



## 202411-Maine-EMS-QI-Committee-Minutes

Wednesday, November 20, 2024

"The mission of Maine EMS is to promote and provide for a comprehensive and effective Emergency Medical Services system to ensure optimum patient care with standards for all clinicians. All members of this committee should strive to promote the core values of excellence, support, collaboration, and integrity. In serving on this committee, we commit to serve the respective clinicians, communities, and residents of the jurisdictions that we represent."

1. Call to Order
2. Reading of the mission statement
3. Attendance
  - a. Committee Members
    - i. Dr. Collamore, Oliver MacKenzie, Brian Langerman, Joanne Lebrun, Dwight Corning, Stephen Smith, Robert Sharkey, Alan Henschke, Melinda Fairbrother-Dyer
  - b. Guests
    - i. David Ireland
  - c. Maine EMS Staff
    - i. Jason Oko, Robert Glaspy, Darren Davis, Wil O'Neal
4. Public Comments
  - a. No Public comments are offered
5. Modifications to the Agenda
  - a. Kango Fix QI Survey being presented to the board by the EMS for Children Committee
6. Previous Meeting Minute Approval
  - a. Minutes are up to date
7. Old Business:
  - a. Subcommittee on QI Manual and Markers
    - i. The need for the meeting to be public has created a slowing of the process
8. New Business
  - a. Group Discussion: Brainstorm possible Statewide QI Markers
    - i. Looking for two or three measures
      1. National EMS guidelines



## 2. Cardiac Performance Measures

- a. Aspirin administration
- b. 12 lead in ten minutes
- c. Did they obtain a twelve lead
  - i. Who gave aspirin
  - ii. Pain assessment
  - iii. Pain treatment
  - iv. Pain improvement
  - v. 12 lead transmission
  - vi. Early notification to receiving facility
  - vii. Serial twelve leads
  - viii. the time it takes for transfer for the cardiac patient from ED to definitive care?
  - ix. Change in rhythm after medication administration
- d. Post-Rosc Care - review the protocol changes
- e. Primary diagnosis of cardiac arrest.
  - i. Primary impression of medical-death is still happening
- f. Alan's hand Grenade
  - i. How do we measure twelve leads in non-chest pain patients?
  - ii. Review inclusion criteria for 12-lead acquisition.
- g. Sharkey
  - i. How do we handle a second truck responding to cardiac arrests?
  - ii. The second unit is a support unit. All care rendered is on the first chart; the second chart is documenting that the unit responded.
  - iii. Hand grenade - time to first set of vital signs.

## 3. Stroke Performance MEASURES

- a. Did they get a stroke assessment



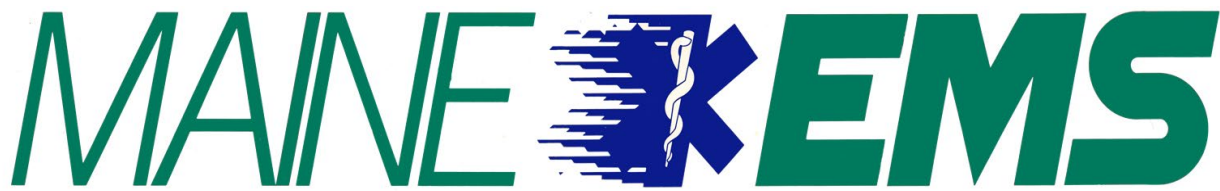
- b. Early notification to the receiving facility
- c. Last Known well
- d. Blood glucose
- e. Good IV access
- f. Appropriate destination choice when multiples exist.
- g. Time on scene should be less than ten minutes
  - i. Time from first EMS assessment to intervention.

