OMD Quality Management Program

The mission of the OMD Quality Management Program is to ensure that the organization designs, controls, and continuously improves performance of the system to meet the changing healthcare needs of patients, populations, and communities in the EMS setting. This program serves to integrate quality planning, quality control, and quality improvement activities across multiple levels of the system and to place quality at the center of the organizational strategy.

To achieve this mission, the functions of the Quality Management Program are divided into four domains:

- Quality Planning (QP) is a process to identify system needs, define quality goals and deploy a quality strategy to meet prioritized needs.
- Performance Measurement evaluates clinical performance and establishes feedback processes to identify gaps between actual and desired results
- Quality Improvement (QI) involves a structured approach to achieving new levels of performance consistent with organizational goals.
- Quality Assurance (QA) is a systematic process to address clinical concerns with individual providers in a non-punitive and educational manner

Quality Planning (QP)

Quality Planning is a systematic process that prioritizes the healthcare needs of the community while balancing the operational needs of the EMS/FRO system to achieve the shared goal of providing clinically excellent patient care in the pre-hospital setting. This process consists of defining the needs of the system, designing strategies to meet these needs, and developing a plan to deploy this strategy across the system.

1. Defining the system needs
   a. Engagement of system stakeholders, the System Performance Committee and the Medical Advisory Board
   b. Development of shared mission, vision, and values
   c. Establishing an organizational definition of quality

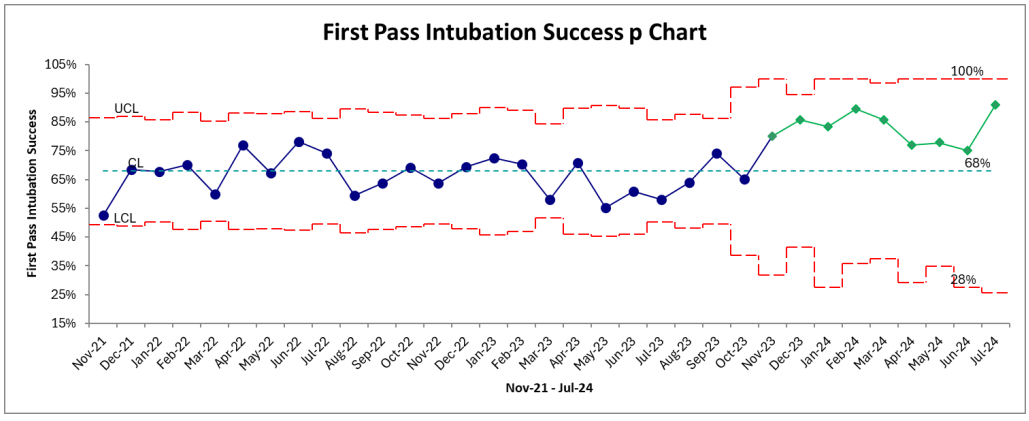
2. Designing the quality strategy
   a. Analyze the existing system and identify opportunities for improvement and innovation.
   b. Develop objectives and annual goals aligned with the strategy

3. Deploy the quality strategy systemwide
   a. Translate quality goals and objectives into actionable plans
   b. Align quality goals with systemwide measures

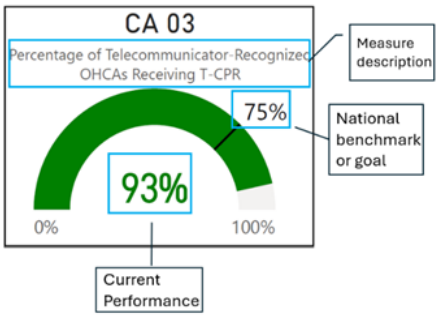
Performance Measurement

Clinical Performance Measuring is a process by which the quality goals of the system are measured and establishes a feedback loop to identify gaps between desired and actual results. Clinical performance measures will be based on nationally endorsed, evidenced-based clinical performance measures from the following sources:

- AHA Mission Lifeline
- AHA Telecommunicator CPR Performance Measures
- National EMS Quality Alliance
- CARES – Cardiac Arrest Registry to Enhance Survival
- Other quality goals established in the quality planning process



Clinical benchmarks will align with national performance on the established measures whenever they are available, follow goals set forth by the American Heart Association (AHA), or will align with quality goals of the system established in the quality planning process. Monthly clinical performance will be communicated frequently to system stakeholders to ensure transparency and accountability.



