Date: 11/5/17

From: Jeffrey M. Goodloe, MD, NRP, FACEP, FAEMS
Medical Director

To: MCB Physicians
cc: Jim Winham, Interim President & CEO, EMSA
OMD Staff

Re: EMSA Patient Care Reports at Emergency Departments – Update for Nov 2017 MCB Meeting

I believe you will find helpful the following summation of interim communication that I have received regarding the issue brought by Dr. David Smith at the Sept 2017 MCB meeting of missing/incomplete EMSA patient care reports:

You will recall the Sept 2017 MCB meeting was held on Wednesday, Sept 13th.

On Wednesday, Sept 20th, I received the document noted as "Attachment A" in email from Sonny Geary, AMR Oklahoma General Manager. Please reference Attachment A.

I replied to Mr. Geary on that same day, Sept 20th, with the following email communication:

"Mr. Geary

I have received this report, yet find two very important questions unanswered:

What specifically is being done to meet the established MCB/OMD policy that completed patient care reports must be delivered within 2 hours of patient arrival to the ED if that EMSA/AMR transporting team was called out of the ED prior to a completed written patient care report being transferred to the ED based treating team? I can find no mention of steps to ensure completion specifically within this 2 hour standard. There is no mention of this time standard at all by my read of your response.

It is mentioned that the Western Division Operations Manager and a single day FOS were surprised of Dr. David Smith's commentary on EMSA/AMR patient care reports. This does not address the issue of inadequate communications between the cadre of Western Division FOS and Alt FOS personnel and the Western Division Operations Director and Western Division Operations Manager. Clearly, we do not call to question Dr. David Smith's integrity in his commentary of previously addressing this issue with multiple Western Division FOS and/or Alt FOS personnel. Yet, the Western Division Operations Director and Operations Manager were obviously completely unaware of this patient care related issue of his concern. Where and why is the breakdown in Western Division Operations leadership communication?

In the interim, my office has received confirmatory information that incomplete and untimely EMSA/AMR patient care records is an issue of physician concern additionally at Mercy and in at least one of the Edmond hospitals.

Dr. Goodloe"

On Wednesday, Sept 27th, I received an email from Sonny Geary as follows:

"Dr. Goodloe,

Our team and I understand your concerns and are committed to finding the best long-term solutions for the system. You asked two very direct questions: **What is being done to meet the two-hour standard regarding leaving PCRs at the hospitals?** and **Where is the breakdown in Western Division's leadership communication?**

Regarding the PCRs, we want to find the most efficient and effective means of delivery to meet the Medical Control Board's two-hour standard and fulfill the needs of all our customers. We believe we can develop this process by deploying a PDSA style methodology. The first step will involve investigating how broad the problem you identified is so that we can look for the best solution. Based on what we learned when we addressed a similar issue with a Tulsa hospital a couple of years ago, I believe this can be accomplished in two weeks, through supervisors and clinical staff talking to hospital and field staff, and observing transfers of care. What we find regarding the scope of this problem – which we will report back to you – will dictate next steps. If the problem is primarily behavioral with our team, we will work on behavioral modification via our newsletter, emails, and other group and individual communication methods. Depending on what we learn, we may initiate an improvement project involving operations and clinical leadership, hospital personnel and others – and would like to request involvement from David or other OMD representatives. The results achieved with the scene time project that you led demonstrate how useful a solution-focused, multi-disciplinary approach can be when addressing issues that involve multiple stakeholders.

As a system, we believe the best scenario for accomplishing all the identified goals might be through an automated delivery method versus a manual delivery method. Zoll ePCR Version 6 allows a possible IT fix (system automation) for this as well, which is considered a best practice in many of Zoll's markets. This would require collaboration and support from EMSA's IT team and is promising. Another possibility is a software EMSA previously looked at, CloverLeaf Solutions, which is being researched to see what new updates have been developed.

Regarding communication, I don't know where the breakdown occurred with this incident – and whether this was an isolated variance or something that suggests a larger problem. Our western division operations director and I will lead a very open and honest conversation regarding the flow of information within the team and between us and our external partners, using this situation as a prime example. He and I will attempt to identify where the breakdown occurred with this incident, what factors could be interfering with effective communications, and how we evolve. I am also consulting with my peers at some of AMR's larger operations for information on best practices in communications and knowledge management. There is always room for growth and improvement.

