2014

Regional EMS & Trauma Performance Improvement Plan

Performance improvement is the concept of organizational change in which the principal officials of an organization put into place and manage a program that measures the current level of performance of the organization, and then generates ideas for modifying behavior and infrastructure to achieve a superior level of output. The primary goal of this performance improvement plan is to improve the regional agency and facility EMS and trauma service effectiveness and operational efficiency within the ODEMSA region

OLD DOMINION EMS ALLIANCE, INC.

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Purpose & Primary Objectives

The Old Dominion Emergency Medical Services Council's EMS and Trauma Performance Improvement Committee's (PI &TPI), have been established as separate standing committees. The PI committees are expected to work cogently with the other ODEMSA standing committees, which include: Operational Medical Directors Review, Trauma Triage, MCI/Hospital Diversion, Air Medical, Professional Development, Pharmacy, STEMI, Stroke Steering and other designated committees or ad hoc work groups. Collectively the PI committee's are responsible for assuring and improving the quality of pre-hospital medical care within ODEMSA region, and for monitoring compliance with the region's Trauma Triage Plan for both field-to-hospital and inter-hospital transfer of trauma patients. The collective committees' work will encompass:

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

These objectives shall be achieved through developing and enhancing partnerships with, and between agencies and hospitals, by providing the highest quality of emergency medical services and by being an innovative leader in the emergency medical field.

Additionally, the collective PI committees will broadly monitor EMS responses in our region through: (1) acquired run data using standardized NEMSIS data sets; (2) disclosed personnel or agency/facility issues; and (3) educational needs as brought to their attention through quarterly QI agency reports, other committees' members, area hospitals, and each agency's Quality Management Committee.

While ODEMSA and its collective PI committees (PI &TPI) have no statutory or regulatory authority to compel agencies and hospitals to participate in data submission, the Committee encourages all EMS agency Operational Medical Directors and hospitals to participate and comply with data submission specific to TPI projects undertaken by the Committee.

Data Collection Methods

Since the 1970s, the need for EMS information systems and databases has been well established, and many statewide data systems have been created. However, these EMS systems varied in their ability to collect patient and systems data and allow analysis at a local, state, and national level. It was through the work of The National Association of State EMS Directors in conjunction with its federal partners at the National Highway Traffic Safety Administration (NHTSA) and the Trauma/EMS Systems program of the Health Resources and Services Administration's (HRSA) Maternal Child Health Bureau that the National EMS Information System (NEMSIS) database emerged. The NEMSIS project was developed to help

states collect more standardized elements and eventually submit the data to a national EMS database.

In Virginia, agencies are required to comply with the Code language related to collecting EMS data. That language states: "*All licensed emergency medical services agencies shall participate in the Virginia EMS Registry (PPCR) by making available to the Commissioner or his designees the minimum data set in the format prescribed by the Board or any other format which contain equivalent information and meets any technical specifications of the Board*". The Office of EMS (OEMS) Patient Care Information System includes the Virginia Statewide Trauma Registry (VSTR) and the Virginia Pre-Hospital Information Bridge (VPHIB).

It is the specific intent of the ODEMSA PI committee's (PI and TPI) to rely upon the data submission to the VSTR and VPHIB. This information will provide useful in the following QA initiatives:

- √ Developing Regional EMS Training Curricula
- √ Evaluating Patient and EMS System Outcomes
- √ Facilitating Research Efforts
- √ Addressing Resources for Disaster and Domestic Preparedness
- √ Providing Valuable Information on Other Issues or Areas of Need Related to EMS Care

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.

Confidentiality

In order to maintain the integrity of the TPI Committee and protect patient and provider privacy, each member at all times will maintain strict confidentiality. However, communication with other entities of the system is essential. Specifically, when an issue is identified within the system involving such matters as skill performance, critical thinking, documentation, equipment, protocol deviation or other general issues, it is the responsibility of this committee to inform the appropriate agency leader and the agency's OMD, and elicit input for possible solutions. All reasonable efforts will be taken to sanitize records and maintain patient anonymity.

Committee Membership

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 council made up of representatives of licensed EMS agencies and hospitals within the planning district. The local councils – Southside (PD13), South Central (PD14), Metro Richmond (PD15) and Crater (PD19) meet separately at least one each quarter.

ODEMSA's Performance Improvement (PI) Committee shall use the local planning district EMS 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 Committee—one the primary and the other the alternate. It is their responsibility to bring forward to the regional committee any PI issues requested by the local PI subcommittee, and to relay PI Committee reports/requests back to the local agencies.