Quality Improvement (QI)

When performance gaps are identified between the organizational goals and current system performance the quality improvement system enables the organization to bring system performance to the desired level. The Model for Improvement will be used as the methodology for quality improvement initiatives. This methodology includes the following key elements:

Planning for improvement

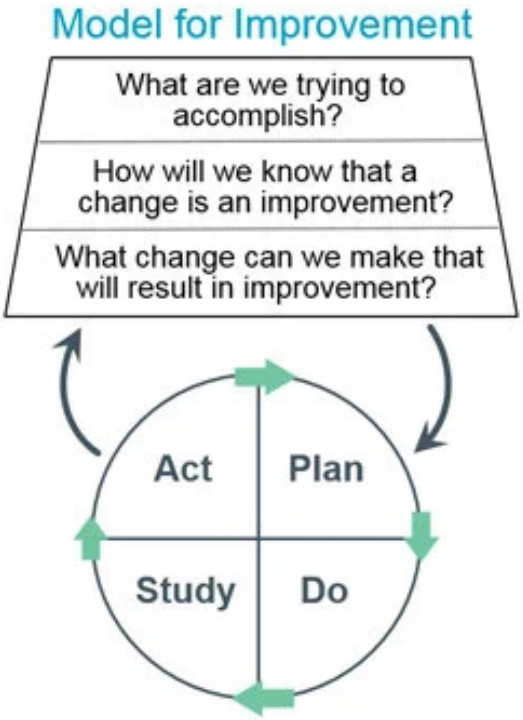
- Identification of gaps between desired and actual performance.
- Prioritizing improvement opportunities

Formation of multidisciplinary teams

- Identification of project manager, project sponsor and team members
- Ensure appropriate system representation and subject matter knowledge

Drafting of project charters

- What are we trying to accomplish
- How will we know change is an improvement
- What changes can we make that will result in improvement?
- Project AIM statement
- Driver Diagram



Establishing project measures

- Outcome
- Process measures
- Balancing Measures

Plan-Do-Study-Act

- Develop changes
- Test changes
- Implement changes
- Spread changes

Quality Assurance (QA)

The goal of the quality assurance process is to be non-punitive and to provide effective and educational feedback while ensuring confidentiality. The following outline provides the structure for this process:

1. Detection and reporting
2. Initial Review
3. Risk Categorization
4. Information Gathering
5. Interview/Evaluation
6. Disposition and feedback
7. Clinical Improvement Plan (if needed)

Sentinel Event

Sentinel events are cases in which there is a high index of suspicion for a critical lapse in clinical care, and for which there is significant concern for further lapses in the absence of appropriate remediation or retraining. This includes potential or actual deleterious patient outcomes directly related to inadequate assessment or inadequate/inappropriate application of protocol or skill.

These cases will be brought to the immediate attention of the Medical Director and may result in the immediate temporary restriction of clinical privileges. A direct clinical review will be scheduled as soon as possible with the investigating OMD staff and the Medical Director. Reinstatement of full clinical privileges may depend on successful completion of a Clinical Improvement Plan, including remediation or training, when determined to be necessary.

Reporting Process

Reporting will be standardized throughout the system. All potential sentinel events or other concerns, reported to or by any of the above (see Internal and external reports) will be entered into a system and QA database. All such events will be reviewed for potential clinical concerns requiring further evaluation and disposition. Whenever an event with associated clinical concern occurs, the event will be reported to the appropriate agency QA representative. For MedStar, OMD serves this function; the FROs may designate their own individuals for this purpose. This report should be sent immediately to selfreport@medstar911.org, and it should include:

- Run Number
- Concerns from reporting party
- Statements from crew, as appropriate

Self-Report

Self-reports may include events in which a provider recognizes that they may have committed a potential error, or situations in which the provider reports a case for which they are seeking guidance on the clinical care that they rendered. The criteria for designation as a self-report are as follows:

- Reported promptly via email to selfreport@medstar911.org
- Did not knowingly inflict harm on the patient
- Did not knowingly neglect the patient

Initial Review

Following initial reporting, the case will undergo an initial review to determine if substantial clinical issues are evident, and if so, a risk category will be determined. If the event is deemed not to be clinical in nature, the case will be closed and will require no further evaluation.

