ODEMSA Performance Improvement Plan

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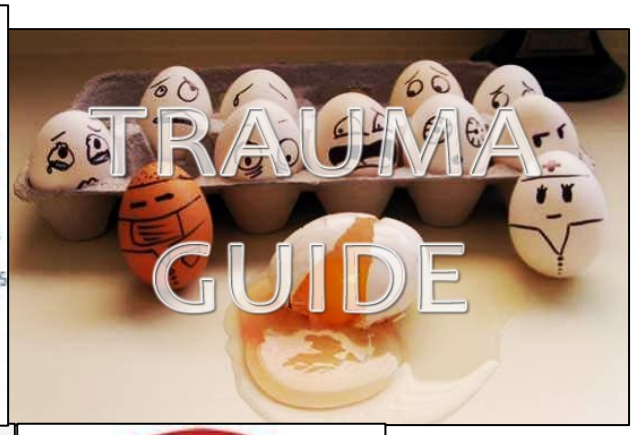

FY23

Old Dominion EMS Alliance, Inc.
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Members of the Old Dominion EMS Alliance (ODEMSA) oversee this plan as a cohesive team. 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 PI plan is to improve the regional agency and facility EMS and prehospital service effectiveness and operational efficiency within the ODEMSA region. All ODEMSA policies, procedures, and guidelines in this plan have received final approval from the ODEMSA Board of Directors.

Reviewed/Approved: ODEMSA Board of Directors 9/14/22

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Purpose & Primary Objectives

The Old Dominion Emergency Medical Services Council's Performance Improvement (PI) Committee is established as a standing committee by the Board of Directors. The PI committee is 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. The PI committee is 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 committee's 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 PI committee 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.

Data Collection

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 Patient Care Report (PPCR) –*** That report used by an agency to record details of out-of-hospital EMS patient care.
7. ***VPHIB – Virginia Pre-Hospital Information Bridge.*** This is the state-controlled database containing all patient care information obtained by each PPCR.
8. ***OSERS – ODEMSA Significant Event Reporting System*** should be used by agencies, providers, and/or hospitals to report Significant Incident Events within the ODEMSA region.
9. ***Significant Event –*** A significant event is one in which harm was done, or may have been done, to the patient, the crew, or provider. These include, but are not limited to, dropping a patient, having a motor vehicle collision while operating a licensed emergency vehicle, patient care equipment malfunction, medication errors, and near misses.

10. ***Report Writer*** **–** A query program used to generate reports from the data in VPHIB.

11. ***Sub-Council*** **–** Each Planning District within ODEMSA makes up its own sub-council. The sub-council is made up of all the agencies within that Planning District.

12. ***Planning District*** **–** A Planning District (PD) is a geographical region described by the Virginia Planning District Commission. The four Planning Districts that make up ODEMSA are PD-13 (Southside), PD-14 (Commonwealth or Central), PD-15 (Metro Richmond), and PD-19 (Crater).

Confidentiality

In order to maintain the integrity of the Performance Improvement 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 PI Committee by-laws state the membership make-up and member responsibilities. The committee's by-laws are approved by the ODEMSA BOD and are reviewed annually.

Meetings

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

Regional PI Projects

In the fourth quarter of the fiscal year, the PI Committee will review and publish minimum of three (3) Regional PI projects that monitor/assess EMS system issues, adherence to regional patient care protocols, triage plans, and/or identify education needs of EMS providers in the region. Data from the PI projects will be reviewed at each PI Committee meeting at least quarterly for the next fiscal year.

The PI Committee will establish and publish an EMS Incidents Transactional Report template for each PI Project for the upcoming year. The template will be shared with each agency in the region. ODEMSA will provide assistance to EMS agencies to run reports for their own data.

To maintain confidentiality, all reports will be blinded to agency and county/city. Reports distributed usually will only be broken down by planning district (PD). If the need arises to focus on a specific PD, every effort will be maintained to blind the agency.

Reports will also be distributed to each sub-council at their regular sub-council meeting. A representative of the PIC or ODEMSA will attend these meetings and present any relevant data. Sub councils are encouraged to distribute data, findings, education, and information for improvement to their agencies.

At times it may be necessary to identify a particular agency regarding adherence to plans/protocols or quality of the data. On the direction of the PI Committee Chair, ODEMSA will provide a report directly to that agency's leadership to include the chief operating officer, president (if applicable), QA Manager, and Operational Medical Director. The report will only contain their agency's data. This agency-specific report will not be shared the PI Committee.

Medical Incident Review *(MIR)*

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.

