

# WASHINGTON STATE SOUTHWEST REGION QUALITY IMPROVEMENT PLAN

Approved 9/3/2025

## MISSION STATEMENT

Our mission improve the quality of care for patients with time-sensitive emergencies in the Southwest Region.

### I. Authority / Scope

As described in WAC 246-976-910 (2) and RCW 70.168.090 (2): Levels I, II, and III trauma care services shall establish and participate in regional quality improvement programs. As described in RCW 70.168.150 (2) (a): designated cardiac and stroke centers shall participate in regional quality improvement activities. Input and participation in the quality improvement programs from Level IV and Level V trauma services and EMS providers are crucial to the mission of the Southwest Region Quality Improvement Committee.

### II. Trauma Patient Population Criteria

The trauma patient is defined as any patient that meets the National Trauma Triage Criteria.

<https://www.facs.org/media/rw4c5kb2/trauma-algorithm-vfinal-revise.pdf>

### III. Cardiac Patient Population Criteria

Any patient 18 years of age or older who presents with signs and symptoms of acute coronary syndrome.

### IV. Stroke Patient Population Criteria

Any patient that meets [Washington State Prehospital Stroke Triage Destination Procedure](#) OR local guidelines for identifying stroke.

### IV. Data Collection and Analysis

We will use multiple sources of data to create a comprehensive picture of the quality of care provided.

#### Systematic Review of Data

- Structured, ongoing evaluation of aggregate data over time to identify system level quality improvement opportunities.
- Monitor overall program performance (volumes and performance on quality measures)
- Guide policy, process, training priorities, or resource allocation changes.
- Whenever possible, data will be presented on run charts or control charts to allow for meaningful discussion of variation.

#### Individual Case Reviews

- Examine patient encounters, prevents reoccurrence, and provides direct learning opportunities.
- Assess adherence to protocols and identify contributing factors.

Together, these processes ensure both system performance and individual cases drive continuous improvement across EMS and hospital partners.

Data sources include, but are not limited to:

- DOH Trauma Registry
- Cardiac Arrest Registry to Enhance Survival (CARES)
- Washington State EMS Information System (WEMSIS)
- Care Outcomes Assessment Program (COAP)
- National Cardiac Data Registry (NCDR)
- American Heart Association Get With The Guidelines Registry (AHA GWTG)

## **V. Regional System Analysis**

This plan outlines the process for quality improvement of the regional system of care for time-sensitive emergencies. It does not duplicate or supplant quality improvement programs of the individual designated trauma services, rehabilitation units, or prehospital agencies involved in regional trauma, cardiac, and stroke care. The EMS/regional trauma, cardiac, and stroke services will provide data to assess regional performance. Confidentiality will be maintained adherence to RCW 4.24.250, 70.41.200, and Health Insurance Portability and Accountability Act.

## **VI. MEMBERSHIP**

As stated in WAC 246-976-910 (3), the regional QAI program: (a) shall include at least one member of each designated services medical staff, an EMS provider, and a member of the EMS/TC Regional Council. WAC 246-976-910 (4): The regional Continuous Quality Improvement program shall invite the MPD of each county and all other health care providers and services providing trauma care in the region, including non-designated services and non-verified prehospital services, to participate in the regional trauma continuous quality improvement program. RCW 70.168.150 (2) (a): allows for cardiac and stroke services to participate in regional QA activities.

In accordance with the above administrative code, the following membership is recommended for the Southwest Region EMS and Trauma Care Council QA Committee.

Invited Voting Members (a quorum shall consist of a majority of voting members and one officer at a regularly scheduled meeting):

- Trauma Service Medical Director from each designated trauma service
- Trauma Program Manager from each designated trauma service
- Representative from each designated rehabilitation service
- Cardiac Service Medical Director from each designated cardiac service
- Cardiac Service Coordinator from each designated cardiac service
- Stroke Service Medical Director from each designated stroke service
- Stroke Service Coordinator from each designated stroke service
- EMS Medical Program Director from each county
- EMS representative from each local County EMS & Trauma Care Council
- Representative of Southwest Region EMS & Trauma Care Council
- Aeromedical transport services representative from each service operating within the region

. Any other system agency representative attending as ad hoc member

\*Any of the above members may be represented by another official designee from the represented service or agency.

