Minutes of the Statewide Trauma and Health Systems (STHS)

Quality Assurance/Quality Improvement (QA/QI) Workgroup Meeting
October 27, 2015, 10 a.m., Room 1182
Call in Information 1-800-491-4585

Strategic Planning Meeting

In attendance: Allan Pace, Augustine Amenyah, Choona Lang, David Garmon, Denise Louthain, Dion Schultz, Joe Acker, John Reed, Leslie Morgan, Mack Weaver, Michael Minor, MisChele White

By Phone: John Blue, II

Absent: William Crawford, M.D., Andrew Lee, Geni Smith, Glenn Davis, Jeremy White, Mark Jackson, Sarah Nafziger, M.D., Spencer Howard, Verla Thomas

Ms Lang welcomed participants.

QA/QI Process

Ms. Lang began the meeting by giving some examples of the STHS Survey results, particularly comments relating to the QA/QI process. She then gave a brief overview of the STHS QA process and opened up discussion of the survey results and commonly experienced problems. Ms. Lang explained that emergency medical services personnel (EMSP) and hospitals can become defensive when QA issues are received and often mistakenly believe that the QA process is punitive. The Workgroup discussed linking the feedback reports to the electronic patient care records (e-PCR), but Mr. Acker explained that it could not be done automatically but could be done manually. Another suggestion was to update training videos to better explain the QA process to EMSP and give the opportunity to submit feedback and concerns, with the goal of making the process clear and precise.

Mr. Garmon informed the Workgroup that hospitals complain that they are not receiving feedback reports from prehospital services, but he has found that the internal process for feedback reports does not route the reports to the appropriate hospital personnel. Mr. Garmon has found that though e-PCR compliance is not 100 percent, it has improved greatly since the activation of the trauma system. Mr. Blue indicated that his region could conduct an audit to determine non-compliance, but to keep in mind that the software that some prehospital providers use does not allow total compliance, and sometimes there are equipment failures that prevent full compliance. Mr. Blue thinks that QA issues could be closed on a case by case basis and that doing so will help further develop the system to improve timely data submission. Mr. Pace suggested examining a percentage of prehospital runs and verifying those against ePCRs. This information would enable the regional offices to work with prehospital providers to develop a reliable system or adjust the systems currently used to be sure they are efficient.

Ms. Lang added that though visitations are time consuming, face to face contact with hospital and prehospital providers gives the regional offices a chance to make simple suggestions that can improve the system. Mr. Blue added that a single process may not work for everyone, and regular contact keeps hospital and prehospital providers engaged in the process. He stated that it is important that they do not see the regional offices only when there is an issue, and it may be helpful to facilitate communication between hospital and prehospital providers since knowledge of system processes varies widely. The regional offices play a significant role in education on system processes.

Dr. Crawford suggested that there may be a negative connotation to "QA Issue" when the issue is usually not major and often resolved by a written explanation. Mr. Schultz suggested renaming these QA issues to "Case Review," however, Ms. Lang expressed concern that changing the name may be a legal issue because of the wording used in the regional trauma plans. Mr. Blue indicated that he did not see a problem with the term and considers QA issues as an opportunity for improvement. He indicated that 90 percent of issues are self-reported. Ms. Lang informed the Workgroup that she would seek an opinion from the Alabama Department of Public Health Legal Council on changing the name of QA issues.

Mr. Schultz advised the Workgroup that making QA process education mandatory for new employees may help alleviate some concerns. QA education is not mandatory and turnover for personnel in hospitals and prehospital providers is high and often new employees are not made aware of ATHS processes. Ms. Lang suggested that education could be made to be a prerequisite annual requirement, and also suggested the use of posters, laminates, and hand outs in an effort to use every opportunity to educate personnel. Mr. Reed also suggested having OEMS partner with the Board of Nursing to make QA Process education part of the mandatory requirements for licensure. He added that this method would ensure that a majority of nurses would be familiar with the process, and the Board of Nursing already makes training available online. Mr. Reed suggested creating training DVDs by trauma center level since each level handles patients differently due to resources. These DVDS could also be made available to hospital and prehospital providers for general training purposes.

