



Regional Medical Performance Improvement Plan

*Includes Template for Local PI Plan
Current September 2014*

OLD DOMINION EMS ALLIANCE, INC.
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Purpose

The Old Dominion EMS Alliance (ODEMSA) Performance Improvement (PI) Committee, a standing committee of ODEMSA, is responsible for assessing and facilitating the improvement of the quality of prehospital medical care within the EMS systems in Planning Districts 13, 14, 15 and 19, which comprise the 9,000-square-mile ODEMSA region.

It will work under the provisions of the ODEMSA Performance Improvement Plan (PIP) and interact with ODEMSA's Medical Control, Trauma Performance Improvement, Trauma Triage, Air Medical and Professional Development Committees. ODEMSA's Board of Directors will receive reports from the PI Committee.

Definitions

1. **Performance Improvement (PI)** -- A systematic process of discovering and analyzing human performance improvement gaps, planning for future improvements in human performance, designing and developing cost-effective and ethically-justifiable interventions to close performance gaps, implementing the interventions, and evaluating the financial and non-financial results.
2. **Quality Assurance (QA)** -- The retrospective review or inspection of services or processes that is intended to identify problems.
3. **Quality Improvement (QI)** -- The continuous study and improvement of a process, system or organization.
4. **Quality Management Program (QMP)** – The continuous study of, and improvement of, an EMS agency or system. It includes the collection of data, the identification of deficiencies through continuous evaluation, the education of personnel, and the establishment of goals, policies and programs that improve patient outcomes in the EMS system.
5. **Medical Incident Review (MIR)** – A process by which an EMS provider or EMS agency can review a questionable incident and report that incident to ODEMSA, have that incident reviewed by the regional PI Committee, and receive feedback from the Committee.
6. **Prehospital Care Report (PCR)** – That report used by an agency to record details of out-of-hospital EMS patient care. This also is known as a Prehospital Patient Care Report or PPCR.

Primary Objectives

1. Conduct regional Incident Reviews (QA) and encourage local agency Medical Incident Reviews as required by state regulation.
2. Collect patient care statistics to evaluate system effectiveness and identify trends (QI).
3. Provide constructive feedback on medical quality improvement to all hospital and out-of-hospital EMS professionals within the ODEMSA region.

Committees' Membership

The regional PI Committee will be comprised of representatives as detailed in the OEMS Requirements contained in Attachment A (Page 15) and Committee Overview (Page 6) of this document to include localities, EMS agencies and accredited education and training organizations or institutions. Each of the four local EMS councils will have one representative. The emergency departments of acute care hospital systems will be represented by four members. The ODEMSA Medical Control, Trauma Triage, Air Medical, and Professional Development committees each will have one representative to the PI Committee. In addition, there will be four at-large EMS health care representatives. Each representative also will have an alternate who will attend in the absence of the designated member and will have the same voting rights.

In order to comply with ODEMSA's contract with the Virginia Office of EMS, the representative, or that person's alternate, must attend 75 percent of PI Committee meetings to remain in the position of an active member or representative.

PI Committee: Maximum Representation, Meaningful Participation

The Old Dominion EMS Alliance (ODEMSA) is made up of four planning districts each of which has three members on the ODEMSA Board of Directors. Each planning district has a local EMS sub-council made up of representatives of licensed EMS agencies and hospitals within the planning district. The local sub-councils, Southside (PD 13), South Central (PD 14), Metro Richmond (PD 15) and Crater (PD 19), meet separately at least once each quarter. Historically, attendance has been excellent.