## **VII. PROCESS**

Regional QI Meetings:

The Chair, Vice Chair, and Secretary are elected by the regional QI Committee, must be voting members of the QI Committee, and hold a two-year, renewable position.

The organization meeting actions shall be governed utilizing general parliamentary procedure when applicable.

The QI Committee will meet quarterly.

### **Meeting Components**

The QI meeting will focus on the activities of the components of the trauma, cardiac, and stroke systems.

- Discuss regional performance data. Data will be distributed in advance of the meeting to preserve meeting time for discussion.
- Discuss regional and local quality improvement initiatives
- As needed, review of regional emergency plans
- Optional: review of cases illustrating system issues

### **Summary Conclusions and Reporting**

The Chair, or designee, is responsible for providing a written or verbal summary to the Regional EMS and Trauma Council.

## **VIII. Implementation**

Component 1: Review of Regional Performance Data

The QI Chair may request data. The current performance measures are located in Attachment B.

Component 2: Review of Identified EMS, Trauma, Cardiac, or Stroke System Issues

Identified issues may be brought forward by committee members. QA Issues within the region may impact multiple constituents of the regional EMS and trauma, cardiac, or stroke systems.

Component 3: Educational component

Rotation of education responsibility; will be assigned by the Chair at each meeting for the next meeting.

**ATTACHMENT A:  
Southwest Region QA Plan  
Confidentiality and Exemption from Discoverability  
Policy and Procedures  
Revised August 2025**

**Policy**

It is the intention of the QI Committee to use information gathered improve patient care through improved systems performance. It is necessary providers have protection from discoverability and liability to reach that end. This activity is protected under **RCW 70.168.090 (3) & (4), WAC 246-50 and RCW 43.70.51.**

**Attendance**

Attendance is limited to only voting members and invited persons. Attendance will be recorded electronically.

**Confidentiality**

Will be reviewed at the start of the meeting. Attending the meeting will be construed as agreement to confidentiality.

**Documentation**

Patient records will be de-identified.

**Minutes**

Minutes from the QI Committee meetings will be prepared by the Secretary of the QA Committee or designee, reviewed and approved by the members.

## ATTACHMENT B

### Southwest Region QI Plan Performance Measures for 2026

\*The committee chair or designee will be responsible for compiling and presenting the data. When requested by the chair the data should be submitted no longer than 2 weeks after the request.

#### EMS

1. NEMSQA Safety-01 Percentage of 911 Responses without Lights and Sirens
2. NEMSQA Safety-02 Percentage of Transports from 911 Response without Lights and Sirens
3. NEMSQA Airway-18/Washington State KPI 8.5 Percentage of invasive airways confirmed with EtCO<sub>2</sub>

#### CARDIAC

1. Washington State EMS KPI 5.2 Percent of patients  $\geq 35$  with chest pain who received 12-lead ECG
2. AHAEMS7 Percent of Patients time from first positive ECG to STEMI alert  $\leq 10$  minutes OR Washington State KPI 5.5 Percentage of STEMI patients with STEMI alert
3. [COAP](#) Percentage of STEMI Patient with D2B < 90 minutes

#### STROKE

1. AHAEMS4 Stroke Screen OR Washington State KPI 6.1 Percentage of patients with suspected stroke receiving stroke screening
2. Washington State KPI 6.6 Percentage of patients with positive stroke screening receiving LAMS
3. AHA GWTG DTN  $\leq 60$  minutes for eligible patients.
4. AHA GWTN DIDO  $\leq 60$  minutes for referring hospitals with EVT candidates

#### TRAUMA

- NEMSQA Trauma-04 Percentage of patients who met trauma criteria transported to a trauma center
- NEMSQA Trauma-08 Percentage of trauma patients with GCS, SBP, and RR documented
- % of total patients transferred out with an ED LOS greater than 3 hours with ISS greater than 16.
- % of patients who received TXA that met criteria

#### HOSPITAL REHABILITATION PROGRAMS:

- Number of stroke patients admitted to IP rehab upon discharge from any hospital.
- Falls and falls with injury on IP rehab.