



OLD DOMINION EMERGENCY MEDICAL SERVICES ALLIANCE

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Medical Direction Committee

February 12, 2026
8:00 am – 10:00 am

Chair: Dr. Allen Yee, Regional Operational Medical Director

Members and Guests Present: N/A
Virtual Attendees: Dusty Anderson, Michael Ferras, Mike Godard, Joanne LaPetina, Raj Mulhotra, Joseph Ornato, Allen Yee
ODEMSA Staff: Heidi Hooker, Ryan Scarbrough
Minutes Scribed by: Ryan Scarbrough
Materials Provided: Previous meeting minutes and agenda

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
Meeting Called to Order	<ul style="list-style-type: none">• Meeting was called to order by the Chair at 8:00 AM.• Roll call was performed.• Meeting Minutes from the previous meeting were approved as provided.	Motion to approve the 11/13/2025 Meeting Minutes made by Joseph Ornato; Seconded by Mike Godar. Motion passed.
State Medical Control		
	<p>Allen Yee</p> <ul style="list-style-type: none">• Reported that the Governor's Advisory Board has reorganized its committee structure.<ul style="list-style-type: none">○ Stated that the number of committees was reduced from approximately fifteen to eighteen committees down to six or seven.○ Explained that several previous committees now function as task-specific work groups.○ Noted that work groups are time-limited and dissolve once their assigned task is completed.	

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	<ul style="list-style-type: none"> ○ Provided an example that Air Medical now falls under Medical Control and will only convene as a work group when specific tasks arise. ● Reported that the restructuring is intended in part to rotate membership participation and reduce costs for the Office of EMS. ● Discussed Freedom of Information Act requirements affecting committee and work group structure. <ul style="list-style-type: none"> ○ Explained that under current bylaws, if three or more members of the Governor's Advisory Board or a standing committee participate in a work group, the meeting must be conducted as a public meeting. ○ Stated that efforts are being made to recruit new participants to work groups to remain compliant with bylaws. ○ Reported that some committees were previously unaware of this requirement and were not following the bylaws, while others attempted to comply. ● Reported that Dr. Ferrada, Chair of the Governor's Advisory Board, created a work group to examine the structure and rules governing work groups. <ul style="list-style-type: none"> ○ Noted the goal may be to revise bylaws so that three or more Governor's Advisory Board members would constitute a public meeting threshold while allowing broader participation on work groups. 	
Hospital Reports		
	<ul style="list-style-type: none"> ● No hospital reports provided 	
EMS Agency Reports		
Chesterfield Fire and EMS	<p>Allen Yee</p> <ul style="list-style-type: none"> ● Reported that they will soon implement a protocol update. <ul style="list-style-type: none"> ○ The protocol update includes emphasis on maintaining warmth for trauma patients. ○ Reported the agency is moving away from the routine use of cervical collars and backboards. ○ Stated that once the update goes live in approximately two weeks, cervical collars will no longer be used. 	

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	<ul style="list-style-type: none"> ○ Reported spinal motion restriction will instead utilize towels, blocks, and other stabilization methods. ○ Alert and cooperative patients will be instructed to minimize movement to reduce spinal motion. ○ For patients with neurologic injury, unresponsiveness, or combative behavior, towels, blocks, and rolls will be used to minimize spinal movement. ● Reported the agency is also updating protocols related to the management of traumatic cardiac arrest. <ul style="list-style-type: none"> ○ Stated that draft guidance from the American College of Surgeons Committee on Trauma is being reviewed in collaboration with national organizations. ○ Reported the revised approach prioritizes hemorrhage control before airway or medication interventions. ○ Stated that after hemorrhage control, chest compressions and then epinephrine administration may be considered. ○ Noted that previous guidance recommended against epinephrine use and limited use of chest compressions in traumatic arrest. ○ Reported that current literature regarding epinephrine use in traumatic arrest is limited and mixed. ○ Noted that some studies demonstrate increased return of spontaneous circulation but not improved neurologically intact survival. ○ Reported that an upcoming publication may include recommendations supporting consideration of epinephrine use. 	
Goochland Department of Fire-Rescue & Emergency Services	Dusty Anderson <ul style="list-style-type: none"> ● Nothing to report. 	
Colonial Heights Fire and EMS Dept.	Dusty Anderson <ul style="list-style-type: none"> ● Currently has an interim fire chief. <ul style="list-style-type: none"> ○ Reported that Stephen Hoke and Steve Gillam are serving in leadership roles until a new fire chief is announced. 	