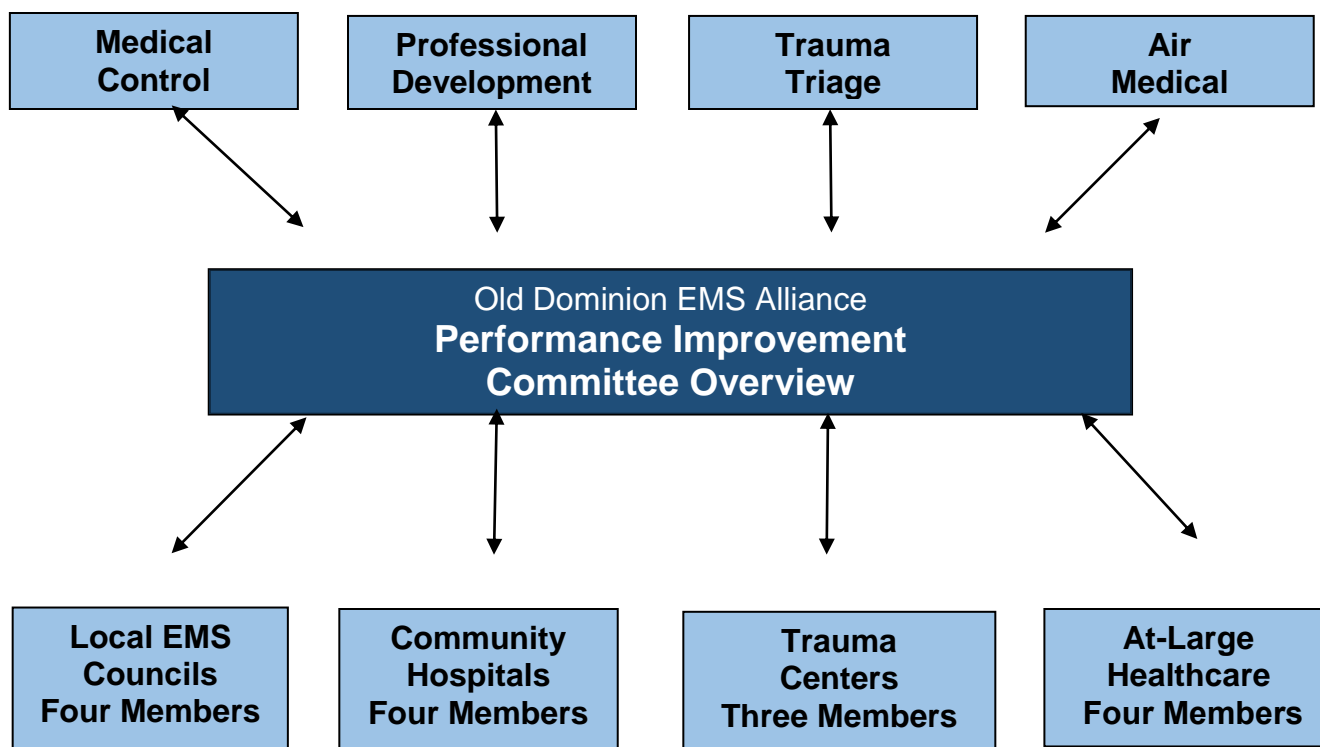
ODEMSA's Performance Improvement (PI) Committee uses the local planning district EMS sub-councils as local PI subcommittees. The groups consider local trauma and medical PI issues at least quarterly during meetings that precede the regular council meeting. Separate minutes and agendas of those meetings are kept. Two members from each of those subcommittees are designated as members of the regional PI

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Committee—one the primary and the other the alternate. It is their responsibility to bring forward to the regional committee PI issues as requested by the local PI subcommittee and as outlined in the PIP, and to relay PI Committee reports back to the local agencies. All correspondence to ODEMSEA will be via email or USPS. Also, four EMS healthcare providers and their alternates are selected to serve as at-large members.

The regional PI Committee includes representatives of four ODEMSEA committees, which also meet at least quarterly. Those committees are Medical Direction, Professional Development, Trauma Triage and Air Medical, all of which are involved in performance improvement issues. Hospital members of the regional PI Committee will include representatives (and alternates) of the three trauma centers in the ODEMSEA region, and one representative (and alternate) each of community hospitals in each of the four planning districts. This group always will include the specific individuals noted in the ODEMSEA contract.

Those 19 representatives (four planning districts, four at-large, four committees, three trauma centers and four hospitals), provide an ideal team to address local and regional PI issues and generate meaningful reports within ODEMSEA. The Committee also believes this arrangement meets the stated goal of the Virginia Office of EMS to provide maximum regional involvement in the PI process.



Member Responsibilities

1. Members of the PI Committee generally are responsible for ensuring that reasonable standards of care and professionalism are met within their respective EMS systems. Members have the following responsibilities:
 - a. They should participate in an ongoing Quality Management (QM) Program that should include PCR review audits and data collection within their respective EMS agency or system.
 - b. They should maintain strict confidentiality of patient information, personnel and Q/A topics.
2. The Chair of the PI Committee will be an appointed member of the Committee and elected by the Committee by majority vote. The Chair will serve 12-month terms or until a replacement is named. The Chair's responsibilities will include:
 - a. Final decisions and actions of the respective Committee.
 - b. Draft all letters of recommendations to local EMS agencies, Operational Medical Directors (OMDs) or Hospitals.
 - c. Draft all proposals for changes to policies, guidelines and protocols.
 - d. Liaison to all local EMS agencies and hospitals.
 - e. Liaison to the ODEMSA Professional Development Committee.
3. The Co-Chair and Medical Director of the PI Committee shall be a licensed emergency physician and an active member of ODEMSA's Medical Control Committee. He/She will be elected by the committee by majority vote and will serve a 12-month term or until a replacement is named. His/Her responsibilities shall include:
 - a. Liaison to local EMS agencies' OMDs and hospital physicians.
 - b. Liaison to ODEMSA's Medical Control Committee.
 - c. Liaison to the Professional Development Committee.
 - d. Final review of all proposals for changes to policies, guidelines or protocols.

Confidentiality

To maintain the integrity of the ODEMSA regional PI Committee and protect patient and provider privacy, each member at all times will maintain strict confidentiality. All reasonable efforts will be taken to sanitize records and maintain patient anonymity.

Meetings

Meetings of the PI Committee will be held at least quarterly. Meeting agendas and minutes will be maintained.

