East Region
Quality Assurance and Improvement Plan
For
Trauma, Cardiac and Stroke

January 2017-January 2019

Mission Statement:

To promote and support a comprehensive emergency care system for the trauma, cardiac and stroke patients in the East Region.

Authority:

As defined in ***RCW 70.168.090 (2); WAC 246-976-910; RCW 70.168.050***, a regional emergency medical services and trauma care system quality assurance program shall be established by those facilities authorized to provide trauma (cardiac and stroke) care services.

Purpose:

The East Region Quality Assurance and Improvement Committee is committed to optimal clinical care and system performance in the Region as it relates to trauma, cardiac and stroke patients as evidenced by patient outcomes. A multidisciplinary team approach to concurrent and retrospective analysis of care delivery, patient care outcomes and compliance with the requirements of Washington State as per ***RCW 70.168.090*** is the fundamental goal. Benchmark comparison and best practice review will be emphasized.

Trauma Patient Population Criteria:

- The trauma patient is defined by Washington State Criteria per guideline policy DOH 530-113 which was effected October 1, 2015. Trauma services may include additional patients who do not meet the state inclusion criteria. However, hospital comparative reports, regional quality improvement reports, and other state-prepared reports will reflect only records that meet the state criteria. This helps assure comparability across facilities and regions.

Cardiac Patient Population Criteria:

- The cardiac patient is defined as any patient 21 years of age or older that presents with signs and symptoms of acute coronary syndrome.

Stroke Patient Population Criteria:

- The stroke patient is defined as any patient presenting with an acute cerebral vascular incident with neurological impairment.

Method for Analysis:

1. Data

Registry data will be provided to the committee in standard reports and Ad hoc reports as requested according to department, regional council or QI committee members. Data will be collected from the state and regional databases such as the Washington State Trauma Registry (Collector), COAP/ACTION, Get with the Guidelines Stroke and WEMSIS and independent facility data. Data elements related to the identification of individual patient's, provider's and facility's care outcomes shall be confidential, shall be exempt from ***RCW 42.56.030*** through ***42.56.570*** and ***42.17.350*** through ***42.17.450***, and shall not be subject to discovery by subpoena or admissible as evidence.

2. Systems Analysis

System assessment will include the ongoing monitoring of provider compliance with state statutes, administrative code and established protocols for adult and pediatric care and rehabilitation. It is not intended to duplicate or supplant quality assurance programs of the individual facilities (designated or non-designated), rehabilitation facilities, or pre-hospital agencies involved in regional care.

3. Focused Case Review

Individual case review emphasizing issues, trends and patterns providing base for discussion of care delivery and areas of concern. Review will include continuum of care from pre-hospital through rehabilitation. Involved individuals will be encouraged to be present for discussion. Patient care quality assurance records and reports developed for QI purposes are confidential, exempt from ***RCW 42.56*** and are not subject to discovery by subpoena or admissible as evidence.

4. Education

The East Region's QI Committee will identify potential and actual areas of concern in the region's care system based on identified trends and focused case reviews. Identification of specific provider educational needs and injury &/or illness prevention strategies will be developed in conjunction with the Regional Training and Education Committee.

Reporting:

1. Opportunities for Improvement and Education

The East Region QI committee will provide reports to the East Region Council and the DOH as needed regarding outcomes, trends, flow patterns and educational opportunities. Any identified injury or illness prevention opportunities for selected patients will be communicated to the East Region Injury Prevention Committee.

2. Summary Conclusions and Reporting

The Chairperson for both the trauma and cardiac/stroke QI committees is responsible for providing summary conclusions of discussions and decisions made by the East Region Cardiac and Stroke QI committee after review of data, PCP's and COP's in regards to clinical care. Actions for identified deficiencies/problems must be determined by a vote of this committee. A yearly report will be provided to the East Region Council at minimum.

