when it finds that the MPD:

(a) Failed to comply with the Uniform Disciplinary Act (chapter 18.130 RCW) and other applicable statutes and regulations;

(b) Is not performing the duties required in applicable statutes and regulations;

(c) Has been recommended for termination by the local EMST council; or

(d) Is no longer authorized to practice within the local medical community.

(11) Modification, suspension, revocation, or denial of certification will be consistent with the requirements of the Administrative Procedure Act (chapter 34.05 RCW), the Uniform Disciplinary Act (chapter 18.130 RCW), and chapter 246-10 WAC.

(12) The department will make the final determination on termination of the MPD.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-920, filed 7/22/24, effective 9/30/24. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-920, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-920, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-920, filed 12/23/92, effective 1/23/93.]

WAC 246-976-930 General responsibilities of the department. In addition to the requirements described in chapters 18.71, 18.73, and 70.168 RCW, and elsewhere in this chapter:

(1) The department shall review, recommend changes to, and approve regional plans and regional patient care procedures based on the requirements of this chapter and recommendations from the steering committee, and upon consideration of the needs of patients.

(a) The department may approve regional plans which include standards that are consistent with chapter 70.168 RCW and other state and federal laws, but which exceed the requirements of this chapter.

(b) The department will develop a process for biennial update of regional and statewide planning. The process will include provisions to amend regional plans between biennial updates.

(2) The department will publish prehospital trauma triage procedures for activation of the trauma system from the field. The procedures will include assessment of the patient's:

(a) Vital signs and level of consciousness;

(b) Anatomy of injury;

(c) Biomechanics of the injury; and

(d) Comorbid and associated risk factors.

(3) The department may approve pilot programs and projects which have:

(a) Stated objectives;

(b) A specified beginning and ending date;

(c) An identified way to measure the outcome;

(d) A review process;

(e) A work plan with a time line;

(f) If training of EMS personnel is involved, consistency with the requirements of WAC 246-976-021(5).

(4) The department will review at least every four years:

(a) Rules, policies, and standards for EMS, with the advice of the steering committee;

(b) Rules and standards for licensure of services and vehicles, and for certification of EMS personnel, with the advice of the L&C committee.

[Statutory Authority: Chapters 18.71 and 18.73 RCW. WSR 04-08-103, § 246-976-930, filed 4/6/04, effective 5/7/04. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-930, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-930, filed 12/23/92, effective 1/23/93.]

WAC 246-976-935 Emergency medical services and trauma care system trust account. RCW 70.168.040 establishes the emergency medical services and trauma care system trust account. With the advice of the EMS/TC steering committee, the department will develop a method to budget and distribute funds in the trust account. The department may use an injury severity score to define a major trauma patient. Initially, the method and budget will be based on the department's *Trauma Care Cost Reimbursement Study, final report (October 1991).* The committee and the department will review the method and the budget at least every two years.

(1) Definitions: The following phrases used in this section mean:

(a) "Needs grant" is a trust account payment that is based on a demonstrated need to develop and maintain service that meets the trauma care standards of chapter 70.168 RCW and this chapter. Needs grants are awarded to verified trauma care ambulance or aid services. Services must be able to show that they have looked for other resources without success before they will be considered for a needs grant.

(b) "Participation grant" refers to a trust account payment designed to compensate the recipient for participation in the state's comprehensive trauma care system. These grants are intended as a tool for assuring access to trauma care. Participation grants are awarded to:

(i) Verified trauma care ambulance or aid services;

(ii) Designated trauma care services; and

(iii) Designated trauma rehabilitation services.

(2) The department will distribute trust account funds to:

(a) Verified trauma care ambulance and aid services;

(b) Designated trauma care services:

(i) Levels I-V general; and

(ii) Levels I-III pediatric;

(c) Designated trauma rehabilitation services:

(i) Levels I-III; and

(ii) Level I-pediatric.

(3) The department's distribution method for verified trauma care ambulance and aid services will include at least:

(a) Participation grants, which will be awarded once a year to services that comply with verification standards;

(b) Needs grants, based on the service's ability to meet the standards of chapter 70.168 RCW and chapter 246-976 WAC (this chapter). The department may consider:

(i) Level of service (BLS, ILS, ALS);

(ii) Type of service (aid or ambulance);

(iii) Response area (rural, suburban, urban, wilderness);

(iv) Volume of service;

(v) Other factors that relate to trauma care;

(4) The department's distribution method for designated trauma care services will include:

(a) Participation grants to levels I-V general and I-III pediatric, which will be awarded once a year only to services that comply with designation standards. The department will review the compliance requirements annually. The department may consider:

(i) Level of designation;

(ii) Service area (rural, suburban, urban, wilderness);

(iii) Volume of service;

(iv) The percentage of uncompensated major trauma care;

(v) Other factors that relate to trauma care;

(b) Trauma care grants, which will be awarded once a year to level I-III designated acute trauma services to subsidize uncompensated trauma care costs. To be eligible for the grants, trauma services must comply with Washington state's DOH trauma registry requirements per WAC 246-976-420 through 246-976-430 including submission of complete financial data and injury coding data. The grants will be calculated by multiplying a hospital's bad debt and charity care ratio times the sum of injury severity scores (ISS) for a specific period. The results for all eligible trauma services are summed, and each trauma service will receive a proportionate share of the available uncompensated trauma care grant allocation based on their percentage of the overall total. The bad debt and charity care ratio is calculated by summing a hospital's bad debt and charity care figures divided by the hospital's total patient revenue for the same period. These figures are from annual financial data reported to the department per chapters 246-453 and 246-454 WAC. Injury severity scores are extracted from trauma registry data for cases that:

(i) Meet the trauma registry inclusion criteria per WAC 246-976-420; and

(ii) Are admitted with an ISS of thirteen or greater for adults, nine or greater for pediatric patients less than fifteen years of age, or trauma patients received in transfer regardless of the ISS.

(c) Trauma care grants, which will be awarded once a year to designated acute trauma services levels IV, V, and/or critical access hospitals (CAH) to subsidize their costs for providing care to the trauma patients, and for stabilizing and transferring major trauma patients. The individual grant amounts are based on designation level.

(5) The department may issue grants to DOH-certified medical program directors (MPD) for their role in the EMS/TCS as described in WAC 246-976-920.

(6) The department's distribution method for designated trauma rehabilitation services, levels I-III and I-pediatric will include at least:

Participation grants, which will be awarded once a year only to services that comply with designation standards. The department will review the compliance requirements annually. The department may consider:

(a) Level of designation;

(b) Volume of service;

(c) Other factors that relate to trauma care.

[Statutory Authority: Chapter 70.168 RCW. WSR 04-12-126, § 246-976-935, filed 6/2/04, effective 7/3/04. Statutory Authority: RCW

70.168.040. WSR 02-04-045, § 246-976-935, filed 1/29/02, effective 3/1/02. Statutory Authority: Chapter 70.168 RCW. WSR 98-05-035, § 246-976-935, filed 2/10/98, effective 3/13/98.]

WAC 246-976-940 Steering committee. In addition to the requirements of chapter 70.168 RCW and elsewhere in this chapter, the EMS/TC steering committee will:

(1) Review and comment on the department's rules, policies, and standards;

(2) Review and comment on the department's budget for the EMS/TC system at least biennially;

(3) Periodically review and recommend changes to:

(a) The department's prehospital triage procedures;

(b) Regional patient care procedures;

(c) Regional plans; and

(d) Interfacility transfer guidelines.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-940, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-940, filed 12/23/92, effective 1/23/93.]

WAC 246-976-960 Regional emergency medical services and trauma care councils. (1) Regional council composition and appointments. The department shall establish regional emergency medical services and trauma care councils (EMS/TC) and shall appoint members to be comprised of a balance of hospital and prehospital trauma care and emergency medical service providers, local elected officials, consumers, local law enforcement representatives, and local government agencies involved in the delivery of trauma care and emergency medical services recommended by the local emergency medical services and trauma care councils within the region.

(a) The department will design and manage the appointment process.

(b) In areas where no local EMS/TC council exists, the regional EMS/TC council shall make recommendations to the department regarding appointing members to the regional EMS/TC council.

(2) Funding and grants. The department, with the assistance of the emergency medical services and trauma care steering committee, shall adopt a program for the disbursement of funds for the development, implementation, and enhancement of the emergency medical services and trauma care system. Under the program, the department shall disburse funds to each emergency medical services and trauma care regional council, or their chosen fiscal agent or agents, which shall be city or county governments, stipulating the purpose for which the funds shall be expended.

(a) The councils shall report in the regional budget the individual source, amount, and purpose of all gifts and payments.

(b) Matching grants may be made under the provisions of chapter 70.168 RCW and awarded for the purposes identified in RCW 70.168.130 and to accomplish other purposes as approved by the department.