Medical Incident Review (QA)

Effective identification, analysis, and correction of problems requires an objective review by qualified, appropriate members of EMS and hospitals programs within the ODEMSA Region, protected by a process which ensures confidentiality.

1. Each EMS agency will report to the regional council all incidents involving preventable deaths or sentinel events that have occurred in the agency since the last meeting of the PI Committee. This may include positive and negative outcomes.
2. The committee may conduct a MIR that could include but not be limited to:
 - a. Multi-agency incidents. Special requests submitted by an agency or system.
3. The process for submitting a MIR to the regional council includes:
 - a. Only one MIR report is needed. This should be done by the agency / faculty / individual that wants a review.
 - b. A MIR form and a copy of the PCR should be submitted to the ODEMSA office as promptly as possible.
 - c. The agency OMD will receive a copy.
4. The agencies and/or individuals involved in the MIR will be notified and a copy of the form will be forwarded to the agency/system representative or the individual as promptly as possible.
 - a. The individuals involved should be notified by their respective agency/system that the MIR process has been started.
5. The MIR process may include:
 - a. A review of pertinent medical records including the PCR, base hospital CORE/HEAR recorded tape, and/or patient outcome data.
 - b. A formal interview with involved personnel to review the facts, to be arranged through the agency/system's representative.
6. The PI Committee will review all information found during the review process.
 - a. The primary goal is to identify and address the root cause. (i.e. lack of knowledge or skills, limitation of resources, poor communications, conduct issue, etc.).
7. The PI Committee will provide to the agency or system and the agency OMD the results of the MIR and recommendations or other feedback to resolve the patient care issue. Any local resulting action will come under the purview of the agency OMD.
8. Recommendations, if any, may include:

- a. Changes to policies, procedures, or protocols, which will be forwarded to the ODEMSA Professional Development Committee.
 - b. Changes in operational procedures or equipment.
 - c. System retraining, individual counseling, individual knowledge and skills evaluation/refresher, and/or clinical monitoring.
9. All recommendations will be forwarded to an agency officer and agency OMD. This letter will be drafted by the PI Committee chair/co-chair.

Regional EMS System Analysis (QI)

Quality Improvement is critical to the evaluation of the medical system in the ODEMSA region. A broad look at what contributes to community health must include data from hospitals and prehospital agencies, so comprehensive care at the right time and at the right place can be ensured. Accurate regional data can provide specific information about the health of the region's medical and trauma systems and individual communities, facilities, and about prehospital services.

1. The QI goals of the ODEMSA PI Committee is to:
 - a. Design and implement PI projects addressing medical issues that are practical and will generate patient care statistics to evaluate system effectiveness and identify trends in patient care.
 - b. Establish regional clinical benchmarks to measure the ODEMSA regional system's effectiveness.
2. Requests or suggestions for PI projects may come from individuals, the Medical Control Committee, PI Committee, TPI Committee, EMS agencies or hospitals in the ODEMSA region.
3. If appropriate, the PI Committee will appoint a task force(s) to address an issue or project.

Regional Training and Assistance

The regional PI Committee will be responsible for maintaining regularly scheduled training programs at various locations in the ODEMSA region to assist local EMS agencies in the performance improvement process. Agencies will be directed to contact the ODEMSA office with any such requests. To provide assistance, the committee will work with the Virginia Office of EMS to secure appropriate updates and PI information along with instructional support as needed. The PI Committee also will draw on the ODEMSA staff for its support of these education, training and administrative efforts.

References A

Virginia Emergency Medical Services Regulations

12 VAC 5-31-600: *“An EMS agency shall have an ongoing Quality Management (QM) Program designed to objectively, systematically and continuously monitor, assess and improve the quality and appropriateness of patient care provided by the agency. The QM Program shall be integrated and include activities related to patient care, communications, and all aspects of transport operations and equipment maintenance pertinent to the agency’s mission. The agency shall maintain a QM report that documents quarterly PPCR reviews, supervised by the operational medical director.”*

Virginia State Laws

45 CFR 164.501 and 45 CFR 164.506 provides EMS personnel with the authority to receive protected health information for purposes of transport and subsequently permits EMS personnel to disclose protected health information to another health care provider such as a hospital for continued patient treatment.

45 CFR 164.501 of the Privacy Rule defines treatment as the provision, coordination or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient or the referral of a patient for health care from one health care provider to another.

45 CFR 164.506 specifically states that a covered entity may disclose protected health information for treatment activities of a health care provider.

45 CFR 164.520 would not require EMS personnel to administer the Notice of Privacy Practices to a patient in transport. That can be done by the treating facility when it is practical to do so. The HIPAA Privacy Rule also requires that covered entities must provide patients with a Notice of Privacy Practices. However, 45 CFR 164.520 provides specific direction related to the administration of notice. 45 CFR 164.520 (i) (B) states that a covered health care provider that has a direct treatment relationship with an individual must provide the notice in an emergency treatment situation, as soon as reasonably practicable after the emergency treatment situation.