3. Confidentiality

Notification in writing of the confidentiality of each meeting is required. The confidentiality agreement for this committee will be read by the Chairperson and signed by the members present at each committee meeting. It will be understood that those who participate by Telehealth are in agreement with the confidentiality statement if they remain online after the statement is read. Information related to provider's and facility's clinical care and patient outcomes will remain confidential in accordance with ***RCW 70.168***. Information identifying individual patients cannot be publicly disclosed without patient consent in accordance with ***RCW 70.168.090***.

Membership:

1. As stated in *WAC 246-976-910(3)*:
The East Region QI Committee shall include at least one member of each designated facility's medical staff, the RN Coordinator for each service, an EMS provider, and a selected member of the East Region Council.

2. As stated in *WAC 246-976-910(4) (5)*:
The East Region QA Committee shall invite the MPD and all other health care providers and facilities providing trauma, cardiac and stroke care in the region, including non-designated facilities and non-verified prehospital services, to participate in the regional trauma quality assurance program. A trauma care provider who does not work or reside in the region shall also be invited.

3. Required Members (Voting):
- Trauma Medical Director from each designated facility
- Trauma RN Coordinator from each designated facility
- MPD from each county
- EMS provider Representative (ALS and BLS, aeromedical and ground transport)
- Selected member of the East Region EMS Council
- Rehabilitation representative from each designated rehab facility
- Regional Injury Prevention Representative

Cardiac and Stroke Members [Voting]:
- Cardiac Medical Director from each categorized facility
- Cardiac RN Coordinator from each categorized facility
- Stroke Medical Director from each categorized facility
- Stroke RN Coordinator from each categorized facility
- EMS provider Representative (ALS and BLS, aeromedical and ground transport)
- Selected member of the East Region EMS Council
- Rehabilitation representative from each designated rehab facility

An official designee from the represented facility, agency, or committee may replace any of the above members. It is requested that the designee is of comparable credentials and that the designee be listed with the QA committee.

4. Invited Members (non-voting):
- Emergency Department Representative
- Representative from each non-designated facility
- DOH representative
- Care provider who does not work or reside in the region
- Appropriated Medical/Surgical sub-specialists as needed and determined by the Chairperson of this committee
- Medical Examiner/Coroner from each county
- Registry personnel from each designated facility

5. Committee Officials: The elected officials of each committee will consist of the Chairperson and Vice Chairperson. The Chair and Vice Chair will be elected by a majority vote of the membership for a 2-year renewable term.

Meeting Process:

1. **Trauma meeting:**
   The Trauma and EMS meeting will be held quarterly the first Thursday in March, June, September and December at the Level II facility. The meeting will start at 1400 and be approximately 2 hours in length.

2. **Cardiac and Stroke meeting:**
   The Cardiac and Stroke meeting will be held quarterly on the last Thursday of January, April, July and October The meeting time will be 0700-0830 and will alternate between a cardiac or stroke focus each quarter.

3. **Meeting officials:**
   - The Chairperson is to set the agenda and to conduct the meeting.
   - The Vice Chairperson is to fulfill the duties of the Chairperson in their absence.
   - A representative of the East Region QI Committee will report to the East Region EMS and Trauma Council on a routine basis.
   - Secretarial responsibility for the trauma meeting will be provided by the Level II facility.

4. **Meeting Components:**
   - Regional & State data presentation by Washington State DOH representative
   - Analysis of East Region data, trends and issues
   - Review of county PCP's and COP's.
   - Focused case review
   - Education opportunity discussion
   - Facility, agency and committee representative reports
   - Future audit filter discussion

Not *all* components will be included in *each* meeting. Meeting minutes will reflect only that a focused case review occurred without specific details. Discussion, action or outcome will not be reflected.

