Barón moved Title Amendment T1.
The motion carried.

T1

12/1/2025
Title Amd

[J. Ngo]

Sponsor: Perry

Proposed No.: 2024-0408

TITLE AMENDMENT TO PROPOSED ORDINANCE 2024-0408, VERSION 2

On page 1, beginning on line 1, strike lines 1 through 99, and insert:

" AN ORDINANCE related to critical area regulations; amending the King County Comprehensive Plan; and amending Ordinance 15053, Section 3, as amended, and K.C.C. 16.82.051, Ordinance 263, Article 2, Section 1, as amended, and K.C.C. 20.12.010, Ordinance 3692, Section 2, as amended, and K.C.C. 20.12.200, Ordinance 10511, Section 7, as amended, and K.C.C. 20.36.100, Ordinance 6949, Section 6, as amended, and K.C.C. 20.44.040, Ordinance 18626, Section 11, as amended, and K.C.C. 21A.06.039, Ordinance 15051, Section 7, as amended, and K.C.C. 21A.06.072C, Ordinance 10870, Section 70, as amended, and K.C.C. 21A.06.122, Ordinance 10870, Section 80, as amended, and K.C.C. 21A.06.200, Ordinance 11481, Section 1, and K.C.C. 21A.06.253C, Ordinance 15051, Section 24, and K.C.C. 21A.06.254, Ordinance 10870, Section 123, as amended, and K.C.C.

21A.06.415, Ordinance 15051, Section 41, and K.C.C. 21A.06.451, Ordinance 15051, Section 64, and K.C.C. 21A.06.578, Ordinance 15051, Section 107, and K.C.C. 21A.06.1331, Ordinance 10870, Section 176, as amended, and K.C.C. 21A.06.680, Ordinance 10870, Section 190, as amended, and K.C.C. 21A.06.750, Ordinance 10870, Section 243, as amended, and K.C.C. 21A.06.1015, Ordinance 10870, Section 288, as amended, and K.C.C. 21A.06.1240, Ordinance 10870, Section 314, as amended, and K.C.C. 21A.06.1370, Ordinance 10870, Section 323, and K.C.C. 21A.06.1391, Ordinance 10870, Section 321, and K.C.C. 21A.06.1405, Ordinance 10870, Section 448, as amended, and K.C.C. 21A.24.010, Ordinance 10870, Section 449, as amended, and K.C.C. 21A.24.020, Ordinance 15051, Section 137, as amended, and K.C.C. 21A.24.045, Ordinance 15051, Section 138, as amended, and K.C.C. 21A.24.051, Ordinance 15051, Section 140, as amended, and K.C.C. 21A.24.061, Ordinance 10870, Section 454, as amended, and K.C.C. 21A.24.070, Ordinance 10870, Section 456, as amended, and K.C.C. 21A.24.090, Ordinance 14187, Section 1, as amended, and K.C.C. 21A.24.500, Ordinance 10870, Section 457, as amended, and K.C.C. 21A.24.100, Ordinance 10870,

Section 458, as amended, and K.C.C. 21A.24.110, Ordinance 15051, Section 149, as amended, and K.C.C. 21A.24.125, Ordinance 10870, Section 460, as amended, and K.C.C. 21A.24.130, Ordinance 15051, Section 151, as amended, and K.C.C. 21A.24.133, Ordinance 10870, Section 464, as amended, and K.C.C. 21A.24.170, Ordinance 10870, Section 465, as amended, and K.C.C. 21A.24.180, Ordinance 10870, Section 467, as amended, and K.C.C. 21A.24.200, Ordinance 11621, Section 75, as amended, and K.C.C. 21A.24.275, Ordinance 10870, Section 475, as amended, and K.C.C. 21A.24.280, Ordinance 10870, Section 478, as amended, and K.C.C. 21A.24.310, Ordinance 10870, Section 476, as amended, and K.C.C. 21A.24.290, Ordinance 15051, Section 158, and K.C.C. 21A.24.205, Ordinance 11481, Section 2, as amended, and K.C.C. 21A.24.311, Ordinance 15051, Section 173, as amended, and K.C.C. 21A.24.312, Ordinance 15051, Section 174, as amended, and K.C.C. 21A.24.313, Ordinance 15051, Section 179, as amended, and K.C.C. 21A.24.316, Ordinance 15051, Section 183, as amended, and K.C.C. 21A.24.318, Ordinance 15051, Section 185, as amended, and K.C.C. 21A.24.325, Ordinance 15051, Section 187, as amended, and K.C.C.