The MIR process is a voluntary process to providers or agencies that provides an objective review of the call. The types of calls that may be submitted includes, but not limited to:

a. Trauma Triage concerns
b. Cardiac arrests involving technology (VADs)
c. Cardiac arrest on the young (less than 35 years of age)
d. Unusual or prolonged extrications or rescues
e. Issues regarding diversion and/or issues with medical direction orders
f. Any incident with extenuating circumstances

The process for submitting a MIR to the regional council includes:

1. The MIR form is available on the ODEMSA website (appendix D). This should be done by the agency / faculty / individual that wants a review.
    a. A MIR form and a copy of the PCR should be submitted to the ODEMSA office as promptly as possible. All patient identifying information should be redacted from all documents submitted.
    b. The agency OMD will receive a copy.
2. The MIR process may include:
    a. A review of pertinent medical records including the PCR, base hospital prehospital notification recordings (i.e., 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.
3. 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.).

4. 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.
5. 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.
6. All recommendations will be forwarded to an agency officer and agency OMD. This letter will be drafted by the PI Committee chair/co-chair.

Significant Event Incident Reporting

ODEMSA will provide a mechanism for EMS agencies and hospitals to report significant events (compliments or criticism of EMS responses) and/or untoward outcomes of EMS responses and trauma related responses.

Located conspicuously on the ODEMSA website, there will be a link directly to a Significant Event Incident Reporting form. The form (Appendix E) will ask for non-agency and non-patient identified information regarding the event. This will be submitted electronically to ODEMSA staff. All reports will be sanitized to remove agency, jurisdictional, or patient identifiers prior to submitting to the PI Committee for review.

The PI Committee will review each reported event at the quarterly meeting. The committee shall make recommendations based on reported significant events. Possible recommendations include, but are not limited to:

- Educational/Training recommendations to the Professional Development Committee
- Protocol change/adjustment recommendations to the Medical Direction Committee
- Medication changes or adjustments with the layout/delivery of medication boxes to the Pharmacy Committee.

Regional Training and Assistance

The PI Committee members, at the request of ODEMSA staff, may be asked to 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). EMS agencies may request assistance by contacting the ODEMSA office.

Regional Triage Plan

The PI Committee will be responsible for reviewing the region's Trauma Triage Plan at the PI Committee's second quarter meeting. The committee will approve the plan by simple majority vote. Trauma Triage plans will be forwarded to the ODEMSA Board of Directors for final approval.

The Trauma Triage plan must meet or exceed the requirements listed in the contract between ODEMSA and the OEMS.

Appendix A - Sample PI Project Template

Lights and Sirens Response to Scene Rate

Category: EMS System

Description: A rate of emergency lights and sirens responses. This includes each vehicle responding to an incident.

Reference: EMS Compass Safety-01

Report Writer: EMS Incident Transactional Report

Columns:

Incident Date
CAD Incident Number (eResponse.03)
Response EMS Unit Call Sign (eResponse.14)
Response Additional Response Mode (eResponse.24)

Criteria:

Response Type of Service Requested (eResponse.05) = “911 Response (Scene)”

Filter:

Incident Date*

*at runtime, select “is between” <first day of quarter> and <last day of quarter>

<u>Post-Runtime Analysis (Excel)</u>
Countif(d:d, “Lights and Sirens”
Countif(d:d, “*Initial Lights and Sirens*”
Countif(d:d, “Lights and No Sirens”
Countif(d:d, “*Updgrated”)

Numerator: Sum these four numbers together.
Denominator: Counta(a:a)

The percentage is the rate of Lights and Sirens Response to Scene

Appendix B - 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.

Appendix C – Contract Extract

The following is taken from the 2017-2018 contract negotiated between the Virginia Office of EMS/VDH and the Old Dominion EMS Alliance:

Regional General EMS Performance Improvement (PI) and Triage Program also referred to as Quality Assurance, Quality Improvement, and Quality Management.

a. The Contractor shall maintain and revise as needed to reflect current practice, a region wide EMS Performance Improvement Plan (PIP) for general EMS responses and Trauma related EMS Responses. The plan shall be submitted to OEMS with the First Quarter deliverables, with proof of review and approval of the plan by the contractor's Board of Directors reflected in board minutes submitted. Any revisions made to the plan during the contract year shall be reviewed and approved by the contract's Board of Directors, and submitted in the appropriate quarterly report. The plan shall maintain and revised as needed to reflect current practice, the PI template that EMS agencies can use to establish or maintain their own PI Programs for general EMS responses and include a method reporting aggregate information to the regional council, for use by the regional council, its committees and submission to the Office of EMS. The contractor shall obtain approval from OEMS when revising the template. This shall occur within the first quarter and shall be used for the following quarters. The template shall include, but not limited to:

    i. A schedule and topics for three concurrent PI projects. One topic shall address a general EMS patient care item, one topic shall address an EMS system related item, and one topic shall address a trauma patient care or trauma system related item.

        1. The contractor shall submit evidence of the PI templates distribution to all EMS agencies in the region with the first quarterly report to the OEMS.

    ii. The plan shall include a demonstrable process that is capable of monitoring/assessing adherence to regional patient care protocols, and triage plans; EMS system issues, and identification of the educational needs of EMS providers in the region.

