Regional Medical Direction
Objectives and Goals

In early 2011, the Foothills and Mile-High Regional Emergency Trauma Advisory Councils (RETACs) were awarded a grant from the Colorado Department of Health and Environment EMTS Section to organize Medical Direction Continuous Quality Improvement efforts within the two RETACs. The program was called Regional Medical Direction. (RMD) The program, already in place in other RETACs throughout the state, is designed to provide consistency in medical direction and provide a format for regional CQI to study and promote best practices in prehospital care.

Rather than appoint a single Regional Medical Director, the two RETACs agreed to combine their resources and appoint 5 medical directors to serve as Regional Medical Liaisons (RMLs) representing prehospital care within the two regions. they also agreed to hire a Regional EMS Coordinator to facilitate many of the CQI projects the group wishes to accomplish. Utilizing the already organized efforts and expertise available in the Denver Metro EMS Medical Directors (DMEMSMD), the two RETACs felt this model would be effective in uniting all of the Medical Directors within the regions to exchange ideas and best practices. With participation from all Medical Directors within the two regions, we would strengthen this approach regardless of the different models under which prehospital agencies operate as well as the varying patient populations served by the multiple facilities.

The DMEMSMD group now has the opportunity for some very exciting CQI efforts led by the Medical Directors throughout the two RETACs. While this is a very exciting opportunity for prehospital within the two regions, it is important to note that this program was never meant to, and is never intended to, supplant or usurp the individual EMS agency relationship and their individual Medical Director. Rather, the RMD/CQI program is actually meant to benefit individual EMS Medical Directors and their agencies by providing a forum for the exchange of ideas and a forum for regional CQI. .

The following is a summary of the desired objectives for the project. This list is intended to be an overview, and therefore is neither complete nor all-encompassing.

Protocols

The Coordinator has assisted in editing, updating and formatting the current DMEMSMD protocols. These protocols are updated every six months and have become a model across the state for other systems. This document provides a consensus approach to prehospital care based on best practices and available literature rather than anecdotal or historical traditions.

Data Submission

While the two RETACs have a better than average rate of submission for prehospital data, there are areas in which progress can continue to be made. In reports provided by CDPHE, data variables have been shown to be less than complete. The

Regional EMS Coordinator has provided technical assistance to agencies and these agencies have seen an increase in their variable completeness.

Data Evaluation and Benchmarking

An area in which the RMLs felt needed more attention was utilizing data to evaluate best practices and create benchmarks for use by agencies and facilities. CDPHE has been willing to assist in this but the available data variables are limited and may not allow for a comprehensive analysis for developing a best practice in certain areas. It has been suggested that a more direct approach would be to use data from agencies or facilities on a voluntary basis to answer research questions. An example of this workflow would include identifying what issue is to be analyzed. Upon agreement of the research question and then identifying what variables would need to be collected, agencies/facilities would be asked to participate. Participation on the agency's behalf would solely be to provide de-identified data in the form of a spreadsheet containing the variables only. It is important to stress that the agencies are providing only the variables in an effort to analyze ranges and variances and not to look at specific care provided by personnel or agencies. The results of these analyses will be shared only internally within the RETACs without naming agencies that participated. It has been suggested that we include broad categories that would be of benefit to agencies to understand differences in demographics, i.e. rural or urban. The analysis of data would eventually help in the creation of benchmarks that agencies can utilize in their Continuous Quality Improvement (CQI) plans. For example, an analysis may show the need for a 12-lead EKG performed within 10 minutes of arrival for patients complaining of non-traumatic chest pain.

While benchmarking is an essential part of a CQI plan, analysis may also indicate the need for different approaches in training. As an example of this, the DMEMSMD group did an informal survey on percutaneous cricothyrotomy in the prehospital setting. Upon analysis of the results, it was clear additional training was recommended to help providers feel more comfortable with the various kits in use.

Regional Training

One of the items that medical directors feel is beneficial is the implementation of group trainings to discuss approaches to common concerns. In June of 2012, a data workshop was held to bring agencies and vendors together to discuss concerns over data submission and the move to ImageTrend by CDPHE. This provided valuable "face time" between agencies and vendors and how bridge products would be implemented and used to facilitate submissions into a new repository. The workshop received high praise from participants, some of whom were not from the two RETACs sponsoring the program. This workshop also allowed for agencies to network and discussed how they were approaching various topics not limited to data submission.