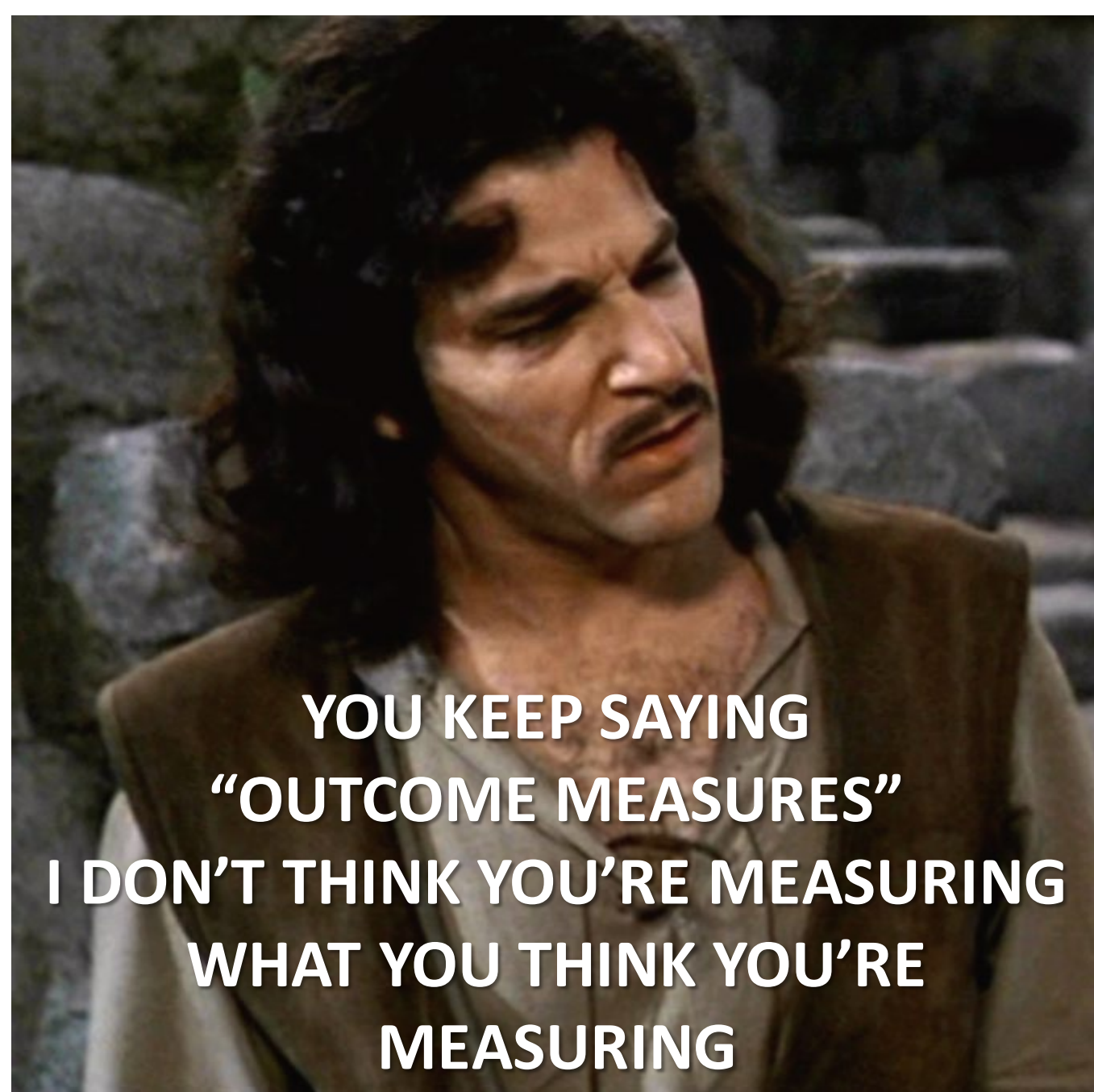


Quality Metrics Committee Report to SEMAC / SEMCSO

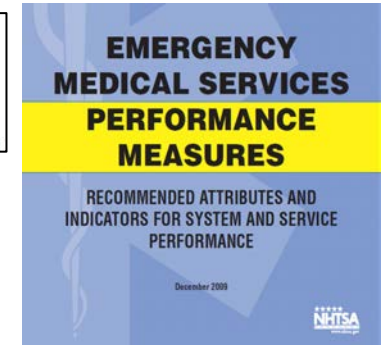
Clinical Quality Measures Rollout Plan
February 2023



**YOU KEEP SAYING
“OUTCOME MEASURES”
I DON’T THINK YOU’RE MEASURING
WHAT YOU THINK YOU’RE
MEASURING**

NEMSQQA

National EMS Quality Alliance



Cardiac	
12-Lead ECG within 10 minutes of patient contact	AHA ML
12-Lead ECG Performed	AHA ML
Pre-Arrival STEMI Alert	AHA
Aspirin Administration	FAIR
Trauma	
Percent of patients transported initially to a NYS Designated Trauma Center	NEMSQA
Percentage of patients with injury who were assessed for pain	NEMSQA
Percentage of patients whose pain score was lowered during the EMS encounter	NEMSQA
Percentage of patients for whom a pre-arrival trauma alert is initiated	FAIR
Respiratory	
Percentage of pediatric patients in Acute Respiratory Distress receiving a Respiratory Assessment	NEMSQA
Percentage of patients with a diagnosis of asthma who had an aerosolized beta agonist administered	NEMSQA
Pediatrics	
Patients <18 who received a weight-based medication and had a documented weight in kilograms	NEMSQA

Stroke/Neuro	
Stroke or Transient Ischemic Attack patients receiving a blood glucose level testing	AHA/Coverdell, FAIR
Stroke or Transient Ischemic Attack transported to a stroke center	AHA/Coverdell
Stroke transports that had a documented time of last known well	FAIR/AHA
Patients suffering from a suspected stroke who had a stroke assessment performed	NEMSQA
Suspected CVA/TIA patients for whom a Code Stroke Alert is activated prior to hospital arrival	FAIR
Patients with status epilepticus who received benzodiazepine	NEMSQA
Airway	
Waveform Capnography Airway Device Monitoring	FAIR
Safety	
Lights and sirens were not used during response	NEMSQA
Lights and sirens were not used during patient transport	NEMSQA
Miscellaneous	
Patients with symptomatic hypoglycemia who receive treatment to correct their hypoglycemia	NEMSQA