V/R

Sonny Geary"

I replied to Mr. Geary on that same day, Sept 27th, with the following email communication:

"Mr. Geary

Thank you for your additional reply and I'm sure all copied are equally interested in the success of local AMR efforts. OMD has in the interim also received unsolicited confirmation that incomplete EMSA records is also a concern and issue at St. Anthony Hospital. By all appearances, this is a widespread deficiency in EMSA's Western Division.

Dr. Goodloe"

I had been keeping the MCB officers (Dr. Michael Smith, Dr. Chad Borin, and Dr. David Smith) apprised of these communications, and continue to do so. Over the next two days, Dr. David Smith and I

communicated via email as indicated below, the thread being read in proper time sequence from bottom to top, with the top listed communication that I received from Dr. David Smith on Sept 29th.

"Random Spotcheck at IBMC emergency department at 3:15 pm shows 0 of eight run sheets present for 8 current EMSA patients. Field super notified.

-David Smith, M.D.

On Sep 28, 2017, at 12:39 PM, Goodloe, Jeffrey M. (HSC) <Jeffrey-Goodloe@ouhsc.edu> wrote:

David

Absolutely. I shall ensure this item per your directive is added to the November MCB agenda and will prepare the background information as you have specified.

Jeff

On Sep 28, 2017, at 12:14, David Smith <davidsmithmd@yahoo.com> wrote:

May you add this run sheet issue to the November MCB meeting agenda so we can follow this important issue at the MCB. At that meeting time, may you brief the MCB regarding MCB, EMSA, and AMR communications and actions since the last meeting regarding this run sheet issue.

David Smith

On Sep 27, 2017, at 3:14 PM, Goodloe, Jeffrey M. (HSC) <Jeffrey-Goodloe@ouhsc.edu> wrote:

I completely share your frustration in that neither question is still answered 2 weeks after the MCB meeting. I will call you to discuss asap..

Jeff

On Sep 27, 2017, at 13:47, David Smith <davidsmithmd@yahoo.com> wrote:

I am surprised and concerned that there is still miscommunication regarding the run sheet MCB protocol.

The MCB requirement is for immediate run sheet reports, with a 2 hour leeway only if the crew is dispatched emergently to another call. The MCB standard is not 2 hours, as referenced in Mr Geary's response.

If you find my summary accurate, may you find and forward that protocol to AMR so we are all on the same page?

-David Smith, M.D."

On Wednesday, Oct 11th, I received the document noted as "Attachment B" in email from Sonny Geary, AMR Oklahoma General Manager. Please reference Attachment B.

I replied to Mr. Geary on that same day, Oct 11th, with the following email communication:

"Received and reviewed.

Dr. Goodloe"

The last communication from any AMR management personnel that I have received on this subject is the following email communication that I received from Mr. Geary on Wednesday, Oct 25th:

"All,

I'd like to take an opportunity to update you both on progress being made regarding the patient care report delivery issues discussed in the September Medical Control Board meeting.

1. The RightFax application, which allows for desktop faxing of PCRs, has been installed in each Communication Center. Our Eastern Division Communication Center team had been handling faxing of completed PCRs to facilities (when crews were unable to immediately finish tickets at destination facilities) prior to the September meeting, however doing so required a team member to desert his station. This new technology solution improves that long-standing process and allows for a strong, new process moving forward in the Western Division. Training of Communication Center team members on RightFax is in process and tracking for completion by the end of the month.

2. A standardized, electronic remediation course related to PCR delivery was created and assigned to all team members. Our focus has been on the Western Division team, and the course was pushed out there first. These employees have until the end of the month to complete the course. Eastern Division team members have until the end of November to complete the course.

3. An anonymous team member survey, designed to help us define the scope of PCR delivery problems, is attached to the training course. We are continuing to collect results and provided initial analysis in the memo dated October 11, 2017. A final report will be completed once the survey is closed.