#### 4. Trauma

- a. Spinal assessment
- b. Use of TXA when appropriate
- c. Tourniquet usage
- d. Transport on backboards - decrease - can we measure this
- e. Chest decompression that has not met the criteria or incorrect placement
- f. Traumatic cardiac arrest should attempt chest decompression

#### 5. Pain management

- a. Are we managing pain appropriately?
- b. Pain management in extremity trauma.
- c. Pain relief rate is probably a better metric.
- d. We have fallen to the wayside of pain reassessment
  - i. in Maine .... 48% of patients with injury are assessed for pain .... 3.2% have their pain scored lowered
- e. Pain management is a ladder, the lowest rung on the ladder is reassurance
- f. Pain management does not need to be straight to narcotic pain management.
- g. Hemostatic agent usage.
  - i. Can you use them on a face wound



- h. Antibiotic administration for open fractures and amputations.
- 6. Sepsis
  - a. Did we call a code sepsis
  - b. IV access
  - c. Appropriate fluid administration
  - d. Pressors when appropriate
  - e. Cold sepsis as well as hot
  - f. Did you identify a source of the infection?
  - g. Transfer of care upon arrival to the facility
  - h. Use of outcome data
  - i. Blood pressure improvement
  - j. Do prehospital sepsis alerts decrease time to complete CMS sepsis measures?
    - i. <https://www.sciencedirect.com/science/article/abs/pii/S0735675723003194>
- 7. Transfer of care
  - a. Do we develop ways to document transfer of care with more granularity?
- 8. Any other Systems of Care topics
  - a. Airway
    - i. If we could get the list of quality measures we've used in the past.
    - ii. The list from today
    - iii. What have we done from dispatch from the past
    - iv. It would be helpful to look at a comprehensive list and discuss where the gaps are.
- 9. Protocols are 911 mainly - do we need to discuss IFT measures?
- 10. Final thoughts from Wil - what are the things we do in terms of caring for patients that are particularly important to us, and how do we measure those things.



11. How we can help support providers with education is a key issue with Quality.
12. How do we include non-transporting services.
13. Jason will meet with Melida offline to discuss how we can loop dispatch into this.

9. Adjourn at 1453

#### **Latest Measures List**

1. EMS Activations (Activations, Emergency Activations, Transfer Activations)
2. Percentage of EMS responses originating from a 911 request during which lights and sirens were not used during patient transport. (All Patients, Patients 2 years of age through 17 years of age, Patients 18 years of age or older)
3. Percentage of EMS responses originating from a 911 request for patients less than 18 years of age who received a medication and had a documented weight in kilograms or length-based weight estimate documented during the EMS response. (Patients less than 18 years of age)
4. Percentage of EMS responses originating from a 911 request for patients not transported by EMS during which a basic set of vital signs is documented (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)
5. Percentage of EMS responses originating from a 911 request for patients suffering from a suspected stroke who had a stroke assessment performed during the EMS response. (All Patients)
6. Percentage of EMS responses originating from a 911 request for patients with a diagnosis of asthma who had an aerosolized beta agonist administered. (All Patients, Patients 2 years of age through 17 years of age, Patients 18 years of age or older)
7. Percentage of EMS responses originating from a 911 request for patients with hypoxia during which oxygen is administered. (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)
8. Percentage of EMS responses originating from a 911 request for patients with primary or secondary impression of respiratory distress who had a respiratory assessment. (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)