The collective regional PI Committee's (PI and TPI) shall similarly include two representatives from each of the ODEMSA standing committee's - Operational Medical Directors, Trauma Triage, MCI/Hospital Diversion, Air Medical, Professional Development, Pharmacy, STEMI, and the Stroke Steering committees', each of which meet at least quarterly. Each committee shall have one primary representative and an alternate. Each of the three trauma centers and each of the community hospitals in each of the four planning districts shall similarly be represented with a primary and alternate member.

While it is reasonably expected the above structure will align the committees' composition with the OEMS requirements, when necessary, modification in membership shall mirror the following: To ensure contractual compliance with the OEMS/ODEMSA Regional Council contract, the collective PI committees' membership shall always reflect current OEMS requirements for composition, designed to provide maximum regional involvement in the PI process (See Attachment "A"). Accordingly, 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.

- √ 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.

An additional OEMS mandate imposed upon ODEMSA is that of membership participation. In order to comply with ODEMSA's contract with the Virginia Office of EMS, the representative, or that person's alternate, must attend 75% of PI Committee meetings to remain in the position of an active member or representative.

Member Responsibilities

1. Members of the Regional 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:
   - √ They should participate in an ongoing Quality Management (QM) Program which should include PCR review audits and data collection within their respective EMS agency or system.
   - √ They should maintain strict confidentiality of patient information, personnel and Q/A topics.
2. The Chair of the Regional 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:
   - √ Final decisions and actions of the respective Committee.
   - √ Draft all letters of recommendations to local EMS agencies, Operational Medical Directors (OMDs) or hospitals.
   - √ Draft all proposals for changes to policies, guidelines and protocols.
   - √ Liaison to all local EMS agencies and hospitals.
   - √ Liaison to the ODEMSA Manpower and Training Committee.
3. The Chair or Co-Chair of the PI Committee shall be a licensed emergency physician and an active member of ODEMSA's Medical Control Committee. H/She will be elected by the committee by majority vote and will serve a 12-month term or until a replacement is named. Specific responsibilities shall include:
   - √ Liaison to local EMS agencies' OMDs and hospital physicians.
   - √ Liaison to ODEMSA's Medical Control Committee.
   - √ Liaison to the Manpower and Training Committee.
   - √ Final review of all proposals for changes to policies, guidelines or protocols.

Meetings

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

Use of Key Performance Indicators

It shall be the responsibility of the collective PI committee's to develop and implement a schedule of system evaluation activities through the development of Key Performance Indicators (KPIs). A KPI is a "quantitative performance measure…a tool that can be used to monitor performance and direct attention to potential performance issues that may require more intensive review." Stated differently, a KPI measures the degree of conformity to an expectation, policy or plan as defined by the stakeholders. KPI's may be related to structures (people, places, things), processes (activities occurring with the system) and outcomes (the results of the structures or activity within the system.

Changes in structure may affect the process and outcome. Likewise, changes in the process may affect the structure and outcome. KPI's, in short, are a way to simplify information so that data can be assimilated and analyzed to evaluate outcomes.

The collective PI committees' will establish and maintain a region-wide EMS Performance Improvement Plan in compliance with state guidelines. The collective PI committee's shall select topics, develop the minimum NEMSIS data-set attributes and establish the review schedule for committee activity. An incomplete, yet representative example, of a KPI derived from a NEMSIS data-set is included in Attachment 'B' of this document. The sample 'Acute Stroke' KPI template is not meant to be all inclusive, rather it is simply representative of the type of PI request that will be generated once adopted. Similar formats will follow specific to EMS and/or Trauma initiatives.

The committee and OMD's will select topics for up to two concurrent PI projects for each quarter. Topics shall include, but not be limited to, contemporary EMS issues such as STEMI management, Stroke Steering issues, Cardiac Arrest outcomes, Trauma Management. The schedule and topics shall be the same for all agencies participating in the regional PI process.

Requests or suggestions for PI projects may come from individuals, other ODEMSA standing committees, EMS agencies or hospitals in the ODEMSA region. If appropriate, the PI

Committee will appoint a task force(s) to address an issue or project. When appropriately developed, implemented and executed, the planned activities will broadly examine the care of pre-hospital patients with the goal of improving that care through:

- √ Monitoring/assessing adherence to regional patient care protocols
- √ Monitor/assessing adherence to regional EMS system issues.
- √ Identify potential educational/training needs of providers in the region.
- √ Identifying methods of resolving patient care, EMS systems, and performance issues through the PI process.
- √ Designing and implementing PI projects addressing contemporary medical issues that are practical and will generate patient care statistics to evaluate system effectiveness and identify trends in patient care.
- √ Establishing regional clinical benchmarks to measure the ODEMSA regional system's effectiveness.