Parameters for initial review may include, but are not limited to, evaluation of the e-PCR, monitor files and supporting documenting for:

- Patient assessment
- Application of patient care protocols
- Patient care management and skills application
- Hospital destination choice
- Transport decision/patient disposition

Risk categorization

High Priority:

High-priority cases are those for which:

- There is a high index of suspicion for a critical lapse in clinical care, and for which there is significant concern for further lapses in the absence of appropriate remediation or retraining
- Potential or actual deleterious patient outcome directly related to inadequate assessment or inadequate/inappropriate application of protocol or skill

Examples of high-priority risk categorization:

- Unrecognized failed airway
- Hypoxic intubation
- Unrecognized/untreated lethal arrythmia
- Conscious disregard of unjustifiable risk or intentional harm to patient

High priority cases will be brought to the immediate attention of the Medical Director(s), and they may result in immediate temporary restriction of clinical privileges. A direct clinical review will be scheduled as soon as possible with the investigating OMD staff and the Medical Director. Reinstatement of full clinical privileges may depend on successful completion of a Clinical Improvement Plan, which may include remediation or training.

Moderate Priority:

Moderate-priority cases are those which involve deviations from protocol or clinical care, or pose potential risks for adverse outcome, not deemed to be high priority in nature, as described above

Examples of moderate-priority cases:

- Inappropriate application of field termination protocol
- Medication errors with potential for adverse outcome
- Inappropriate delegation of care, skill, or treatment based on provider scope
- Protocol variance with potential for adverse outcome (i.e. under or over treating)

Moderate cases will be brought to the attention of the individual agency QA representative but will not result in immediate temporary restriction of clinical privileges. A direct clinical review may be scheduled with agency QA staff, as well as with OMD staff and the Medical Director, as appropriate.

Low Priority:
Low-priority cases involve potential deviations from protocol or clinical care but do not pose a substantial risk for adverse outcomes

Examples of low-priority cases:

- Inadequate documentation
- Medication dosing error with minimal potential for adverse outcome.
- Protocol variance with minimal potential for adverse outcome
- General complaints

Low priority cases will be brought to the attention of the individual system QA representative but will not result in immediate temporary restriction of clinical privileges. Agency QA staff will review these cases either in person or through telephone interview in collaboration with OMD, as appropriate.

OLPG/OLMC QA

The QA process for On-Line Medical Control (OLMC) calls will include a monthly review of all calls that are referred to the OLPG/OLMC QA process by OMD personnel, operations, or external sources. These reviews will be conducted with the OMD Medical Directors to ensure the highest standard of care and compliance with clinical protocols. Additionally, the Medical Directors may randomly select OLMC calls each month for review to further evaluate adherence to clinical guidelines and to identify potential areas for improvement.

Weekly QA Meeting

In the weekly QA meeting with the Medical Director(s), all cases referred to the QA process will undergo review. During this review, any cases that have not yet been categorized as high priority will be assigned an appropriate risk categorization. The meeting will also determine the case feedback, disposition, and action plan, including clinical improvement plans, which will then be communicated to the relevant agency staff.

Disposition

Based on findings from the QA process, the case will be given a final disposition and logged into the database. The final dispositions are as follows:

No Fault: These cases include those where no deviation from protocol or clinical care was found, and where the care provided did not pose a substantial risk for an adverse outcome.

Clinically Appropriate: These cases include those where deviations from protocol or clinical care were found, but which did not pose a substantial risk for an adverse outcome and may have resulted in improved clinical course or outcome.

Needs Improvement: These cases include those where deviations from protocol or clinical care were found and may have posed potential risk for an adverse outcome.

Clinically Inappropriate: These cases include those where a critical lapse in clinical care was identified, and where significant concern for further lapses exists in the absence of appropriate remediation or retraining.

Clinical Improvement Plan

A Clinical Improvement Plan (CIP) consists of clinical objectives which must be completed prior to case closure and, in some cases, prior to restoring provider to full credentialed status. The CIP must be approved by the Medical Director prior to implementation. Once the CIP is put into place, any deviation from the plan must be brought to the immediate attention of the Medical Director and QA representatives, for re-approval. The clinical improvement plan formed must include:

- Objectives and process for completion
- Timeline
- Expectations for feedback throughout the CIP

The CIP may include remediation, designed to correct identified deficits. This focuses on patterns of practice rather than individual deviations from protocol, with an emphasis on education and retraining. Examples include:

- CE or another educational tool
- Placement with a Field Training Officer for real-time remediation
- Scenario based education
- Clinical knowledge discussion
- Online education module(s)