Mr. Acker informed the Workgroup that the communicators at the ATCC often do not receive feedback, and he would like a copy of the feedback report to be sent on all closed issues. Mr. Acker stated that for the Statewide Trauma and Health Systems (STHS) to work all patients need to be entered at the scene so that the ATCC can coordinate patient destination. He reported that 70 percent of calls for patient entry occur while the patient is already in route to a hospital. This issue, in particular, is preventing the system to work as designed because the EMSP would not know if resources are available at the hospital they are delivering the patient to. He feels that the standard should be changed or EMSP should be required to comply since this issue makes up the bulk of QA issues. He reported that some patients are redirected three times before making it to the appropriate hospital, some services will not leave their coverage areas, and some transport twice to increase transport numbers. He would like to see EMSP comply with standards, and asked for suggestions to improve this issue, or he would like to stop flagging this as an issue for resolution. Mr. Garmon added that the issue is further complicated because some prehospital services use an internal transfer process rather than calling the ATCC.

Ms. Lang stated that the entry criteria are good, but behavior has not changed, and though hospital participation in the STHS is voluntary, it is not voluntary for prehospital services. Ms. Lang encouraged the regional offices to send feedback to the ATCC when issues are resolved. She suggested to the Workgroup that a step should to be added to the QA form to close the loop with the ATCC. Mr. Blue agreed that, although it should not appear that EMSP are being unduly criticized, patient entry with the ATCC has to be a priority because the patient is adversely affected. He stated that the ATCC not being the point of entry into the STHS and failing to close the loop with the ATCC wastes resources and available time to treat patients. Mr. Blue added that the regional directors know which prehospital providers are not complying and that those providers should be dealt with directly, rather than implementing something punitive statewide. He suggested that each prehospital service be evaluated by late entry into the system and not accepting ATCC direction, and that the regional directors check to be sure that there is not a communication issue that is affecting compliance. He also recommended a more robust effort to educate prehospital providers and hospital staff.

Ms. Louthain reported that she has experienced 80-90 percent late or no system entry, and follows up on all issues, but she has no authority to force compliance. Ms. Lang agreed that the prehospital providers that are not complying need to be identified and dealt with by the regional directors rather than institute changes statewide. The regional directors reported having these issues with air medical services as well. Mr. Acker suggested that air medical dispatchers may be able to fill this need. Ms. Louthain suggested that OEMS decide on a maximum number of QA issues that would automatically trigger mandatory education to try and maintain more consistent compliance. Mr. Pace suggested requiring the medical director to sign-off on all QA issues to develop accountability, and Ms. Lang suggested adding a time frame for responding to non-compliance issues, and she asked the Workgroup to consider breaking down QAs based on EMSP and hospitals to better tailor OEMS and regional responses and educational opportunities.

Mr. Acker reported that hospitals are finding they cannot treat some patients that are entered under EMSP Discretion criteria, and that less than 10 percent of those cases are entered into the QA/QI process. He suggested that this issue may need to be examined due to the large number if inter-facility transfers. He indicated that hospitals have a large volume of instances where these patients did not need to be entered at all. He requested that OEMS be sure that they do not require further action.

The Workgroup agreed to follow-up on the issues mentioned, listen to QA recordings as they come in, and close the loop with the ATCC by providing resolution upon issue closure. The Workgroup also agreed to add a prompt to the QA form to assist with that. Mr. Acker agreed to send the regional directors a two week sample (November 9 to 23) of late or no entry QA issues and the regional directors will track those issues and conduct education where appropriate. Ms. Lang added that further action for non-compliance for EMSP and hospital providers will be considered, and that Mr. Jackson would handle ATCC and EMSP issues, and Ms. Lang will handle hospital issues.

Next Meeting

The next meeting is to be determined.

Adjournment

The meeting was adjourned at approximately 1:37 p.m.