Attachment A
Performance Measures 2017-2019

Trauma:

1. Percentage of patients with ED LOS > 3 hrs prior to transfer, adult and pediatric
2. Hypotensive patients with full trauma team activation (age-appropriate)
3. Anticoagulated patients with intercranial hemorrhage and reversal not initiated within 2 hrs

Cardiac:

Acute Therapies

1. % of patients receiving Reperfusion therapy
    a. % of patients receiving Primary PCI
    b. % of patients receiving Fibrinolytics
2. % of patients with Arrival to Primary PCI $\leq$ 90 min
3. % of patients with FMC to Primary PCI $\leq$ 90 min and < 120 min
4. % of patients receiving ASA at arrival

Stroke:

1. % of all stroke patients arriving at hospital via EMS
2. Stroke indicators/tPA eligible:
    - % of ischemic stroke patients arriving within 3.5 hours of symptom onset
    - % of ischemic stroke patients receiving rt-PA
    - Median Door to Needle times for tPA treated patients
    - % of ischemic stroke patients receiving endovascular/mechanical thrombectomy

EMS/Aeromedical:

Trauma:

1. % of patients with spinal injury and appropriate spinal precautions placed
2. % of patients with femur injuries and placed in appropriate splint.
3. % of patients with GCS $\leq$ 8 that had an airway placed

Suspected ACS/Chest pain patient (>21 yrs of age with suspected cardiac chest pain/discomfort or other symptoms suggestive of ACS)

1. % who received ASA/ % who received NTG
2. % who received a 12 lead ECG in <10 min from EMS arrival
3. % with an EMS Scene time of <20 min
4. % of STEMI patients taken to Level 1 Cardiac Center
5. % of High Risk patients taken to a Level 1 Cardiac Center

Cardiac Arrest

1. % Bystander CPR for Cardiac arrest patients, with suspected cardiac etiology
2. Time from EMS dispatch call receipt until 1st unit on scene
3. Documentation of initial ECG rhythm
4. Time from 911 receipt at Fire/EMS dispatch until 1st VF defibrillation
5. % witnessed VF patient ROSC on ED arrival

6. % witnessed VF survival to discharge from hospital
7. % of CPA-ROSC patients taken to a Level 1 Cardiac Center

Suspected Stroke/TIA patient management

1. % FAST Exam/Lams score performed on all stroke/TIA patients
2. % stroke patients with advanced notification of stroke symptoms to receiving hospital
3. % of stroke patients receiving blood glucose check
4. EMS arrival to departure of ambulance (scene time)

Rehabilitation:

1. Percentage of admissions of each specialty admitted to a rehab facility vs ECF; adult and pediatric
2. Hospital LOS prior to admission to the rehab facility, adult and pediatric
3. Percentage of rehab disposition to home vs ECF and others
4. Rehab LOS
5. Percent of patients discharged to Acute

Attachment C

2017 Trauma Meeting Schedule

March 2, 2017— Rehab Focus

DOH presentation:
Presentation: Lara Ray
Performance Measures: Percentage of admissions of each specialty admitted to a rehab facility vs ECF, adult and pediatric. Hospital LOS prior to admission to the rehab facility, adult and pediatric, Percentage of rehab disposition to home vs ECF and others, Rehab LOS

June 1, 2017—Prehospital Focus

DOH presentation:
Presentation: Dominic Pomponio RN, Lifeflight
Performance Measures:

September 7, 2017—Pediatric Focus

DOH Presentation:
Presentation: Peds {TBA}
Performance measures:

December 7, 2017 –Acute Care Focus

DOH Presentation:
Case Presentation: Adult {TBA}
Performance Measures: Percentage of admissions of each specialty admitted to a rehab facility vs ECF, adult and pediatric. Hospital LOS prior to admission to the rehab facility, adult and pediatric, Percentage of rehab disposition to home vs ECF and others, Rehab LOS

2017 Cardiac/Stroke Meeting Schedule

January 26th, 2017 - Stroke Focus

April 27th, 2017 - Cardiac Focus

July 27th, 2017 - Stroke Focus

October 26th, 2017 - Cardiac Focus