Virginia Codes

§ 8.01-581.16, 8.01-581.17, 32.1-116.2, data or information in the possession of or transmitted to the Commissioner, the Advisory Board, or any committee acting on behalf of the Advisory Board, any hospital or prehospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery

proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

§ 8.01-581.16. Civil immunity for members of or consultants to certain boards or committees. Every member of, or health care professional consultant to, any committee, board, group, commission or other entity shall be immune from civil liability for any act, decision, omission, or utterance done or made in performance of his duties while serving as a member of or consultant to such committee, board, group, commission or other entity, which functions primarily to review, evaluate, or make recommendations on (i) the duration of patient stays in health care facilities, (ii) the professional services furnished with respect to the medical, dental, psychological, podiatric, chiropractic, veterinary or optometric necessity for such services, (iii) the purpose of promoting the most efficient use or monitoring the quality of care of available health care facilities and services, or of emergency medical services agencies and services, (iv) the adequacy or quality of professional services, (v) the competency and qualifications for professional staff privileges, (vi) the reasonableness or appropriateness of charges made by or on behalf of health care facilities or (vii) patient safety, including entering into contracts with patient safety organizations; provided that such committee, board, group, commission or other entity has been established pursuant to federal or state law or regulation, or pursuant to Joint Commission on Accreditation of Healthcare organizations requirements, or established and duly constituted by one or more public or licensed private hospitals, community services boards, or behavioral health authorities, or with a governmental agency and provided further that such act, decision, omission, or utterance is not done or made in bad faith or with malicious intent.

§ 8.01-581.17. Privileged communications of certain committees and entities.

- A. For the purposes of this section: "Centralized credentialing service" means (i) gathering information relating to applications for professional staff privileges at any public or licensed private hospital or for participation as a provider in any health maintenance organization, preferred provider organization or any similar organization and (ii) providing such information to those hospitals and organizations that utilize the service.

"Patient safety data" means reports made to patient safety organizations together with all health care data, interviews, memoranda, analyses, root cause analyses, products of quality assurance or quality improvement processes, corrective action plans or information collected or created by a health care provider as a result of an occurrence related to the provision of health care services.

"Patient safety organization" means any organization, group, or other entity that collects and analyzes patient safety data for the purpose of improving patient safety and health care outcomes and that is independent and not under the control of the entity, that reports patient safety data.

- B. The proceedings, minutes, records, and reports of any
- i. medical staff committee, utilization review committee, or other committee, board, group, commission or other entity as specified in § 8.01-581.16;
 - ii. nonprofit entity that provides a centralized credentialing service; or
 - iii. quality assurance, quality of care, or peer review committee established pursuant to guidelines approved or adopted by (a) a national or state peer review entity, (b) a national or state accreditation entity, (c) a national professional association of health care providers or Virginia chapter of a national professional association of health care providers, (d) a licensee of a managed care health insurance plan (MCHIP) as defined in § 38.2-5800, or (e) the Office of Emergency Medical Services or any regional emergency medical services council, or (f) a statewide or local association representing health care providers licensed in the Commonwealth, together with all communications, both oral and written, originating in or provided to such committees or entities, are privileged communications which may not be disclosed or obtained by legal discovery proceedings unless a circuit court, after a hearing and for good cause arising from extraordinary circumstances being shown, orders the disclosure of such proceedings, minutes, records, reports, or communications. Additionally, for the purposes of this section, accreditation and peer review records of the American College of Radiology and the Medical Society of Virginia are considered privileged communications. Oral communications regarding a specific medical incident involving patient care, made to a quality assurance, quality of care, or peer review committee established pursuant to clause (iii), shall be privileged only to the extent made more than 24 hours after the occurrence of the medical incident.
- C. Nothing in this section shall be construed as providing any privilege to health care provider, emergency medical services agency, community services board, or behavioral health authority medical records kept with respect to any patient in the ordinary course of business of operating a hospital, emergency medical services agency, community services board, or behavioral health authority nor to any facts or information contained in such records nor shall this section preclude or affect discovery of or production of evidence relating to hospitalization or treatment of any patient in the ordinary course of hospitalization of such patient.
- D. Notwithstanding any other provision of this section, reports or patient safety data in possession of a patient safety organization, together with the identity of the reporter and all related correspondence, documentation, analysis, results or recommendations, shall be privileged and confidential and shall not be subject to a civil, criminal, or administrative subpoena or admitted as evidence in any civil, criminal, or administrative proceeding. Nothing in this subsection shall affect the

discoverability or admissibility of facts, information or records referenced in subsection C as related to patient care from a source other than a patient safety organization.

- E. Any patient safety organization shall promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. Patient safety organizations shall maintain the confidentiality of all patient-identifying information and shall not disseminate such information except as permitted by state or federal law.
- F. Exchange of patient safety data among health care providers or patient safety organizations that does not identify any patient shall not constitute a waiver of any privilege established in this section.
- G. Reports of patient safety data to patient safety organizations shall not abrogate obligations to make reports to health regulatory boards or other agencies as required by state or federal law.
- H. No employer shall take retaliatory action against an employee who in good faith makes a report of patient safety data to a patient safety organization.