3-Phase Rollout

1

REQUIRED
STATEWIDE CORE
MEASURES

2

WIDER MEASURES FROM
SPECIFIC SPHERES

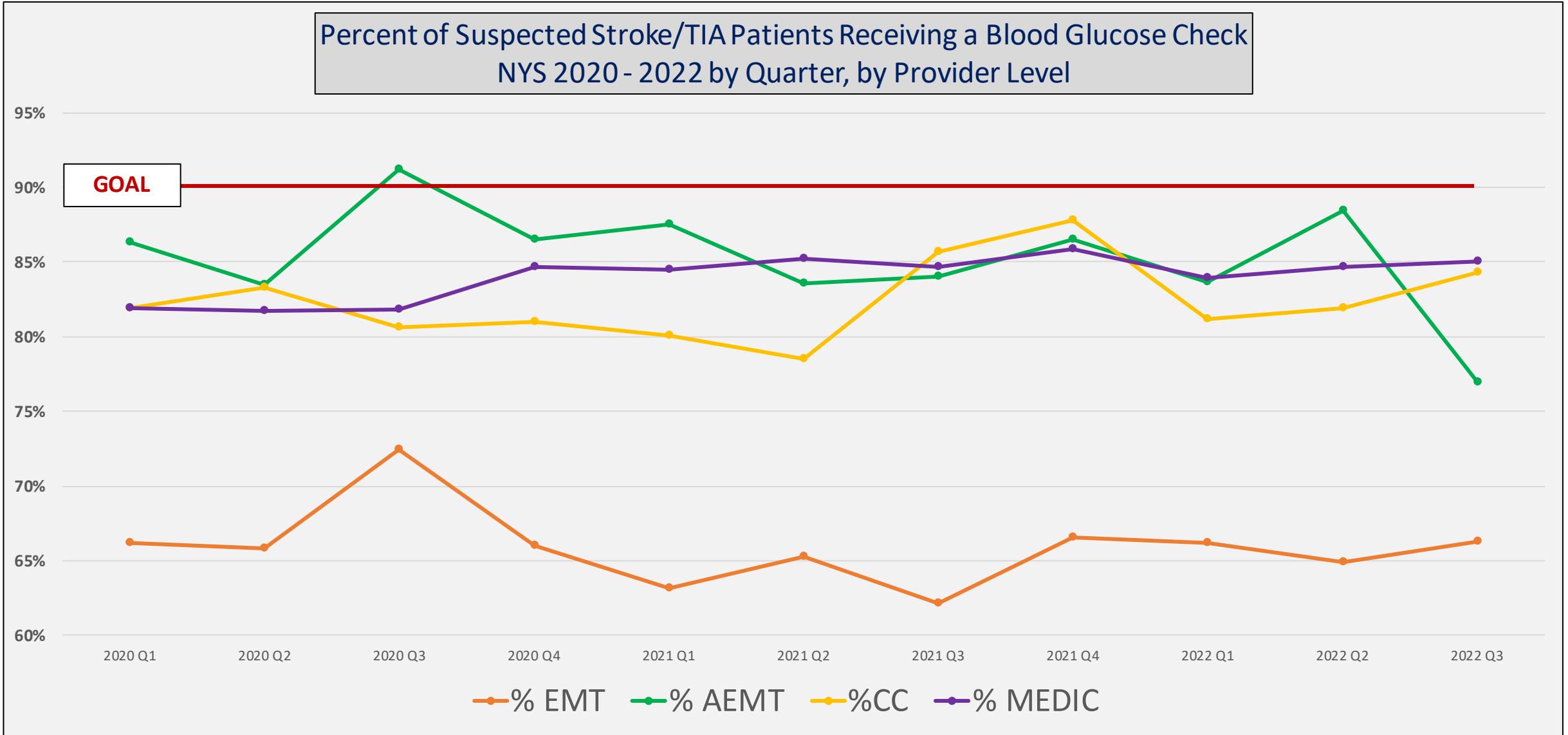
*PEDIATRICS, TRAUMA, CARDIAC,
STROKE / NEURO, RESPIRATORY,
AIRWAY, SAFETY...*

3

A LARGE NUMBER OF
OPTIONS WITH PROGRAM
AGENCY, REGIONAL, AND
INDIVIDUAL AGENCY
SELECTION

State Outcomes in a Run Chart

Percent of Suspected Stroke/TIA Patients Receiving a Blood Glucose Check
NYS 2020 - 2022 by Quarter, by Provider Level



Quality Improvement Process

NYS
Bureau of EMS
DOH Cover Page

NYS Quality Improvement for Prehospital Clinicians: The New York State Manual

2022

1

4. CREATE A STARTING POINT AND BEGIN TO MEASURE YOUR PERFORMANCE
Use automated software from your ePCR vendor, the ImageTrend NYS Bridge, or your Regional Program Agency to do a review for a given timeframe. It is important to select collection methods which meet the needs of the intended quality improvement project. Data should describe the desired outcome and the collection process should not be onerous.