4. We've also shared in previous memos information about technology solutions. All ten of the EMS operations we surveyed about PCR delivery utilize a system (such as Zoll ePCR Version 6 or CloverLeaf) that automatically transmits PCRs by fax or email to receiving facilities, rather than relying on printing and manual delivery of PCRs. EMSA's Chief Information Officer has been working toward implementation of a technology solution; on October 24, he established a goal implementation date of November 30, 2017. This would ensure automatic faxing of draft and completed reports to receiving facilities as soon as the reports are saved to the server. Some education of our own internal team members and external partners will be required to ensure optimization.

Our work in this regard will continue. Please advise if you have any questions or suggestions.

V/R

Sonny Geary"

I hope this summation of all topic specific communications, all known in the interim by the MCB Officers, will help in your preparation for any comments you wish to share at this week's MCB meeting and meets the expectations of Dr. David Smith in his directive to me in preparing this report for your use.

September 19, 2017

TO: Dr. Jeffrey Goodloe,
Medical Director – Medical Control Board

Jim Winham,
EMSA Chief Operating Officer

FR: Sonny Geary
General Manager

RE: Patient care report delivery concerns

Learning during this last week's Medical Control Board meeting that some ED physicians are dissatisfied by the information we provide during transfers of care was a surprise. Our team understands that timely, consistent delivery of complete patient care reports to receiving facilities is vital to continuity of care.

Below are some steps we have already taken and are continuing to pursue to meet patients' and providers' needs.

I. Long term plan for system automation.
   a. During the electronic patient care report update meeting in April 2017, the need for consistent delivery of complete patient care reports was discussed. The proposed resolution is the implementation of an automated fax server.
   b. Benefits of proposed fax server implementation include:
      i. The fax server offers automated delivery of every completed patient care report at time of completion.
      ii. The fax server allows the crew to send a draft version of the patient care report while at the destination facility.
      iii. The fax server records accurate records when patient care reports are delivered which increases accountability and allows for quality improvement.
   c. Completed implementation steps
      i. Information technology accepted the project and began requesting proposals to acquire hardware or service provider in May of 2017

ii. Meetings with destination facilities to obtain support for increased costs secondary to paper and ink were completed by clinical services staff in August 2017.
iii. The clinical services team completed testing of known fax numbers and confirmed that hospital administrations are aware of the location faxed patient care reports will be delivered in August 2017.

d. Implementation steps to be completed.
i. Information technology will need to review and decide on requests for proposal; the current time frame is not known.
ii. Information technology will need to install hardware or connect to service provider.
iii. The setup and activation of the feature in the patient care reporting software will take place after the previous two steps are completed.
iv. Education of current and future team members will be completed prior to activation of the feature.

II. On September 22, the quality assurance section of the EMSA Update newsletter (distributed to all employees) will include an article that addresses the following:
a. To ensure the continuity of care it is imperative that completed patient care reports are delivered to staff at the receiving facility.
b. If a completed patient care report is unable to be delivered at the receiving facility, then a draft report must be left. Vital information, including initial, significant and final vital signs, ECG tracings, pertinent history, physical finding exams and treatments provided, should be communicated to the hospital via ePCR and verbally at the time of transfer.
c. When crews are unable to leave completed PCRs at the hospital prior to returning to service, they must report the incident number and receiving facility name to the communications supervisor. The patient care report must also be sent to the server. This will facilitate delivery of completed PCRs to the involved facilities. (Note: this is a change from our previous approach in which FOSs took the lead on faxing over PCRs; the fax interface used in the Comm Center provides fax confirmations, whereas the interface used by the FOSs does not notify when a fax has processed or failed.)
d. If a printer or computer issue prevents printing at the receiving facility, an email will be sent to EPCRHELP@EMSA.NET with the destination facility name and computer identification number.

III. The clinical services team is drafting a memo to be posted at all operational locations. The memo will contain the same information as the newsletter and will be posted this week.

IV. Patient Care Report Education – for new/future team members
a. The lecture/didactic training provided during the new hire orientation academy has recently been enhanced. The clinical services team will review the current presentation which covers the expectation to deliver completed patient care reports by September 30, 2017.

b. The clinical services team will implement any improvements by October 15, 2017.