(3) Regional council responsibilities. In addition to meeting the requirements of chapter 70.168 RCW and elsewhere in this chapter, regional EMS/TC councils must:

(a) Develop and submit to the department regional EMS/TC plans that meet the minimum standards of the department. In developing and modifying the plans EMS/TC regions must:

(i) Use regional and state analyses provided by the department based on the statewide electronic emergency medical services data system, trauma registry data and other appropriate sources provided by the department;

(ii) Identify and analyze system trends to evaluate the EMS/TC system and its component subsystems, using statewide electronic emergency medical services data system, trauma registry data and other appropriate sources provided by the department;

(iii) Identify the need for and recommend distribution and level of care (basic, intermediate, or advanced life support) for verified aid and ambulance services to assure adequate availability and avoid inefficient duplication and lack of coordination of prehospital care services for each response area. The recommendations will be based on criteria established by the department and will include information related to agency response times, geography, topography, and population density;

(iv) Identify the need for and recommend distribution and level of facilities to be designated which are consistent with state standards and based upon availability of resources and distribution of trauma within the region;

(v) Identify prehospital training and education to meet regional and local needs;

(vi) Identify EMS/TC services and resources currently available within the region;

(vii) Summarize improvements and outcomes from the last approved plan;

(viii) See and consider the recommendations of local EMS/TC councils and systems established by ordinance, resolution, interlocal agreement or contract by counties, cities, and other governmental bodies;

(ix) Include in the plan, patient care procedures adopted by the region that meet the requirements of RCW 18.73.030 and 70.168.015 and the minimum standards of the department and must include:

(A) The level of medical care personnel to be dispatched to an emergency scene;

(B) Guidelines for rendezvous with agencies offering higher levels of service;

(C) Air medical activation and utilization;

(D) On scene command;

(E) Procedures for EMS to identify and triage patients experiencing trauma, cardiac, or stroke emergencies. Procedures must include destination determination including the type and level of facility to first receive the patient, and the process EMS must use to alert the receiving facility;

(F) For major trauma patients, regional patient care procedures must identify procedures to alert and activate the trauma system;

(G) Patient care procedures must include interfacility transport procedures including the name and location of other trauma, cardiac, or stroke care facilities to receive the patient should an interfacility transfer be necessary;

(H) Procedures to allow for the appropriate transport of patients to mental health facilities or chemical dependency programs, as informed by the alternative facility guidelines adopted under RCW 71.168.170;

(I) Procedures to handle types and volumes of medical and trauma patients that may exceed regional capabilities, taking into consideration resources available in other regions and adjacent states;

(J) Procedures for how hospital diversion is managed in the region; and

(K) EMS and medical control communications;

(x) Include a schedule for implementation and identify goals, objectives, and strategies;

(xi) Include strategies that may promote improvements in the regional EMS/TC system;

(xii) Describe how the roles and responsibilities of the MPD are coordinated with those of the regional EMS/TC council and regional plan; and

(xiii) Describe and recommend improvements in medical control communications and EMS/TC dispatch, with at least the elements of the state communication plan described in RCW 70.168.060 (1)(h).

(b) Review applications for verification of ambulance and aid services and make recommendations to the department regarding:

(i) Compliance with the department-approved minimum and maximum number of verified trauma services for the level of verification being sought by the applicant;

(ii) How proposed service will impact care in the region in relations to clinical care, response time to prehospital incidents, and resource availability;

(iii) How the proposed service impacts unserved and underserved trauma response areas;

(iv) How the proposed service will impact existing verified services in the region; and

(v) Include any comments from local EMS/TC councils and systems established by ordinance, resolution, interlocal agreement or contract by counties, cities, or other governmental bodies.

(c) Review applicants for designation of hospital trauma services and make recommendations to the department.

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-960, filed 7/22/24, effective 9/30/24. Statutory Authority: RCW 18.73.081 and 70.168.120. WSR 02-14-053, § 246-976-960, filed 6/27/02, effective 7/28/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-960, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-960, filed 12/23/92, effective 1/23/93.]

WAC 246-976-970 Local emergency medical services and trauma care councils. (1) Local council composition. If a county or group of counties creates a local EMS/TC council, it must be composed of a balance of representatives of hospital and EMS providers, local elected officials, consumers, local law enforcement officials, local government agencies, physicians, and prevention specialists involved in the delivery of EMS/TC.

