

Testimony in Support of SB 83

Jim DeTienne, EMS and Trauma Systems Section, Department of Public Health and Human Services

In the last year, the Legislative Audit Division conducted an audit of Montana's EMS system. One key finding of that audit was a recommendation that the Department develop an objective, data-driven system evaluation and quality improvement oversight approach. SB 83 institutionalizes the development of EMS councils and the conduct of medical run reviews performed under these councils as a method to provide system evaluation and improve patient care.

There are three general approaches to improving patient care. The most common process utilized by hospitals, EMS services and others are quality assurance or quality improvement (QI) methods which look at individual patient care from a bottom up approach. Historically, QI methods have sought to investigate 'what went wrong' in order to make patient care better.

Second, a top down approach, total quality management (TQM), is utilized in which an organization sets standards for a component of an event (response times, rates of infection, etc) and tracks these benchmarks over time to evaluate care. TQM seeks to find out root causes and to improve care, but it takes time to measure these trends and to make incremental improvements.

While QI and TQM are successful methods in their own right, SB 83 proposes to promote a systems approach or **systems performance improvement** method which is a blend of these traditional approaches. System performance improvement is a modern model of improving patient care. While there is a great deal of overlap between system PI and these other methods, system performance improvement starts with different assumptions and often leads to different outcomes. System performance improvement takes an entire event apart and considers how improving each component of the system can result in a tailored solution.

The members of an EMS council represent a broad coalition or team which encompasses each subsystem of emergency care system. This team – the dispatcher, fire department, law enforcement, EMS, hospital and others – all need to be at the table in order to consider the

many elements that influence a patient's care. An EMS council conducting system performance improvement may find that an issue may have a range of solutions and a variety of ways to improve the process. They will often have to consider how limited resources can be used to support a strategy with the most improvement.

As an example, an EMS Council reviewing a cardiac case could be faced with several opportunities for improvement which would be lost without the run reviews encouraged and protected under SB 83. For example, an EMS Council may observe - as a team - that out several factors, it appears that law enforcement is generally the first on the scene in their community. This finding would not have been discovered under QI or TQM processes. As such, under system performance improvement, the council may implement strategies to assure AEDs are in every patrol vehicle and then monitor if this strategy improves patient care.

SB 83 proposes protections for specific activities of an EMS council. Persons who participate in teams believe that they are most effective working together in an environment of trust. SB 83 is not about protecting the members of the team; it's about protecting the patient's right to privacy. System performance is about how the patient did but primarily assesses care from the standpoint of how each part of the system performed and where improvements can be made. Such introspection may involve discussion of a specific patient or group of patients. The confidentiality section of this bill makes it clear that any private information learned about the patient is protected and cannot be revealed under penalty of this law if enacted.

SB 83 will improve patient outcomes in Montana. We thank the interim committee and Senator Liable for sponsoring this bill and we would appreciate your support also.

Thank you.

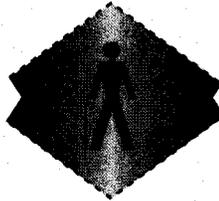
EMS Council

Medical Run Review of a Cardiac Event

1 - The patient

Was this a high-risk patient (smoker, sedentary, etc)?

Did the patient recognize they may be having a heart attack?



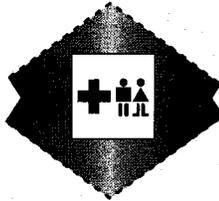
Is there a need for more public education on heart attack risks?

Is there a need for better education on the signs of a heart attack?

2 - The public

Did bystanders know how to call 9-1-1 quickly?

Did bystanders know CPR?



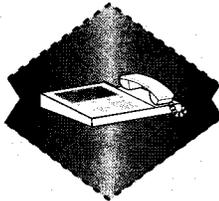
Is there a need for public education about 9-1-1 and CPR?

Is this a high risk area where a Public Access Defibrillator may be useful?

3 - Dispatch

Did the dispatcher have Emergency Medical Dispatcher training?

Was the dispatcher able to provide dispatch CPR instructions?



Is there a need to provide more EMS-D training?

Is there a need for training on how to provide phone CPR instructions?

4 - First Response - Basic Life Support

Which responders arrived first? - law, quick response unit, ambulance, etc.

Did first response have an AED and apply it quickly?



Is there a need for more AEDs for first response units?

Is there a need for increased training on the rapid application of an AED?

5 - Advanced Life Support

Was BLS care followed up with ALS care as quickly as possible?

Did the patient have access to advanced cardiac life support?



Is there a need to increase ALS cardiac capability in some areas?

Can elements of an ACLS program be improved?

6 - Hospital cardiac care

Did the patient have ready access to cardiac cath, etc?

Did the cardiac 'chain of survival' result in a long-term outcome?



Can patient access to advanced cardiac care be improved?

What is patient outcome at 3 months, 6 months, 12 months?