V. Patient Care Report Education – for current team members.
   a. The clinical services team is creating a standardized, electronic remediation course. This curriculum is scheduled to be complete by September 30 and will be assigned to all team members.
   b. Upon implementation of the fax server project, reports will be created to identify team members who do not meet the standard of delivering patient care reports while at the destination facility.
   c. We will create a stepped process to remediate team members unwilling or unable to meet expectations. This may include Just Culture reviews to determine root causes, temporary reassignment of repeat offenders, individualized remedial education training, and corrective action.

VI. Patient Care Report Education – for communication leads and operations supervisors.
   a. The clinical services team will confirm that all personnel who have the responsibility to fax patient care reports possess the following skills by October 2017:
      i. The ability to access webpcr website to print patient care reports.
      ii. Demonstrated competency using right fax computer-based fax software or the physical fax machine at their location.
      iii. Understanding of the expectation that the patient care reports are delivered to the receiving facility as soon as they are available.

VII. System review.
   a. The clinical services team is creating an anonymous survey to study the reasons that patient care reports are not consistently delivered to the receiving facility. The survey is expected to be completed by September 30.
   b. The clinical services team with review the results of the survey by October 15 and update this action plan as needed.

Our western division operations director addressed this issue with his team. Both the operations manager and our dayside supervisor were taken aback by Dr. Smith's displeasure, as neither report receiving any calls or contact from him in some time. If either of you become aware of concerns – in this or any other regard – or have ideas for improvement, please don't hesitate to share them with our operations leadership team. We share a common mission and greatly appreciate the unique perspectives that you and your teams can provide us.

Please let me know if you have any questions about our steps moving forward and the recommendations we've posed herein.

October 11, 2017

TO: Jeffrey Goodloe, MD
Medical Director – Medical Control Board

Jim Winham
EMSA Chief Operating Officer

FR: Sonny Geary
General Manager

RE: Patient care report delivery – performance improvement updates

---

Please find below a follow-up regarding how our team has responded thus far to the patient care report delivery issues discussed in the last Medical Control Board meeting. We are continuing work to improve performance and improve stakeholders' confidence in our performance.

Include detailed article in EMSA Update newsletter on 9/22/17, re: PCR delivery expectations.

Done. The "Ticket Talk" column in the 10/13/17 newsletter also included a link to an external journal article explaining the reasons why good documentation is important. We will continue to use this space to help reinforce training and expectation.

Utilize mobile data terminal messaging to help reiterate PCR delivery expectations.

We are using MDTs to regularly remind on-duty crews of the expectations. Below is a message sent out on October 4:

> Please remember that we must make every attempt to provide each ER with a PCR for each patient delivered. We understand that sometimes IT issues and system demand does not always allow you to print before leaving the ER. It is very important that if you can not leave a DRAFT or COMPLETE PCR, you call 7022/7042/7081 and ask that a completed PCR be faxed.
>
> If IT issues are preventing you from printing, call 7022/7042. We will be happy to report the IT issue for you AND FAX your PCR.
>
> If we have to call you out for an emergency call, please call 7022/7042 or text/email or MDT the FOS, so we know to get your ticket faxed.
>
> Sometimes the issue printing is with the Printer Version in options when printing. I will be happy to show you, if you like, how that can be changed and help you print successfully.

Guys, the supervisors need you to work with us on this so we can be compliant with state guidelines and OMD directives. Please work with us and make attempts to print and leave your reports.

Thank You all!

Draft and share memo outlining PCR delivery expectations.

Accomplished on 9/19/17.

Review and improve didactic training presentation on PCR delivery used in orientation academies.

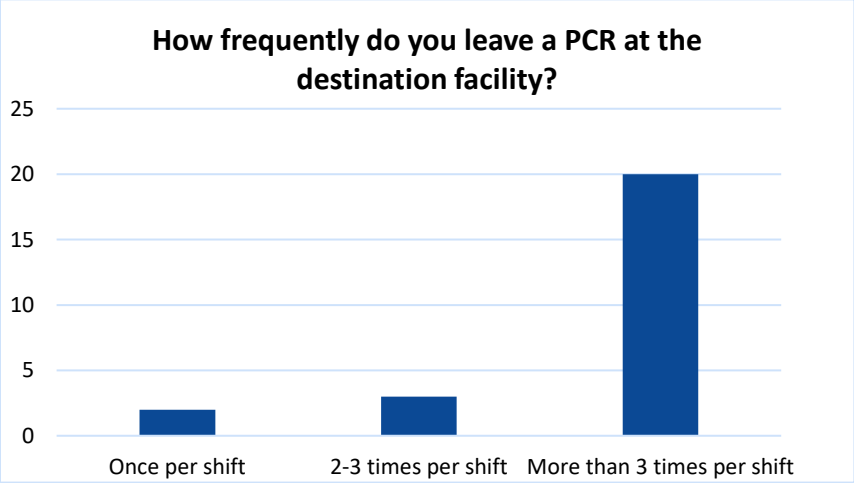
Accomplished on 10/2/17.