The collective PI committees shall also provide assistance to council agencies upon request and assist them in complying with State EMS Regulations related to quality management reporting (12 VAC 5-31-600)

Sentinel Event 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. Accordingly, in addition to planned KPI review, the committee is empowered to perform sentinel event incident review.

1. Field Coordinators shall encourage agencies to submit sentinel events that have occurred in the agency to the respective PI committee (PI or TPI). This may include positive and negative outcomes.
2. The process for submitting an IR request to the regional council includes:
   - √ The agency/facility/individual requesting the incident review should contact an ODEMSA staff member or PI Committee member with event specifics.
   - √ If possible a copy of the ePCR or PPCR should be forwarded to both the agency OMD and ODEMSA staff member.
   - √ The agencies and/or individuals involved in the IR will be notified and a copy of the form will be forwarded to the agency/system representative or the individual as promptly as possible.
3. The IR process may include:
   - √ Reviews of pertinent medical records including the PCR, base hospital CORE/HEAR recorded tape, and/or patient outcome data.
   - √ A formal interview with involved personnel to review the facts, to be arranged through the agency/system's representative.
4. The PI Committee will review all information found during the review process.

- √ 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.).

5. 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.

6. Recommendations, if any, may include:

   - √ Changes to policies, procedures, or protocols which will be forwarded to the ODEMSA Professional Development Committee.
   - √ Changes in operational procedures or equipment.
   - √ System retraining, individual counseling, individual knowledge and skills evaluation/refresher, and/or clinical monitoring.

7. 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 Training and Assistance

The collective PI Committees (PI & TPI) shall assist in ensuring a provision for regularly scheduled training programs at various locations in the ODEMSA region to assist local EMS agencies in the performance improvement process. Agencies are directed to contact the ODEMSA office with 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.

Pertinent Regulations/Code

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. 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. 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.

Attachment A – Contract Extract

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.
- 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:
    - √ The Operational Medical Director must be current as an OMD approved by OEMS.
    - √ 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.
    - √ The air medical agency shall be an active member of a Virginia licensed air medical agency and may be either a registered nurse an administrator, or an EMT-Paramedic.
    - √ The fire-based service member must be currently active with a fire-based service that is licensed as an EMS agency by OEMS.
    - √ 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.
    - √ 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.

    The above requirements 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% 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.
- Attendance of the PI committee must constitute a quorum as defined in Robert's Rules.
- 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 – Sample KPI 'Acute Stroke'

Purpose:

This section will provide descriptive information related to the acute stroke patients who have been cared for by the EMS System during the date range selected for this KPI.

Definition of Acute Stroke Patient:

For the EMS Acute Stroke Care KPI, an Acute Stroke Patient is defined as any patient presenting with focal neurologic findings or mental status changes which could represent an acute stroke event. It is not always possible for EMS to determine if stroke-like symptoms are acute or long standing. For this reason all patients with documented stroke-like symptoms are used within this KPI.

Record Selection Information:

- √ An Acute Stroke Patient (E01_01 Patient Care Report Number) is identified by the following criteria:
- √ The Unit Notified Date is used to select the records for the Date Range
- √ Incident/Patient Disposition (E20_10) = No Treatment Required; Patient Refused Care; Treated and Released; Treated, Transported by EMS; Treated, Transferred Care; Treated, Transported by Law Enforcement; or Treated, Transported by Private Vehicle
- √ An "Acute Stroke Patient" is any patient whose age is greater than 35 years of age
- √ In addition to the above criteria, one of the following criteria must be met:
    - An "Acute Stroke Patient" is defined by the use of the following protocol (E17_01): Stroke/TIA
- √ Any records with the Stroke Screen documented with the following is considered an "Acute Stroke Patient":
    - Cincinnati Stroke Scale Non-Conclusive
    - LA Stroke Scale Non-Conclusive
    - Cincinnati Stroke Scale Positive
    - LA Stroke Scale Positive

Required Data Elements:

The following data elements are required to complete the analysis in this section:

- √ E02_04: Type of Service Requested
- √ E02_20: Response Mode to Scene
- √ E05_02: PSAP Call Date/Time

- √ E05_04: Unit Notified by Dispatch Date/Time
- √ E05_05: Unit En Route Date/Time
- √ E05_06: Arrived on Date/Time
- √ E05_09: Unit Left Scene Date/Time
- √ E05_10: Patient Arrived at Destination Date/Time
- √ E06_14: Age
- √ E06_15: Age Units
- √ E14_24: Stroke Screen
- √ E17_01: Protocols Used
- √ E20_01: Destination Name
- √ E20_10: Incident/Patient Disposition
- √ E20_14: Transport Mode from Scene

ODEMSA Performance Improvement Committee - Approved 8/2014
ODEMSA Board of Directors - Approved 9/18/2014