21A.24.335, Ordinance 10870, Section 481, as amended, and K.C.C. 21A.24.340, Ordinance 15051, Section 192, as amended, and K.C.C. 21A.24.355, Ordinance 15051, Section 193, as amended, and K.C.C. 21A.24.358, Ordinance 15051, Section 195, as amended, and K.C.C. 21A.24.365, Ordinance 10870, Section 485, as amended, and K.C.C. 21A.24.380, Ordinance 15051, Section 198, as amended, and K.C.C. 21A.24.382, Ordinance 11621, Section 52, as amended, and K.C.C. 21A.24.385, Ordinance 11621, Section 53, as amended, and K.C.C. 21A.24.386, Ordinance 15051, Section 204, and K.C.C. 21A.24.388, Ordinance 16958, Section 31, as amended, and K.C.C. 21A.25.100, Ordinance 16985, Section 32, as amended, and K.C.C. 21A.25.110, Ordinance 3688, Section 415, as amended, and K.C.C. 21A.25.150, Ordinance 16985, Section 39, as amended, and K.C.C. 21A.25.160, Ordinance 3688, Section 414, as amended, and K.C.C. 21A.24.190, Ordinance 16985, Section 46, as amended, and K.C.C. 21A.25.210, Ordinance 11168, Section 3, as amended, and K.C.C. 21A.30.045, Ordinance 10870, Section 534, as amended, and K.C.C. 21A.30.060, Ordinance 15051, Section 228, and K.C.C. 21A.50.035, and Ordinance 17485, Section 50, adding new sections to

K.C.C. chapter 21A.06, adding new sections to K.C.C. chapter 21A.24, recodifying K.C.C. 21A.06.578, K.C.C. 21A.06.1331, K.C.C. 21A.24.500, K.C.C. 21A.24.310, K.C.C. 21A.24.205, K.C.C. 21A.24.210, K.C.C. 21A.24.220, repealing Ordinance 15713, Section 2, as amended, and K.C.C. 2.36.080, Ordinance 15051, Section 67, and K.C.C. 21A.06.628, Ordinance 15051, Section 139, as amended, and K.C.C. 21A.24.055, Ordinance 17539, Section 47, as amended, and K.C.C. 21A.24.072, Ordinance 15051, Section 152, as amended, and K.C.C. 21A.24.137, Ordinance 10870, Section 461, as amended, and K.C.C. 21A.24.140, Ordinance 11481, Sections 3 and 5, as amended, and K.C.C. 21A.24.314, Ordinance 15051, Section 189, as amended, and K.C.C. 21A.24.342, Ordinance 15051, Section 234, as amended, and K.C.C. 21A.24.550, Ordinance 19820, Section 15, and Ordinance 19820, Section 16, and establishing effective dates."

EFFECT prepared by *J. Ngo*: *Conforms Title to Striking Amendment S1.*

December 2, 2025

Dennis Worsham,
Secretary of Health
Washington State Department of Health
PO Box 47890
Olympia, WA 98504-7890

RE: DOH Draft Trauma Services Assessment

Delivered via email

Dear Secretary Worsham:

On behalf of Harborview Medical Center (Harborview), we collectively request that the Washington State Department of Health (DOH) amend the proposed process outlined in the draft 2025 Washington State Trauma Services Assessment as it relates to the designation of new Level I and II Trauma Centers.

We make this request because the process outlined in the draft would allow for the proliferation of new Level I Trauma Centers without answering the single most important question: given outstanding patient outcomes and significant capacity at our existing Level I Trauma Center what problem are we trying to solve by adding more Level I Trauma Centers?

Harborview is a national leader in Level I adult and pediatric trauma and burn care, with our trauma teams of nurses, technicians, and physicians—achieving a 96% survival rate. This success is due in large part to maintaining sufficient patient volumes, which ensures we continue to build the expertise required for the highest Level I trauma specialty and subspecialty care in the country.

Harborview has no capacity challenges in serving the State of Washington and the broader region. In fact, our capacity and reach are core strengths that support our standing as a nationally ranked trauma center.