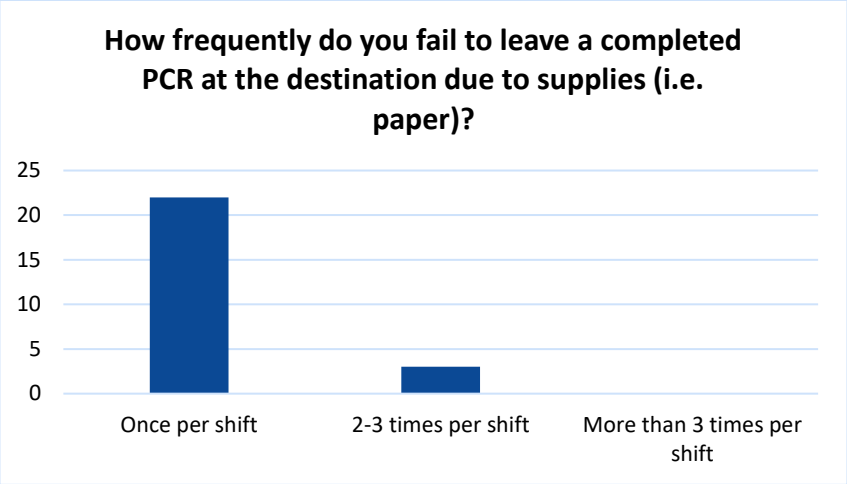
Create a standardized, electronic remediation course related to PCR delivery and assign to all team members.

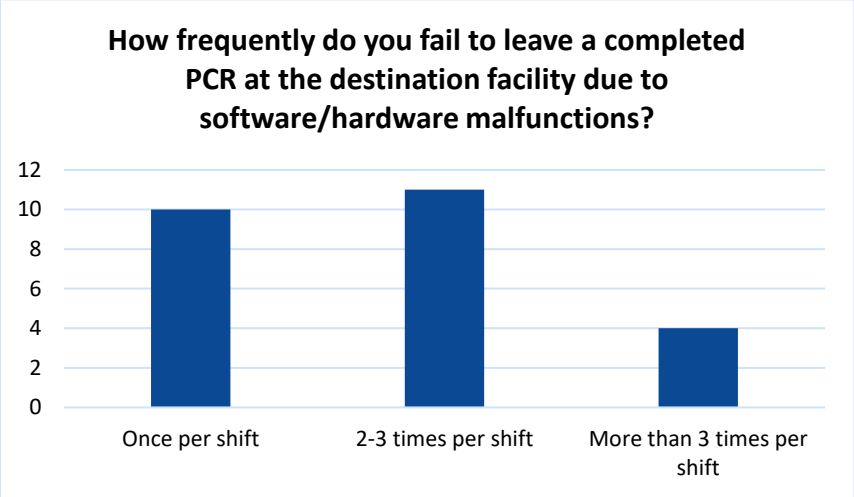
Accomplished on 9/30/17. Team members have until 10/30/17 to complete the course.