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Richmond Ambulance Authority	<p>Joseph Ornato</p> <ul style="list-style-type: none"> • Reported that they are currently conducting a comprehensive review and revision of its clinical protocols. <ul style="list-style-type: none"> ○ Reported that the review process has been underway for several months. ○ Noted that updates include incorporation of the most recent Advanced Cardiac Life Support guidelines. ○ Reported that the review also includes a comprehensive evaluation of all existing protocols. 	
H2H Emergency Services	<p>Michael Ferras</p> <ul style="list-style-type: none"> • Continues to expand operations. • Ongoing updates and revisions to internal protocols to better align with operational needs and the needs of hospitals and intensive care units served. • More than twenty ambulances are currently on order as part of system expansion. • Ongoing recruitment to hire additional staff to meet increasing service demand across the state. 	
Halifax County	<p>Michael Godard</p> <ul style="list-style-type: none"> • Nothing to report. 	
HCA Air Care Eagle	<p>Raj Mulhotra</p> <ul style="list-style-type: none"> • Clarified representation for both Air Care Eagle and Chippenham Medical Center, though Air Care Eagle has appointed John Perry as the OMD since Dr. Mulhotra was appointed as the Chief Medical Officer for Chippenham. • Reported that Air Care Eagle operations continue to be active and growing. <ul style="list-style-type: none"> ○ Two additional ground ambulances have been added to support transfer operations. ○ Units will primarily conduct transfers from freestanding emergency departments such as Swift Creek to Chippenham Medical Center and Johnston Willis Hospital. ○ Units may also assist with patient discharges and other transfers as permitted under local ordinance. • Reported no major operational issues at Chippenham Medical Center. 	

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	<ul style="list-style-type: none"> • Noted that the hospital experienced several STEMI coverage gaps during the previous year due to the departure of four interventional cardiologists. <ul style="list-style-type: none"> ○ Temporary reliance on locum tenens providers created reliability challenges. ○ The facility was on STEMI diversion for approximately two days in 2025. ○ Five new interventional cardiologists have since been added to stabilize coverage. 	
Multiple Agencies	Joanne LaPetina <ul style="list-style-type: none"> • Nothing to report for her agencies. 	
Old Dominion EMS Alliance Report		
ODEMSA	Heidi Hooker <ul style="list-style-type: none"> • Thanked members for attending. • Mentioned restructuring at the Office of EMS and regional council level, transitioning from 11 councils to 7. • ODEMSA has experienced staffing losses and operational limitations over the past two years. • Two new positions have been offered, including a Training Director and a Field Coordinator. • Committees previously overseen by Tarsha Robinson are being reassigned to other staff members. • ODEMSA is reviewing committee rosters to ensure correct membership and quorum. 	
Old Business		
Protocol Review / Suggestions	<ul style="list-style-type: none"> • Allen Yee noted that protocol review remains a standing item under Old Business and asked whether any protocols had been uploaded for committee review. <ul style="list-style-type: none"> ○ Ryan Scarbrough confirmed that no protocols had been uploaded for review and that the item remains a standing agenda item. ○ Allen Yee stated the committee needs to return to the previous practice of dividing protocol reviews quarterly so that the entire set of protocols is reviewed over the course of the year. 	Committee to review and update protocols at the next meeting with the goal of completing updates by July 1. Responsible Person: Medical Direction Committee

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	<ul style="list-style-type: none"> ○ Referenced the committee deliverables of protocol updates expected in April and June. ○ Heidi Hooker clarified that under the previous contract protocol updates were scheduled, but the new contract allows the region to set the timing. Recommended that protocols be updated by July 1 for the current fiscal year since an update has not yet been issued. ○ Allen Yee recommended that the next meeting focus on reviewing and updating protocols. <ul style="list-style-type: none"> ▪ Noted that resuscitation protocols will need updates to reflect current ACLS guidance. ▪ Noted that trauma protocol updates will likely incorporate elements of the Trauma Compendium. 	
Legislative Update	<p>Ryan Scarbrough</p> <ul style="list-style-type: none"> • Reported no specific legislative updates at this time. • Noted awareness of ongoing work related to legislation addressing seatbelt requirements for EMS providers working in the patient compartment. <p>Allen Yee</p> <ul style="list-style-type: none"> • Stated uncertainty regarding the current status of the EMS seatbelt legislation. • Noted that proposed legislation requiring EMS providers to comply with Department of Transportation requirements related to marijuana use appears to have been tabled following union opposition. • Mentioned legislation related to retirement or hazard classification for dispatchers that appears to be moving forward. • Noted that typical weekly legislative updates from the Office of EMS had not yet been received. • Dusty Anderson asked whether Region 6 retained the same EMS organizations or would be expanded or contracted. <ul style="list-style-type: none"> ○ Clarified that ODEMSA and Region 6 have identical boundaries and that the organizations within the region remain the same, and noted that other regional EMS councils were consolidated as part of the statewide restructuring. 	