That is why clearly defining the problem we are trying to solve is essential as we move forward in this trauma assessment process.

With this in mind, we note the following concerns and make the following recommendations related to the DOH's recently released draft trauma assessment.

Concerns with the Draft Assessment:

Instead of answering the fundamental question - *what problem are we trying to solve* - the draft assessment speculates that the state may need new Level I centers because 1) Washington's population has grown, 2) speculation that our existing Level I center, Harborview, "may be overburdened" and 3) erroneously emphasizing the time to transport to highest level of care vs. the more critical factor of time to stabilization for trauma patients.

These misplaced emphases distract from the factors that truly affect trauma patient outcomes – including maintaining sufficient volumes to ensure the expertise of trauma care teams. Finally, the draft assessment defers to the regional EMS & Trauma Councils to recommend new Level I or II trauma centers in each local trauma region, rather than evaluating these needs with a statewide lens of trauma services and maximizing patient outcomes through needed minimum and maximum patient volumes.

Washington state established its nationally regarded trauma system decades ago by focusing on statewide need for Level I & Level II trauma care, establishing a minimum/maximum volume analysis that focused trauma care based on relative need, patient stabilization and overall quality of outcomes.

This assessment puts our system at risk by focusing on these speculative factors, ignoring the need to maintain patient volumes, and deferring Level I & II decisions to regional committees. As a result, the assessment risks harming the quality of Level I trauma care in Washington state rather than improving it by diluting patient volumes through the proliferation of new centers without first demonstrating actual need based on the most critical factor, trauma patient outcomes.

Analysis of Trauma Patient Volumes Impacting Patient Outcomes is Still Missing from the Draft Assessment:

Throughout this process which began in 2018, we have repeatedly highlighted the fact that the nationally respected patient outcomes our trauma teams achieve are due in large part to having a sufficient volume and complexity of trauma patients come to Harborview for their care. We pointed out the need to examine impact on patient volumes and patient outcomes in determining the need for more trauma centers when the DOH review first began its review of the system in 2018.

After being asked to review Washington's trauma system, the American College of Surgeons made the same recommendation to DOH in 2019. In 2021, Washington State's own Trauma Directors' Workgroup recommended the same patient outcome impact analysis of adding new Level I Centers. We collectively wrote and made similar public comments to the DOH during its aborted trauma rulemaking process in 2023 and its subsequent internal policy making process in 2024.

Despite these repeated efforts, the draft assessment fails to address impact on patient outcomes by patient volume. Instead, the draft suggests without analysis that population growth and a "theoretical" lack of capacity at Harborview are justifications for more Level I trauma centers.

Notably, population growth alone does not necessarily burden trauma capacity and decrease quality Level I trauma outcomes. Population growth can actually improve patient outcomes by providing sufficient volumes to develop, maintain and improve specialty care.

Moreover, Harborview has no capacity constraints whatsoever in providing Level I trauma care. The supposition in the draft assessment on page 58 that Harborview "may be overburdened..." is baseless. Not once during this seven-year process has DOH asked Harborview about its Level I trauma capacity. The truth is Harborview has more than sufficient capacity to continue providing level I care to the state and region with nationally respected patient outcomes. This speculative statement is not supported by fact and should be removed from the final assessment. There is no evidence or supporting documentation to suggest Harborview has trauma capacity challenges.

The DOH has now collected more recent statewide trauma data (2023) and included it in the assessment. However,

nothing in this new data suggests that Harborview does not meet capacity needs in providing Level I trauma care across the State. In fact, the outcomes support the conclusion that Harborview achieves these national leading results because it has sufficient patient volumes to recruit and retain highly skilled patient care teams that have first-rate specialty and sub-specialty expertise.

Examples of this care include ophthalmologic trauma, craniofacial trauma and complex pelvic injuries. Sufficient patient volumes are directly correlated to improved patient outcomes and have allowed Harborview to provide top-tier patient outcomes for the people of Washington. Yet the draft assessment fails to require this analysis be done before new Level I Trauma Centers are contemplated. Dilution of trauma volumes will result in reduced ability to maintain subspecialty skills, reduced ability to recruit and train the best trauma surgeons and care teams, ultimately reducing outcomes for patients in Washington State with traumatic injuries.

