EMS System for Metropolitan Oklahoma City and Tulsa
Medical Control Board/Office of the Medical Director
Monthly CQI Meeting – June 2016

System Stressors:

- Call volume in excess of 200,000/year and perhaps as high as 240,000 in calendar yr 2016
- Call volume rising every year
- Supply of system resources very often stretched by system demands
- Hospital impacts
    - Turn-around times (TATs)
        - Bedwaits over 60+ mins at times, some occasions over 120+ mins
    - Diversion requests
- Increasing mission times year by year
    - Chute times
    - Response times
    - Scene times
    - Transport times
    - Hospital times (see impacts above)
- Providing mutual aid for other systems
- Receiving mutual aid from other systems unfamiliar with our standards of care
- "Fatality of thought" meaning we always feel the push to find a way to succeed
    - Public relations always stresses "we can handle it" it = anything
- Increasing violent call types = increasing frequency and lengths of staging adding to mission time
- Weather impacts
    - Heat increasing calls; heat physical impacts on personnel
    - Cold physical impacts on personnel and roadways eg. ice, snow
    - Thunderstorms/tornados potential impacts and actual impacts on MCIs
- Increasing mental illness call types; as many as 10% of calls are likely mental illness related
    - Substance abuse calls independently and also related to mental illness calls
    - Poor resources in service communities: demands >> resources
- Spans of control, oversight, awareness
    - Systemic, agency, and individual levels
- Nature of the work in EMS/public safety systems
    - Mental and physical stresses on personnel
    - Public expectations/demands
- Culture of the system – intentional and unintentional
    - Fear of taking action – thinking outside the protocols/box
    - Ambulance crew configuration often new hire + new hire
    - "Momentum of tradition"
        - Ideology of "We cannot do this because…" instead of "How can we do…."
    - Are we managing calls for service OR are calls for service managing us?
- Communication – missing, misunderstood, timing
- Personnel turnover/retention challenges

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System Solutions:

- "Active listening" to patients, persons, personnel, colleagues
- Personnel are willing to help others and themselves
- Situational awareness to help manage incident dynamics
    - Refusals
    - Complex clinical and/or logistic calls
    - Routine calls
    - System-wide or agency-wide
- Public education
    - Not just how to access 911, but when is it appropriate
- Mental health resources, including mobile intervention teams
    - Current resources
    - Future resources – Mobile Integrated Healthcare
- Communication – accurate, timely
- New personnel want to join the system
- Education
    - Initial/Continuing
    - Making it real and relevant, based upon actual experiences
    - OMD and other online resources
    - In system meeting or exceeding state/national requirements
- Personnel getting feedback
    - Not just opportunities to improve
    - Reinforce best practices care

Scene Time Efficiency Project - "STEP Wise" Reduction in Scene Times

- **May 2016 – 90% fractile EMSA on-scene times 37:30 minutes (10% of calls longer than this)**
- **Goal to reduce average and 90% fractile scene times by 5:00 by July 1, 2017**
- **Achieving the goal will conservatively add 694 24-hour DAYS of ambulance unit availability/yr**
- Same benefit of increasing FD apparatus unit availability
- Increased unit availability =
    - More supply of resources when patients need our help
    - More downtime between calls for mental and physical health benefits
    - Leaving end of shift AT end of shift (less 1-2 hr holdovers)
- Truly a system issue to fix, not just AMR, not just FDs
    - Teamwork in data analysis, solutions, and monthly progress towards goal is key
- Much more to come on this – will be a standing discussion/action item at monthly CQI