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	<ul style="list-style-type: none"> ▪ Noted that the Northern Virginia Emergency Response System (NVERS) now encompasses three regional councils. ○ Stated that those combined regions are still in the process of establishing their infrastructure and may not yet be fully operational as an EMS Council. <ul style="list-style-type: none"> - Lord Fairfax and Central Shenandoah - Rappahannock and TEMS - PEMS and TEMS - Blue Ridge and Western 	
New Business		
DEA Update	<p>Allen Yee</p> <ul style="list-style-type: none"> • Reported that the Drug Enforcement Administration (DEA) recently published final regulations related to the Protecting Patient Access to Emergency Medications Act. <ul style="list-style-type: none"> ○ Stated the regulations were finalized after several years in draft form. ○ Noted that the Virginia Board of Pharmacy previously based many of its state regulations on the draft federal guidance. ○ Reported that the final rule allows controlled substances in Schedules II through V to be issued directly to paramedics for use during their shift and that this practice is already common in air medical operations where medications are issued to the provider and secured at the end of the shift. ○ Noted that additional guidance exists regarding EMS agencies that cross state lines and may require a second DEA registration in another state but those that do transport should verify this information before taking action. ○ Reported that the definition of “station house” was revised in the final rule. ○ Explained that the draft rule required a licensed EMS vehicle to be present at a station house in order to store medications. ○ Stated the final rule now allows storage in logistical or supply facilities even if EMS vehicles are not present. 	<p>Encouraged medical directors to review the final DEA regulations in detail, depending on their EMS systems.</p>

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	<ul style="list-style-type: none"> ○ Noted that medications still may not be stored in private residences, which may affect some smaller EMS agencies that operate from residential locations. 	
<p style="text-align: center;">PI Data</p>	<p>Ryan Scarbrough</p> <ul style="list-style-type: none"> • Presented a regional Performance Improvement (PI) data overview for OEMS Region 6 based on ESO analytics and NEMSIS 3.5 data for October – December 2025 quarter. The presentation included regional trends related to call volume, common provider impressions, patient transport destinations, medications administered, procedures performed, and several clinical performance measures. The full presentation slides are attached to the minutes for reference. • Ryan reviewed overall EMS call trends and highlighted the most common provider primary impressions documented in the region. He also presented call volume data by agency and reviewed patient transport destinations both within and outside the region. Discussion noted that transport destination reporting may be affected by how providers select destinations within their electronic patient care reporting systems. It was emphasized that providers should select coded destination options when available rather than entering free text to ensure data accuracy. • The presentation also reviewed the most commonly documented medications administered and procedures performed across the region. Allen Yee noted that some procedure counts, such as cardiac monitoring and physical assessments, appear lower than expected and may reflect documentation practices rather than actual clinical care provided. Ryan noted that when procedures are documented only in narrative text rather than structured fields, they are difficult if not impossible to capture in data reporting based on the number of reports. • Cardiac related data was reviewed, including STEMI related impressions and documentation of cardiac arrest events. AED use prior to EMS arrival was also reviewed, with discussion noting that AED use appeared lower in more rural planning districts. Pediatric call data was also presented, including pediatric cardiac arrest events and time intervals for scene time and epinephrine administration. 	<p>Information only. Committee discussion noted that future performance improvement initiatives may focus on selected quality metrics using a Plan Do Study Act (PDSA) approach.</p>

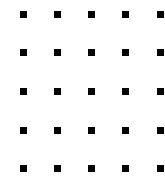
Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	<ul style="list-style-type: none"> Stroke-related measures were reviewed, including provider impressions, stroke scale usage, blood glucose documentation, and pre-arrival stroke alerts to receiving hospitals. Blood glucose documentation in suspected stroke patients remained high across the region. Discussion noted that stroke scale documentation may vary depending on how providers select options in electronic reporting systems. Trauma related measures were also reviewed including pain scale documentation and pain management effectiveness. Adult and pediatric pain score documentation rates were similar, though incomplete documentation of reassessment pain scores may limit analysis of treatment effectiveness. Seizure related measures were presented including provider impressions and benzodiazepine administration during seizure encounters. Approximately half of eligible seizure encounters included medication administration, which may reflect that some patients are no longer actively seizing upon EMS arrival. Following the presentation, Allen Yee noted that reviewing regional performance improvement data should support ongoing system improvement efforts using a Plan Do Study Act approach. He stated that identifying priority measures for focused improvement efforts may be beneficial moving forward. 	
<p>State Hypothermia Data and Definition Alignment</p>	<ul style="list-style-type: none"> Allen Yee requested that Ryan Scarbrough display statewide hypothermia data from the Virginia Office of EMS epidemiology report. The report reviewed initial temperatures of trauma patients recorded in the Virginia Statewide Trauma Registry from 2021 through 2025. Current EMS reporting uses a threshold of 35.5°C to define hypothermia, while the trauma registry defines hypothermia as 35°C or below. This difference results in a larger number of patients being classified as hypothermic on the EMS side. It was noted that using the trauma registry definition would reduce the statewide percentage of hypothermic patients from approximately 20 percent to closer to 10 percent. The state is working toward aligning EMS and trauma registry definitions so that both systems use the same criteria. The data 	