To find the percent of 911, stroke or TIA patients receiving Blood Glucose Checks:
$$\frac{65 \text{ patients met glucose measurement}}{100 \text{ patients met 911 call}} = 0.65$$

$$0.65 \times 100 = 65\%$$

1. FORM A QUALITY IMPROVEMENT COMMITTEE REPRESENTATIVE OF THE ORGANIZATION, INCLUDING THE MEDICAL DIRECTOR AND OPERATIONAL LEADERSHIP
The committee must take ownership of agency issues and commit to addressing them. The best way of doing this is by documenting the commitment in writing.
We, Bill Johnson - VP of Operations, Maggie Smith - Medical Director, Christine Jones - Training Coordinator, Steven Fernandez - Quality Assurance Director, Charles McGrath - Paramedic, and Kelly Williams - EMT, are committed to improving patient care by our organization.

2. IDENTIFY AN IMPORTANT PROBLEM AND CREATE A WRITTEN AIM STATEMENT
An aim statement answers the question of "what is trying to be accomplished?" The aim statement should be well defined, evidence-based, and patient-centric outcomes that should be addressed by an improvement project. An effective Aim Statement should meet the SMART criteria for goals/objectives: Specific, Measurable, Achievable, Relevant, and Timely-bound.
90% of patients with suspected stroke will have a blood sugar measured and documented within six months.

3. USE AN EXISTING QUALITY MEASURE OR IF NECESSARY, CREATE A QUALITY MEASURE
Quality Measure Statement
Title: A description of what the measure relates to:
New York State Department of Health, Bureau of Emergency Medical Services and Trauma Systems - New York State Quality Standards - Standard 2019 DQS 06: Stroke and TIA patients receiving Blood Glucose Monitoring.
Denominator: The total population to which a measure applies.
• Response Type of Service Representative (eResponse 05) is equal to 911 Response (Survey) unspecified) or TIA (Transient cerebral ischemic attack, unspecified)
• Provider Primary Impression (eImpression.11) is equal to Stroke (Cerebral infarction, unspecified) or TIA (Transient cerebral ischemic attack, unspecified)
Numerator: The total population receiving the measure.
• Procedures Performed (eProcedures.03) is equal to: Glucose measurement, blood (procedure)
Exclusions/Exceptions: A condition that removes a defined group of patients from the denominator because the measure would not appropriately apply to them.
• None

CHANGE IDEAS
• Create quality measure & performance rate with training procedures
• Educations on why behind BG measurement in stroke
• Regular feedback on all measured stroke cases
• Target reminder rate for 90% as part of prehospital stroke check
• Report of BG level in every call with primary response of stroke or TIA
• Report in every EMS log

2. CONTINUE THE PDCA CYCLE AND EVALUATE OPPORTUNITIES FOR IMPROVEMENT WITH THIS AND OTHER MEASURES
Consider the ideas in the psychology of change section and adapt to changes in technology, the environment, the workforce, society, and the industry. Consider dashboards that provide insight to current performance. They may include color indicators to describe data that meets a goal, is in process, or not meeting a goal. Be sure to plot them over time in a run-chart to see if your AGENCY'S NEWLY ESTABLISHED "BEST PRACTICES" ARE BEING MAINTAINED.

TEST YOUR CHANGE IDEAS WITH PDCA CYCLES.
Plan: This requires making a prediction of what will happen and why and developing the plan for testing it including a plan for collecting the data.
Execute: the plan and test the change. Document problems or observations.
Review: Review the test, analyze the results, and identify learnings.
Act: act on what you learned in the study step - if the change did not work, go through the cycle with a different plan using what you learned in the first round. If successful, take lessons learned from the test into broader changes. Use what was learned to plan and begin the cycle again.

4. RUN CHART
Measure improvement over time.
911 PATIENTS RECEIVING BLOOD GLUCOSE MONITORING

HEALTH STRATEGY
IMPROVEMENT STRATEGY
CYCLE 2
CYCLE 3
MONTH

IMAGETREND[®]

 biospatial