(2) Local council responsibilities. In addition to meeting the requirements of chapter 70.168 RCW and this chapter, local EMS/TC councils:

(a) Must make recommendations to the regional council regarding appointing members representing the local council to the regional EMS/TC council;

(b) Must develop county operating procedures as defined in WAC 246-976-010 in collaboration with the county medical program director;

(c) Must participate in regional council meeting and activities;

(d) Must make recommendations to the regional council about the development of regional patient care procedures;

(e) Review applications for EMS training programs and make recommendations to the department;

(f) Conduct activities to assess, support, and improve EMS training programs within the county;

(g) Identify prehospital training and education to meet local needs and make recommendations to the regional council for regional planning;

(h) Review applications for EMS service verification at the request of regional EMS councils. The review must include:

(i) Compliance with the department-approved minimum and maximum number of trauma verified services for the level of verification being sought by the applicant;

(ii) How the proposed service will impact care in the region in relation to clinical care, response time to prehospital incidents, and resource availability;

(iii) How the proposed service impacts unserved or underserved trauma response areas;

(iv) How the proposed service will impact existing verified services in the region; and

(v) Seek and include any comments from local systems established by ordinance, resolution, interlocal agreement or contract by counties, cities, or other governmental bodies;

(i) Provide recommendation to the regional EMS/TC council in accordance with RCW 70.168.080, for remediation activities to support a prehospital provider that is out of compliance with regional plan;

(j) Identify how the roles and responsibilities of the MPD are coordinated with those of the local council.

(3) Local EMS/TC councils may make recommendations to the department regarding certification and termination of MPDs, as provided in RCW 18.71.205(4).

[Statutory Authority: RCW 18.71.205, 18.73.081, 43.70.040, 70.168.050, 2017 c 70, 2017 c 295, 2020 c 76, 2021 c 276, 2019 c 314, 2021 c 69, and 2022 c 136. WSR 24-15-104, § 246-976-970, filed 7/22/24, effective 9/30/24. Statutory Authority: RCW 18.73.081 and 70.168.120. WSR 02-14-053, § 246-976-970, filed 6/27/02, effective 7/28/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-970, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-970, filed 12/23/92, effective 1/23/93.]

WAC 246-976-990 Fees and fines. (1) The department shall assess individual health care facilities submitting a proposal to be designated as a level I general trauma care facility a fee, not to exceed seven thousand dollars, to help defray the costs to the department of inspections and review of applications.

(2) The department shall assess individual health care facilities submitting a proposal to be designated as a level II general trauma

care facility a fee, not to exceed six thousand dollars, to help defray the costs to the department of inspections and review of applications.

(3) The department shall assess individual health care facilities submitting a proposal to be designated as a level III general trauma care facility a fee, not to exceed one thousand nine hundred fifty dollars, to help defray the costs to the department of inspections and review of applications.

(4) The department shall assess individual health care facilities submitting a proposal to be designated as a level I pediatric trauma care facility a fee, not to exceed nine thousand two hundred dollars, to help defray the costs to the department of inspections and review of applications.

(5) The department shall assess individual health care facilities submitting a proposal to be designated as a level II pediatric trauma care facility a fee, not to exceed eight thousand dollars, to help defray the costs to the department of inspections and review of applications.

(6) The department shall assess individual health care facilities submitting a proposal to be designated as a level III pediatric trauma care facility a fee, not to exceed two thousand dollars, to help defray the costs to the department of inspections and review of applications.

(7) The department shall assess health care facilities submitting a joint proposal to be jointly designated as a level I general or pediatric trauma care facility a fee, of at least seven thousand dollars, and based upon a determined hourly rate and per diem expense per inspection team member, not to exceed fourteen thousand five hundred dollars to help defray the costs to the department of inspections and review of applications.

(8) The department shall assess health care facilities submitting a joint proposal to be jointly designated as a level II general or pediatric trauma care facility a fee, of at least six thousand dollars, and based upon a determined hourly rate and per diem expense per inspection team member, not to exceed twelve thousand five hundred dollars to help defray the costs to the department of inspections and review of applications.

(9) The department shall assess health care facilities submitting a joint proposal to be jointly designated as a level III general or pediatric trauma care facility a fee, of at least one thousand nine hundred fifty dollars, and based upon a determined hourly rate and per diem expense per inspection team member, not to exceed three thousand one hundred dollars to help defray the costs to the department of inspections and review of applications.

(10) The department shall assess health care facilities submitting a proposal to be designated at multiple levels to provide adult and pediatric care a fee, not to exceed nine thousand two hundred dollars to help defray the costs to the department of inspections and review of applications.

(11) The department shall not assess such fees to health care facilities applying to provide level IV and V trauma care services.

(12) If an ambulance or aid service fails to comply with the requirements of chapters 18.71, 18.73, 70.168 RCW, the Uniform Disciplinary Act, or with the requirements of this chapter, the department may notify the appropriate local, state or federal agencies.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-990, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapter 70.168 RCW. WSR 93-20-063, § 246-976-990, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-990, filed 12/23/92, effective 1/23/93.]