§ 8.01-581.19. Civil immunity for physicians, psychologists, podiatrists, optometrists, veterinarians, nursing home administrators, and certified emergency services personnel while members of certain committees.

- A. Any physician, chiropractor, psychologist, podiatrist, veterinarian or optometrist licensed to practice in this Commonwealth shall be immune from civil liability for any communication, finding, opinion or conclusion made in performance of his duties while serving as a member of any committee, board, group, commission or other entity that is responsible for resolving questions concerning the admission of any physician, psychologist, podiatrist, veterinarian or optometrist to, or the taking of disciplinary action against any member of, any medical society, academy or association affiliated with the American Medical Association, the Virginia Academy of Clinical Psychologists, the American Psychological Association, the Virginia Applied Psychology Academy, the Virginia Academy of School Psychologists, the American Podiatric Medical Association, the American Veterinary Medical Association, the International Chiropractic Association, the American Chiropractic Association, the Virginia Chiropractic Association, or the American Optometric Association; provided that such communication, finding, opinion or conclusion is not made in bad faith or with malicious intent.
- B. Any nursing home administrator licensed under the laws of this Commonwealth shall be immune from civil liability for any communication, finding, opinion, decision or conclusion made in performance of his duties while serving as a member of any committee, board, group, commission or other entity that is

responsible for resolving questions concerning the admission of any health care facility to, or the taking of disciplinary action against any member of, the Virginia Health Care Association, provided that such communication, finding, opinion, decision or conclusion is not made in bad faith or with malicious intent.

- C. Any emergency medical services personnel certified under the laws of the Commonwealth shall be immune from civil liability for any communication, finding, opinion, decision, or conclusion made in performance of his duties while serving as a member of any regional council, committee, board, group, commission or other entity that is responsible for resolving questions concerning the quality of care, including triage, inter-facility transfer, and other components of emergency medical services care, unless such communication, finding, opinion, decision or conclusion is made in bad faith or with malicious intent.

Documents: Template and Forms for Local EMS Agencies

Attachment A	Virginia OEMS Requirements for Committee Representation
Attachment B	Local Agency PI Template
Attachment C	Agency PCR Checklist
Attachment D	Agency PCR Review Form

Attachment A

Virginia OEMS Requirements for Committee Representation

The following is taken from the 2010 - 2011 contract negotiated between the Virginia Office of EMS/VDH and the Old Dominion EMS Alliance and the 10 other regional EMS councils in the Commonwealth:

The EMS Performance Improvement Plan (PIP) shall identify the membership of the regional PI committee, objectives of the committee, and rules for participation in the meetings. The PIP should allow for a representative of the OEMS to attend the PI meetings as desired by OEMS. The committee composition shall include, but not be limited to: One active representative from each city and county in the region; should a region not have ten cities or counties within it, then the committee shall, at minimum, consist of ten active members that includes at least one representative from each city and county in the region. Attendance of the PI committee must constitute a quorum as defined in Robert's Rules.

The committee composition shall contain equal representation of Operational Medical Directors, hospitals from varied areas of the region, and EMS providers from each of the following, air medical agency, fire based service, career, and volunteer services.

To ensure equal representation reflective of the system the following shall apply:

- (a)** The Operational Medical Director must be current as an OMD approved by OEMS.
- (b)** The hospital representative must be currently employed by a hospital in the region that serves in a role at the facility that can act on behalf of the facility and functions in a capacity that relates to the EMS system.
- (c)** The air medical agency shall be an active member of a Virginia licensed air medical agency and may be an administrator, registered nurse, or EMT-Paramedic.
- (d)** The fire-based service member must be currently active with a fire-based service that is licensed as an EMS agency by OEMS.
- (e)** The career EMS member must be currently active with a paid Virginia licensed EMS agency and not affiliated with a fire-based or air medical agency and not be an OMD.
- (f)** The volunteer EMS member must be currently active with a volunteer EMS agency and not be affiliated with a fire-based or air medical agency and not be an OMD.

Items (a) through (f) are intended to exclude members from serving in dual roles and to allow true representation of each contributor to the EMS system, i.e. an emergency department nurse manager who also volunteers as an EMS provider shall not represent volunteer EMS.

Active membership is defined as 75 percent attendance by each committee member and/or their replacement at all quarterly meetings (replacements shall be from the same locality and/or agency).

The contractor shall hold, at a minimum, quarterly PI committee meetings to review the input from the EMS agencies and reported significant events. The committee shall identify needs based on review of PI information received by the contractor, plan a course of corrective action to resolve/improve the identified deficit and reassess the deficit to “close the loop” on issues. The items/deficits and the process used to correct them shall be reflected in the minutes of the meeting.

The contractor shall submit to OEMS the agenda, minutes and attendance rosters for each meeting held. The agenda, minutes, and attendance rosters shall be submitted each quarter as part of the contractor’s quarterly report to the OEMS.