Time to Trauma Patient Stabilization is the Key

No trauma assessment should be considered complete without assessing whether proposed changes to the trauma system will ultimately hurt or help trauma patient outcomes. The draft assessment does not center its analysis on trauma patient outcomes; instead, it cites to the average time to transport patients to the highest level of care to justify possible additional designations. This metric is not the critical factor in trauma care analysis, as it includes a large number of patients who are already stable and are transferred primarily for specialty care – transfers that are not time sensitive.

A strong trauma system must instead be built on the time it takes to **stabilize** trauma patients. In a state with significant rural areas, our regional Level III Trauma Centers along with the Level I & II Trauma Centers play a key role in this stabilization. Once a patient is stabilized, transport to higher levels of care can occur safely for specialty and subspecialty care as needed.

Level I & II Designations Should be Made based on Statewide Analysis & Impact:

Washington's trauma system is nationally respected because it was originally designed to assess trauma care needs based on both a minimum and maximum patient threshold at each level of trauma care. This framework ensures that the needs for the most complex cases, cared for at the Level I and Level II Trauma Centers, should be determined based on a statewide assessment of access and patient volumes. For this reason, decisions regarding new Level I and Level II Trauma Centers must be grounded in a clear understanding of where true gaps exist in the current system and how proposed changes would impact the functioning and viability of existing centers.

The draft assessment proposes that the Regional Trauma Councils make recommendations to the state regarding new trauma center designations. Unfortunately, the regional councils are not positioned to assess the statewide impact of their recommendations. Therefore, we recommend that the DOH develop a review process that considers the statewide impact on patient outcomes prior to entertaining the addition of new Level I or Level II Trauma Centers.

Inclusion of Aeromedical Transport and Financial Impact of Adding New Trauma Centers

We appreciate the additional information that has been added to the assessment since its last iteration in 2024, including an analysis of aeromedical transport and a financial analysis of the costs of trauma care completed by the Office of Financial Management (OFM). The air transport analysis suggests that the current system provides excellent access to care for the vast majority of the state's population, with 96% of the population residing **within an hour flight time of Level 1-III trauma care and 87% within an hour's flight time to a Level 1 or 2 Trauma Center.**

The OFM report further highlights the escalating costs of trauma care across the state and the significant financial burden on hospitals and healthcare systems providing this care. Increasing higher-level trauma centers without clinical justification will add additional financial strain to our ability to provide these services without improving patient outcomes and likely harming them.

Conclusion

Prior to considering any new Level I or II Trauma Center applications, we ask the DOH to develop a thoughtful and comprehensive process that considers the implications detailed in this letter and includes an analysis on the impact of the proliferation of additional Level I or II Trauma Centers on the State's current trauma system including our existing Level I Trauma Center, Harborview.

This process should ask and answer these basic questions before reviewing applications: 1) what is the current access to and outcomes of Level I trauma care at Harborview 2) what is the role of having sufficient patient volumes at Harborview to maintain these universally respected outcomes? and 3) what could happen to the highly successful trauma patient outcomes at Harborview if patient volumes are reduced with the proliferation of new Level I or II Trauma Centers?

Our coalition of the University of Washington (UW Medicine), King County's elected leadership, and our Labor organization partners who represent the frontline trauma teams who provide our nationally ranked care every day have made these same points again and again to the DOH: adding more Level I Trauma Centers without measuring the potential impacts on Harborview's trauma volumes risks less effective trauma care and poorer patient outcomes across the state.

Thank you for considering these points in the statewide trauma system assessment process. We ask that these important changes be made to ensure Harborview's outstanding patient outcomes, achieved every day on behalf of Washington's trauma patients, continue into the future.

Sincerely,

Timothy H. Dellit, M.D.
CEO, UW Medicine
Dean, UW School of Medicine

Girmay Zahliay
King County Executive

Sommer Kleweno-Walley
CEO, Harborview Medical Center

Sarah Perry
Chair, King County Council (possible signatures of all Councilmembers

Jane Hopkins
President, SEIU Healthcare 1199NW

Tricia Schroeder
President, SEIU Local 925

Mike Yestramski, LICSW
President, AFSCME Council 28/WFSE

WSNA Signee being considered

Commented [KC1]: Font

cc: Kristin Peterson, Chief of Policy, DOH