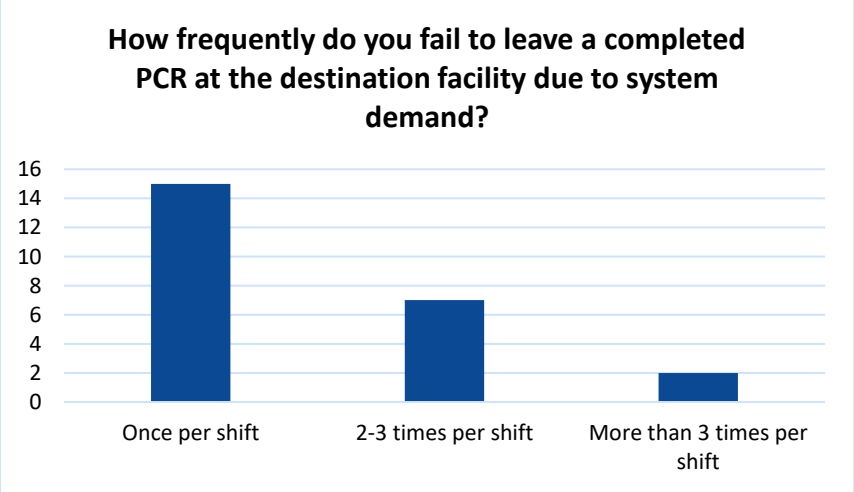
Create an anonymous survey to help define scope of PCR delivery problems.

This survey is connected to the remediation course mentioned above. We are continuing to collect responses as team members complete the remediation course. Results to date are:









Additionally, we asked team members if they had any suggestions for improving these processes; no suggestions have been provided to date.

The data from these surveys and our investigation noted below will be used to help us make changes to improve our performance.

Investigate scope of PCR delivery issues, via discussion with hospital staff and field personnel, and observations of transfers of care.

We found a number of issues impacting the successful, timely delivery of patient care reports. At all hospitals, multiple crews at a single destination can present printer access problems. This would be resolved with the implementation of a dedicated fax server.

Additionally, misuse of printers can impede our performance. At Integris Baptist, we witnessed a nurse trying to help a medic from another service access the EMSA printer. Though well-intentioned, this inexpert troubleshooting can negate our settings and prevent our team members from having reliable access. We are requesting that the Authority allow us to put signage on these hospital-based printers saying, "For EMSA Use Only."

Paramedics are generally out of physicians' sight-lines when they retreat to EMS rooms to complete patient care reports. This could lead to a perception that team members are leaving hospitals without providing PCRs. We found this on September 30, when a physician called about an undelivered patient care report. In this instance, the crew was found in the hospital's EMS room completing the report in question.

Some hospitals also do not have clear processes themselves for receiving/distributing and filing PCRs. We found this to be a contributing factor when working with Saint Francis Hospital in 2016. We will be working with all facilities to ensure there are designated areas for PCRs and to support them as they review their own processes.

The EMS liaison at OU Children's Hospital reported strong satisfaction with our performance related to PCR delivery and praised our work in this area.

Change processes so that the on-duty communications supervisor (as opposed to the mobile field operations supervisor) has responsibility for sending completed patient care reports to facilities, when crews are unable to immediately finish them at the destination facilities.

With this modification, processes in the Western Division now align with those utilized in the Eastern Division. We are in the process of confirming that all individuals who have responsibility for faxing PCRs to destinations possess the required competencies and technology access.

Meet with supervisors and other members of the operations management team regarding the flow of information internally and between us and external partners.

Rick Ornelas and I met on October 3 with the operations manager, seven of the eight field supervisors (one is out on medical leave), and one of our two quality assurance coordinators (one was out of town) regarding communication. Our team admitted to having a "nothing we can do about it" attitude regarding some problems and challenges; additionally, they admitted receiving calls from hospitals about missing tickets but viewed these calls as requests for information as opposed to complaints. We have re-set expectations for sharing information and brought heightened awareness regarding management of hospital relationships. Additionally, we reviewed the OMD reporting matrix with our team and added more internal parties to our notification protocols.

Consult with peers at large AMR operations on best practices related to PCR delivery.

Several operations utilize state-approved short-forms to satisfy patient care reporting requirements. All ten of the operations surveyed have an IT solution in place – specifically a system that automatically transmits PCRs by fax or email to receiving facilities – rather than relying on printing and manual delivery of printed reports. We are working with the Authority to encourage implementation of a system (such as Zoll ePCR Version 6 or CloverLeaf) that provides a reliable, technical solution. A technical solution would also allow us to create objective reports and identify trends related to PCR delivery.

We are continuing work to improve performance and will continue to provide you updates and reports on our progress through this process.