The attendance roster shall contain the name, affiliation and e-mail address of the attendees.

The minutes of these meetings shall not contain patient or provider identifiers, but should reflect a general statement of items worked on by the committee.

The meeting dates for the EMS PI committee shall be submitted to the OEMS, in advance, as part of each quarterly report to OEMS.

The contractor shall provide technical assistance to EMS agencies to assist them in complying with State EMS Regulations related to quality management reporting (*12 VAC 5-31-600*). The names of agencies and the nature of assistance provided to those agencies shall be submitted by the contractor as part each quarterly report to the OEMS.

The contractor shall actively encourage, not enforce, all EMS agencies within its region to meet state requirements for quality management reporting (*12 VAC 5-31-600*) and submission of prehospital patient care data on a quarterly basis (*12 VAC 5-31-530*). Each of the contractor’s quarterly reports to the OEMS shall include language that describes how this contract item was achieved.

Attachment B

Regional Performance Improvement Plan

(Local Agency Name)

Local Medical Response

Purpose

The primary purpose of this Performance Improvement Program is to establish a system that objectively, systematically and continuously monitors the quality of EMS medical care provided by (Local Agency Name) in the Old Dominion EMS Alliance (ODEMSA) region. It also provides for assessment, feedback and improvement of quality and appropriateness of patient care given by the agency's EMS providers. This program is geared to ensure the highest standard of care in the prehospital setting, and to identify problems and help correct them. The focus of this program is to improve overall out-of-hospital patient care without being critical or punitive to providers and their individual performances. When a problem is found, the goal will be to prevent its reoccurrence through the process of feedback, education and mentoring.

This program must comply with the Virginia Department of Health, Office of EMS Rules and Regulations 12-VAC §5-31-600, to provide for quality management and performance improvement at the agency level. This plan must be approved by the agency operational medical director (OMD), and (other local entity). Dated approval signatures will be located on the last page of this document. Specific data must be submitted to (Name of Person) quarterly and will be tabulated by the agency Performance Improvement (PI) Committee. The data also should be shared with the agency OMD and the ODEMSA Performance Improvement (PI) Committee within 30 days of the end of each quarter. While the data is shared, all personal information will remain confidential.

The ODEMSA Trauma Triage Committee and ODEMSA PI and TPI committees are responsible for monitoring quality improvement issues in the region to include run data, personnel or agency problems as brought to their attention through the regional Medical Control Committee, area hospitals, and each agency's PI Committee.

(Agency Name) is encouraged to send reports of unusual or troublesome events that have been addressed locally to the ODEMSA Trauma Triage Committee or the PI Committee for review. The ODEMSA Trauma Triage and/or the Regional PI Committee may be asked to report or make recommendations to the ODEMSA Medical Control Committee. The ultimate goal of these committees is education of the provider and improved patient care in the ODEMSA region. While ODEMSA has a PI and a TPI plan, local agencies are only required to have one PI plan. Local agencies are encouraged to give equal time to PI and TPI during their monthly PI process.

Definitions

1. **Performance Improvement (PI)** -- A systematic process of discovering and analyzing human performance improvement gaps, planning for future improvements in human performance, designing and developing cost-effective and ethically-justifiable interventions

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to close performance gaps, implementing the interventions, and evaluating the financial and non-financial results.

2. **Quality Assurance (QA)** -- The retrospective review or inspection of services or processes that is intended to identify problems.
3. **Quality Improvement (QI)** -- The continuous study and improvement of a process, system or organization.
4. **Quality Management Program (QMP)** – The continuous study of, and improvement of, an EMS agency or system. It includes the collection of data, the identification of deficiencies through continuous evaluation, the education of personnel, and the establishment of goals, policies and programs that improve patient outcomes in the EMS system.
5. **Medical Incident Review (MIR)** – A process by which an EMS provider or EMS agency can review a questionable incident and report that incident to ODEMSA, have that incident reviewed by the regional PI Committee, and receive feedback from the Committee.
6. **Prehospital Care Report (PCR)** – That report used by an agency to record details of out-of-hospital EMS patient care. This also is known as a Prehospital Patient Care Report or PPCR.

Primary Objectives

1. Conduct local Medical Incident Reviews (MIR) to include any actual or apparent inappropriate care by an out-of-hospital EMS provider in the jurisdiction.
2. Collect patient care statistics to evaluate system effectiveness and identify trends (QI).
3. Provide constructive feedback on quality improvement to all hospital and out-of-hospital EMS professionals within the local jurisdiction.

Membership

(Agency Name) will establish a peer review committee. Membership in this PI Committee should represent the local EMS system. Its members should work toward fulfilling the purpose and objectives of the regional PI Committee and TPI Committee. At a minimum, the local PI Committee should consist of:

1. The agency Operational Medical Director.
2. The agency EMS performance improvement officer.
3. The agency training officer.
4. The chief operational officer.
5. An agency Emergency Medical Technician-Paramedic (career and/or volunteer).
6. An agency EMT-Basic (career and/or volunteer).
7. A local EMD/EMS dispatcher.
8. A nurse representative of the local hospital(s).
9. A nurse with training (e.g. TNCC) in trauma care.