9. Percentage of EMS responses originating from a 911 request for patients with status epilepticus who received benzodiazepine during the EMS response. (All Patients, Patients 2 years of age through 17 years of age, Patients 18 years of age or older)
10. Percentage of EMS responses originating from a 911 request for patients with symptomatic hypoglycemia who received treatment to correct their hypoglycemia. (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)
11. Percentage of EMS responses originating from a 911 request for patients with syncope during which a 12-lead (or greater) ECG is performed. (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)
12. Percentage of EMS responses originating from a 911 request in which lights and sirens were not used during response. (All Patients, Patients 2 years of age through 17 years of age, Patients 18 years of age or older)
13. Percentage of EMS transports originating from a 911 request for patients who meet ACS prehospital field triage criteria for whom a pre-arrival trauma alert or activation is initiated. (Patients 65 years of age or older, Patients less than 10 years of age, Patients 10 to 64 years of age)
14. Percentage of EMS transports originating from a 911 request for patients who meet CDC criteria for trauma and are transported to a trauma center. (Patients 65 years of age or older, Patients less than 10 years of age, Patients 10 to 64 years of age)
15. Percentage of EMS transports originating from a 911 request for patients with injury who were assessed for pain. (All Patients, Patients 18 years of age or older, Patients 2 years of age through 17 years of age)
16. Percentage of EMS transports originating from a 911 request for patients with injury whose pain score was lowered during the EMS encounter. (All Patients, Patients 2 years of age through 17 years of age, Patients 18 years of age or older)
17. Percentage of EMS transports originating from a 911 request for patients with suspected traumatic brain injury during which oxygen level, ETCO<sub>2</sub>, and systolic blood pressure are documented. (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)





18. Percentage of EMS transports originating from a 911 request for patients with trauma during which GCS, systolic blood pressure, and respiratory rate are documented. (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)
19. Percentage of EMS transports originating from a 911 request or interfacility request for patients less than 8 years of age during which patients are transported using a pediatric restraint device. (Patients less than 8 years of age)
20. Percentage of endotracheal intubation attempts performed during an EMS response originating from a 911 request in which adequate patient oxygen levels were achieved prior to intubation attempt. (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)
21. Percentage of endotracheal intubation attempts performed during an EMS response originating from a 911 request that are successful on first attempt with neither hypotension nor hypoxia documented during the peri-intubation period, without hypotension and hypoxia (Age Adjusted). (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)
22. Percentage of endotracheal intubation attempts performed during an EMS response originating from a 911 request that are successful on first attempt with neither hypotension nor hypoxia documented during the peri-intubation period, without hypotension and hypoxia. (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)
23. Percentage of Patient Care Reports completed with 24 hours. (On Time Completion Ratio)
24. Percentage of Patient Care Reports having a validity score of 100 (Score of 100)
25. Percentage of Patient Care Reports having a validity score of 90 (Score of 90 or greater)
26. Ratio of Schema Violations to Patient Care Reports (Ratio)
27. Successful last invasive airway procedures performed during an EMS response originating from a 911 request in which waveform capnography is used for tube placement confirmation. (All Patients, Patients less than 18 years of age, Patients 18 years of age or older)



28. The duration in hours for EMS activations for emergency response within the primary service area. (Emergency Event Duration)
29. The duration in hours for EMS activations for interfacility transfers. (IFT Event Duration)
30. The percentage of patients encountered for a suspected overdose who were offered a referral to the Maine OPTIONS Program (Attempts)
31. The percentage of patients encountered for a suspected overdose who were referred to the Maine OPTIONS Program (Success)
32. The percentage of patients meeting the protocol for naloxone dispensation who were offered naloxone in the event of a future overdose. (Attempts)
33. The percentage of patients meeting the protocol for naloxone dispensation who were provided naloxone in the event of a future overdose. (Success)
34. The time in minutes from the unit arriving on scene until the unit is enroute to the hospital for patients where on scene time should be limited for emergency response within the primary service area. (On Scene Time)
35. The time in minutes from when the call is received until the unit arrives on scene for emergency response within the primary service area. (Total Response Time)
36. The time in minutes from when the call was received by dispatch until a unit is dispatched for emergency response within the primary service area. (Call Received To Unit Notified)
37. The time in minutes from when the unit goes enroute until it arrives on scene for emergency response to ALS activations within the primary service area. (Unit Enroute To Onscene (ALS))
38. The time in minutes from when the unit goes enroute until it arrives on scene for emergency response within the primary service area. (Unit Enroute To Onscene)
39. The time in minutes from when the unit is dispatched until it goes enroute for emergency response within the primary service area. (Unit Notified To Enroute)