20240221-Maine-EMS-QI-Committee-Minutes

Wednesday, February 21, 2024, 1:30 PM

“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
    a. At 1334
2. Reading of the mission statement
    a. Chip read the mission statement
3. Attendance
    a. Committee Members

☑ Ben Zetterman, ☑ Beth Collamore, MD ☑ Brian Langermam, ☑ Chip Getchell, ☑ Dwight Corning, ☑ Joanne Lebrun, ☑ Kate Zimmerman, DO, ☑ Matt Sholl, MD, ☑ Melinda Dyer ,☑ Rick Petrie, ☑ Robert Sharkey

1. Guests
    a. Robert McGraw, Fred Porter
2. Maine EMS Staff
    a. Jason Oko, Ashley Moody, Anthony Roberts, Darren Davis
4. Public Comments
    a. Chip encouraged everyone to encourage their staff to be vigilant of COVID, RSV, and Influenza
5. Modifications to the agenda
    a. Go back to Zoom.
    b. Role to play in the Vision 2035 document.
6. Previous Meeting Minutes
    a. January 17, 2024
        a. Motion by Joanne to approve the minutes, second by Dr. Collamore. Motion is unanimous of all present
7. Old Business:
    a. Chair Position Discussion
        a. There were no takes on the chair position.

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b. Pediatric Newsletter
    a. https://www.canva.com/design/DAFjL_UfOSE/Zm_9IIGpQDj55pqvDIgk_A/edit
    b. Marc's Notes on the newsletter:
        i. Page 1 states "in the period measured, 19 of 1141 run reports contained a primary impression of BRUE". What was the period measured? I also could not find a primary impression of BRUE in the MEFIRS system – I am just missing where this is? How was this determined?
        ii. On page 2, the statement of Fentanyl IN admin is that 31 administrations were done in 2022 and the citation is to a 2021 NASEMSO data measure. I suspect the data is from Maine and not NASEMSO, but this is confusing. I am not sure anyone cares who designed the performance measure as it is a reasonable measure for anyone to show, interesting and appropriate, but not magical or innovative from NASEMSO (and I say this as a NASEMSO Board of Directors member!). What might be more useful is that statement from the report of "There is a strong recommendation for the use of IN fentanyl over opioids (IM or IV) for the treatment of moderate to severe pain in children in the prehospital environment when pain management is indicated prior to, or in the absence of, IV access" and "Existing research has established the safety and efficacy of intranasal administration of fentanyl in children. (Borland 2002, Setlur 2008, Saunders 2009, Murphy 2017)". This might provide consideration for those having reluctance to use IN fentanyl when in reality it may be better.
        iii. Also on page 2, there is the statement "53.3% (1,737 of 3,259 records) of all emergency responses where transport was not provided for patients under 18 were for the authorized decision maker feeling that ambulance transport

was unnecessary", I get a bit concerned with the term "feeling" as this is very hard to quantify. I might suggest approaching this as "deciding", but again this is just general editing and

iv. Page 3 references "In 2022, 266 EMS patient care reports contained a primary impression, primary symptom, or primary complaint of a behavioral or mental health-related issue in a pediatric patient (age less than or equal to 17 years)." My quick review of MEFIRS data for 2022 for under 18 years old only showed:

c. Under "Primary Impression"
   i. Behavioral - Anxiety – 413, Behavioral – Excited Delirium – 35, Behavioral – Psychiatric Episode – 676, Behavioral – Suicide Attempt – 130, Homicidal and suicidal ideations – 8, Homicidal ideations – 5, Suicidal ideations – 120. This gives us 1,387 cases, and of these, 1,358 were listed as a 911/mutual aid/intercept/standby/public assistance/blank. That means only 29 were listed under primary impression for IFT/PIFT/SCT (which we know is not true), so to find these I dove further. Under "Primary Symptom" and we select the behavioral symptoms, then filter out the 911/mutual aid/intercept/standby/public assistance/blank, leaving only medical transport/IFT/PIFT/SCT, we add an additional 683 cases (which also seems VERY low), Finally, if we select "Transfer Reason" as "Psychiatric/Behavioral Care" and filter out any behavioral conditions under "Primary Symptom" and "Primary Impression", we add an additional 247 cases, This results in a total of 2,288 cases, and out of 13,403 PCRs for patients under 18 years, equates to 17% of all PCRs. My gut says we are still missing a lot of IFTs. As an example, if we select "Primary Impression" as ".", "Primary Symptom" of one of the behavioral care items, we can see 71 of those patients have a transfer reason of

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"Pediatric Specialty Care, Rehab, Return to Home, Extended Care, Medical Specialty Care, or Convenience Transfer", so there are likely others buried in the data.

ii. I love the opportunities on the last page of both improving documentation and cqi – I wonder if some specific tips of documentation might be more helpful and easier to implement such as:
    1. Remember to document the patient weight in kilograms
    2. Remember to ensure the age and units of age are accurate
    3. Document use of OLMC if you suspect a BRUE and the patient is not transported
    4. Ensure you use the correct protocol (i.e. do not document you used "ACLS guidelines" for a pediatric cardiac arrest as ACLS is Adult Cardiac Life Support)

1. The future of the newsletters
    a. Time consumption of the newsletter
        a. Should this be a concept newsletter rather than reporting on our actual data. There is an issue from those drafting the newsletter accessing data available to them to.
        b. Chip wants to think about this further.
        c. Joanne - is there a way we might be able to report on the things that are already being done? Community Paramedicine - SUD - Systems of care data/AED - reports already written that this committee could look at in what the quality pieces of these might be that might improve the data or help to explain the data. To help inform quality leaders and service leadership.
        d. Ashley - Communicating with clinicians - has the QI committee considered guiding individual services by establishing guidelines. There is not a lot of support and structure to manage the QA/QI system. Could this committee do that? Benchmarking for services to look at their own information.

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e. Dr. Sholl - same direction of Joanne - we have been doing what we have been doing. Time to think towards the future. Supporting services - becoming a resource to help folks learn to fish - NEMSQA measures. Be an active participant in reviewing certain things. Ask Stakeholders - How can the QI committee help you? Teaching folks about QI - Giving folks tools for QI
f. Rick - MEMS QI Manual - review and update the manual.

8. New Business:
    a. Outcome data
        a. Work in progress - need MRN and Encounter Number
            i. Jason gave an update on the process
                1. Joanne - can we circulate the info to hospitals to have this information ready. Joanne is willing to help facilitate the discussion to make this easier.
                2. Sharkey - where is this on the run form - Transport tab.
    b. NEMSIS 3.5 Transition
        a. Jason gave an update on CQI Criteria
    c. Return to Zoom
        a. No objections.
9. Next Meeting
    a. March 20, 2024
        a. Agenda Items
            i. Vision 2035 - Send to committee
            ii. Finalize pediatric newsletter with Chip - Updates from Marc.
            iii. Newsletter conversation
            iv. QI Manual
        b. Adjournment at 1434