Procedure

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The committee will be responsible for the design, implementation and ongoing operation of the agency PI program, and for suggestions about and modifications to the program.

Patient Care Reports (PCRs) will be used to gather statistical data regarding the delivery of specific patient care. The published result of the reviews will be compiled in a statistical format and will contain no unit or provider identifiable information. PCR reviews of certain incident types will be conducted on a rotating basis to measure the efforts of the system to improve quality. Incident types selected for review will be dictated by the needs of the EMS system and will be selected by the agency PI Committee. PCR reviews will be conducted on a quarterly basis, at a minimum.

All “major” run reports will be reviewed by the committee. Reports will include:

- All Intubations.
- All IO attempts.
- All CPR.
- Patients with critical multiple trauma.
- Patients who suffer cardiac arrest during transport.
- Patient care turned over to air medical transport.
- Serious equipment failures.
- Extended extrications.
- All declared Mass Casualty Incidents (MCIs) or as defined by regional protocol.
- All calls for which a complaint is received (internally or from the hospital).
- Preventable deaths and other sentinel events.

Reports selected for review will have a Prehospital Quality Improvement Program Review Form (see Attachment D) attached to the report. The form signifies that the selected report has been reviewed by the agency PI Committee and also is a means for follow-up by the regional PI Committee or at the OMD level, if necessary.

All deviations from accepted patient care standards and/or documentation should be noted during the PCR review process. Deviations from the standard of care will be categorized as follows:

Class I: Deviations from the standard of care and/or regional policy that have been identified as patient care trends that detract from the effectiveness of the EMS system. Examples may include, but not limited to:

1. Failure to use monitoring devices such as pulse-oximetry where appropriate.
2. Common patient care documentation failures (reassessment, lung sounds, justification for deviation, etc.).
3. Improper documentation of interventions.
4. Failure to appropriately document controlled substances that are wasted.

Class II: Deviations from the standard of care that possibly could affect patient outcomes negatively. Examples may include, but are not limited to:

1. Failure to properly confirm tube placement.
2. Failure to contact medical control when required as indicated by ODEMSA Prehospital Patient Care Protocols.
3. Inappropriate transport decisions.

- Class III:** Deviations from the standard of care that have a high possibility or probability of negatively effecting patient outcomes. Examples may include, but are not limited to:
1. Improper medication administration (wrong medication, wrong dose, wrong patient, wrong route, wrong time).
 2. Inappropriate medical procedures.
 3. Failure to provide required/indicated interventions.
 4. Interventions performed beyond the provider's scope of practice.

Committee Actions

Upon review of the above criteria, the agency PI Committee, OMD or (Agency's Chief Officer) may recommend specific actions. These actions may include, but should not be limited to, a suggested modification to protocols or special training sessions.

In all instances, the (Agency Name) Chief Officer will be made aware of any problems involving an individual and/or the system. Any recommendations for disciplinary action will be presented through the (Agency Name) Chief Officer and will be handled in accordance with (Agency Name) Rules of Conduct. Meetings between the agency's PI Committee chair, the (Agency's Chief Officer) and OMD(s) will be scheduled as necessary. Action taken by this group will be presented confidentially by the (Agency's Chief Officer) to the individual in the presence of the PI Committee chair.

The agency OMD must participate in any actions or decisions as they relate to patient care, as outlined by the Code of Virginia. An OMD may suspend a provider from practicing his or her skills in this agency. This action must be reported to the Virginia Office of EMS/VDH.

Regional Support and Assistance

Agency leaders and OMDs are encouraged to request assistance from the regional PI Committee through the Old Dominion EMS Alliance to address any issues or problems they encounter in setting up or maintaining the local PI program. The regional committee will hold regularly scheduled update and general PI training programs as financing and staffing permit. However, agency leaders and OMDs should not wait for these programs if an immediate problem is encountered.

Summary

This performance improvement process is prospective, concurrent and retrospective. In being prospective, information will be viewed so that improvements can be made to prevent future problems. The concurrent process evaluates how things are done now. Suggestions may be made on issues such as new provider training, preceptor programs, and peer reviews. The retrospective process looks at how things were done recently, such as run reviews, PI issues, etc. This process is an avenue for evaluating and improving overall agency performance.

This policy requires that the following PI indicators (criteria) be reported on a quarterly basis:

1. Number of patient care report forms reviewed for each quarter.
2. Any commendations made to agency members.
3. Any disciplinary actions based on patient care.

REGIONAL MEDICAL PERFORMANCE IMPROVEMENT PLAN

These statistics will be reported to the agency’s OMD and chief officer on a PCR Checklist (see Attachment C). (Agency Chief Officer or OMD) reserves the right to expand or revise these criteria at their discretion. A copy of the PCR Checklist also must be sent to the OMD and ODEMSA within 30 days of the end of each quarter.