        1. The contractor shall include in its quarterly report to OEMS any identified performance issues and their resolution.

    iii. The Contractor shall maintain, and revise as needed, a PI template that an EMS agency can use to establish their own PI programs for general EMS responses.

    iv. The contractor shall provide information on the topics of quarterly PI projects to be conducted in the contract year.

1. The contractor shall provide information and/or reports of PI projects for use by the region's committees and reporting to OEMS.
2. The contractor shall submit a copy of the schedule and topics distributed to all EMS agencies, with the contractor's first quarterly report to OEMS. The Contractor shall have a PI based method for EMS agencies and hospital to report significant events (compliments or criticisms of EMS responses) and/or untoward outcomes for EMS responses and trauma related responses.
3. The EMS PIP shall identify the membership of the regional PI committee, objectives of the committee, and rules for participation in the meetings. The PIP shall allow for a representative of the OEMS to attend the PI meetings as desired by OEMS.
    a. The committee composition shall contain equal representation of Operational Medical Directors, hospitals for varied areas of the region, EMS providers from each of the following, air medical agency, fire based service, career, and volunteer services. The committee shall, at a minimum, consist of ten active members.
        i. To ensure equal representation reflective of the system the following shall apply:
            1. The Operational Medical Director must be current as an approved OMD by OEMS.
            2. A representative of a Designated Trauma Center in the region, and functions in a capacity that relates to EMS.
            3. A representative of a hospital in the region, and functions in a capacity that relates to the EMS system.
            4. A representative of air medical agency that provides service in the region.
            5. A representative of a career EMS agency that provides service in the region.
            6. A representative of a volunteer EMS agency that provides service in the region.

v. The contractor shall hold quarterly PI committee meetings to review the input received and/or significant events reported. The committee shall identify needs based on review of the PI information received by the contractor, and plan a course of action (protocol change, educational opportunity, process improvement, etc). The items/deficits and the process used to correct them shall be reflected in the minutes of the meeting, and shared with other regional stakeholders as needed and appropriate.

1. The agenda, minutes, and attendance rosters shall be submitted each quarter as part of the contractor's quarterly report to the OEMS.
2. The attendance roster shall contain names, affiliation, and email address of attendee.
3. The minutes of these meetings shall not contain patient or provider identifiers, but should reflect a general state of items worked on by the committee.

a. 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 contactor as part each quarterly report to the OEMS.

b. The contractor shall actively encourage, no enforce, all EMS agencies within their region to meet state requirements and submit pre-hospital patient care data on a quarterly bases as required by the *Code of Virginia* (§ 32.116.1) and EMS Regulations 12 VAC 5-31-560. Each of the contractor's quarterly reports to the EMS shall include language that describes how this contract item was achieved.

c. The contractor shall be responsible for disseminating regional, jurisdictional, and agency level performance improvement reports developed and provide by the OEMS, Trauma System Oversight and Management Committee (TSO&MC), and/or the Trauma Performance Improvement Committee.

Trauma Triage Plan

All Regional Trauma Triage Plan shall be reviewed annually, and revised as needed. This information shall be reported to OEMS in the third quarterly report.

a. The plan shall follow the current version of the Commonwealth's Pre-hospital and Inter-hospital State Trauma Triage Plan and include the following as appendices to reflect the capabilities of the Regional EMS System:

   i. A "field triage decision scheme" based on the state field decision scheme that assists individual EMS providers with transport destination decision making guidance.

   ii. The field triage decision scheme shall be include within the trauma section of the Regional medical Protocols applicable to all level of EMS certification.

   iii. A definition of a trauma patient

   iv. Pre-hospital physiological, anatomic, mechanism of injury, and special consideration criteria (previously titled Trauma Patient Transport & Transfer Criteria)

   v. Medevac utilization for trauma

vi. Trauma center descriptions (names, locations, level of designation).

vii. Description of each of the Virginia Trauma Center Designation

b. The contraction shall notify all EMS agencies, local governments, EMS physicians, and hospitals within their service delivery area that the trauma plan has been revised and post the revised triage trauma medical protocol conspicuously on the regional council's website. The Contractor will make a copy of either revised document available upon request.

Appendix D - MIR Request Form

Date of Incident: _____ Incident of Event: _____

Your Name: _____ Title: _____

Email: _____ Phone: _____

Agency/Hospital:_____

Do Not Include Protected Healthcare Information

Describe the Incident to be reviewed. Do not include PHI on this form:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Fax this form to ODEMSA at 804-560-0909

Appendix E – ODEMSA Significant Event Reporting System (OSERS)

Date of Event: _____ Time of Event: _____

Do Not Include Protected Healthcare Information

Describe the Event: _____

Fax this form to ODEMSA at 804-560-0909