(Agency Name) is required by the Virginia Office of EMS/VDH to maintain a quality management report that documents quarterly PCR reviews. The completed PCR Checklist(s) will serve as a written legal record. The checklist and this plan shall be made available to an Office of EMS representative if requested during an agency inspection.

(Local Agency Name)

PERFORMANCE IMPROVEMENT/CONTINUOUS QUALITY IMPROVEMENT PROGRAM APPROVALS

(Date)

Operational Medical Director date (Agency Name)

Chief Officer date (Agency Name)

(County or other entity representative) date

References B

Virginia Emergency Medical Services Regulations

12 VAC 5-31-600: “An EMS agency shall have an ongoing Quality Management (QM) Program designed to objectively, systematically and continuously monitor, assess and improve the quality and appropriateness of patient care provided by the agency. The QM Program shall be integrated and include activities related to patient care, communications, and all aspects of transport operations and equipment maintenance pertinent to the agency’s mission. The agency shall maintain a QM report that documents quarterly PPCR reviews, supervised by the operational medical director.”

Virginia State Laws

45 CFR 164.501 and 45 CFR 164.506 provides EMS personnel with the authority to receive protected health information for purposes of transport and subsequently permits EMS personnel to disclose protected health information to another health care provider such as a hospital for continued patient treatment.

45 CFR 164.501 of the Privacy Rule defines treatment as the provision, coordination or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient or the referral of a patient for health care from one health care provider to another. 45 CFR 164.506 specifically states that a covered entity may disclose protected health information for treatment activities of a health care provider.

45 CFR 164.520 would not require EMS personnel to administer the Notice of Privacy Practices to a patient in transport. That can be done by the treating facility when it is practical to do so.

The HIPAA Privacy Rule also requires that covered entities must provide patients with a Notice of Privacy Practices. However, 45 CFR 164.520 provides specific direction related to the administration of notice. 45 CFR 164.520 (i) (B) states that a covered health care provider that has a direct treatment relationship with an individual must provide the notice in an emergency treatment situation, as soon as reasonably practicable after the emergency treatment situation.

Virginia Codes

§ 8.01-581.16, 8.01-581.17, 32.1-116.2, data or information in the possession of or transmitted to the Commissioner, the Advisory Board, or any committee acting on behalf of the Advisory Board, any hospital or prehospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

Attachment C

(Agency Name)

AGENCY P.C.R. CHECKLIST

This PCR Checklist must be completed after each quarterly review by the regional Performance Improvement Committee or Trauma Performance Improvement Committee. A copy of this form must be sent to the OMD and to ODEMSA within 30 days of the end of each quarter. A copy also must be kept by the agency and made available to the OEMS representative upon request and at agency inspections. Please print all information.

Date of review: _____ Number of reports reviewed: _____

Period Covered: _____ Number of ALS patients: _____

Number of **total** EMS responses during the evaluation period: _____

Number of agency EMS transports: ALS _____ BLS _____

Number of patients transported to trauma centers _____ Level 1 _____ Level 3 _____

Number of cardiac arrests (total): _____

Number of patients receiving CPR _____

Number of patients transported after receiving CPR _____

Number of patients with pulse upon arrival at hospital _____

Number of patients requiring airway management (at least a BVM was used): _____

Number of times air medical was used for patient transport: _____

Number of patient refusals: _____

Number of response delays (due to staffing issues, high call volume, multiple responses in same jurisdiction, EMS vehicle accident or other unusual circumstances): _____

Comments: _____

Attach Additional Sheets If Necessary
ODEMSA: 1463 Johnston-Willis Drive, Richmond, VA 23235-4730

Attachment D

(Agency Name)

Prehospital Performance Improvement Program

PCR REVIEW FORM

Use this form to document every PCR review that the agency Performance Improvement Committee conducts, and attach it to the agency copy of that report.

Incident Number _____ Unit OIC _____ Date of Call _____ Date of Review _____

1. Is the written report legible? yes no

2. Is there a question of procedural competence? yes no

If yes, please explain:

3. Was patient care appropriate? (consider protocol adherence and/or deviation from standard practice)
 yes no

If no, please explain:

4. Is there a question regarding response or on-scene time? yes no

If yes, please explain

5. Was medical control contacted? yes no

For patient report only? yes no

For on-line orders outside of standing orders? yes no

Please explain _____

6. Other Comments

CORRECTIVE ACTIONS

Individual training – Date completed _____ Trainer _____

Protocol Review - Date Completed _____ Trainer _____

REVIEWED BY:

REGIONAL MEDICAL PERFORMANCE IMPROVEMENT PLAN

[] PI Committee (Print): _____, _____, _____

[] OMD _____ Date Reviewed _____

[] (County or other entity representative) PI Committee Date Reviewed _____

Attach Additional Sheets If Necessary. Remember to Attach Copy of PCR

ODEMSA Performance Improvement Committee - Approved August/2014
ODEMSA Board of Directors - Approved - Sept 2014