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	<p>referenced during the discussion is included in the OEMS epidemiology report.</p> <ul style="list-style-type: none"> • Reported several trauma-related initiatives currently under discussion. <ul style="list-style-type: none"> ○ Data indicates approximately twenty percent of trauma patients with an Injury Severity Score (ISS) greater than twenty arrive at trauma centers hypothermic on the first recorded temperature. ○ Noted that trauma registry data contains limitations because timestamps are lost when hospital data is imported into the registry. ○ Explained that while temperature measurements should occur within the first thirty minutes, it is unclear whether hypothermia occurs in the prehospital or hospital phase of care. ○ Reported that Medical Direction Committee leadership and Dr. Ferrada agreed to prioritize efforts to maintain patient warmth and improve data quality. ○ Stated the goal is to obtain the first documented patient temperature within the first ten minutes of arrival. ○ Noted that a trauma registry update expected in April may correct some data issues. • Reported additional trauma care initiatives being discussed at the state level. <ul style="list-style-type: none"> ○ Emphasized prioritizing restoration of circulation before airway management in trauma patients. ○ Noted this approach aligns with recent American College of Surgeons recommendations. ○ Reported encouragement to reduce routine IV fluid administration in trauma care. ○ Reported increased emphasis on prehospital blood transfusion programs. • Reported that ODEMSA secured funding through the new contract process to support development of a regional blood program. <ul style="list-style-type: none"> ○ Stated funding is anticipated to begin in July and will support a two-year phased implementation. ○ Reported that a draft plan and preliminary budget have already been developed. 	

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	<ul style="list-style-type: none"> ○ Explained the initial concept is to create a “ring” around the Metro Richmond area where agencies equipped with blood products could provide transfusions to patients being transported by ground through the “ring”. ○ Reported that the second phase would focus on agencies in southern portions of the region with longer transport times to increase access to blood products. ○ Noted that planning discussions are ongoing with blood bank partners. 	
Required Emergency Vehicle Equipment List Workgroup	<ul style="list-style-type: none"> ● Allen Yee reported that the State Medical Direction Committee has established a workgroup to review the required emergency vehicle equipment list. There is interest in moving away from inspections that focus on counting individual items such as bandages during annual inspections. Instead, the state is considering a system that identifies required categories of equipment while allowing agencies to determine the appropriate quantities. 	
EMS Inspection and Regulatory Modernization Efforts	<ul style="list-style-type: none"> ● Allen Yee also reported that there is discussion at the state level about transitioning EMS agency inspections toward an accreditation-style process. Under this approach, inspectors would review clinical capabilities, policies, training, and quality assurance processes rather than only verifying equipment inventories. Inspectors may review clinical scenarios such as STEMI or exposure events to confirm agencies have appropriate equipment, policies, and feedback processes in place. ● In addition, the Governor’s EMS Advisory Board has created a workgroup to review EMS regulations. There is concern that current regulations in Chapter 31 and proposed revisions in Chapter 32 are overly prescriptive. The concept being explored is to keep core regulatory requirements in regulation while placing operational details in a document incorporated by reference (DIBR), which could be updated more frequently without a lengthy regulatory revision process. 	
Adjourn		
	<ul style="list-style-type: none"> ● Next Meeting May 14, 2026, at 8:00 AM ● The meeting adjourned at 8:59 AM. 	With no additional business from the floor,

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
		the meeting was adjourned.

Quarterly Performance Improvement Report



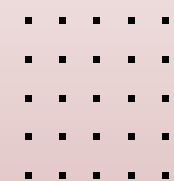
Reporting Period

Q4 2025

October -December

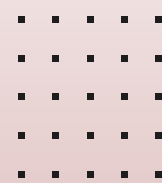
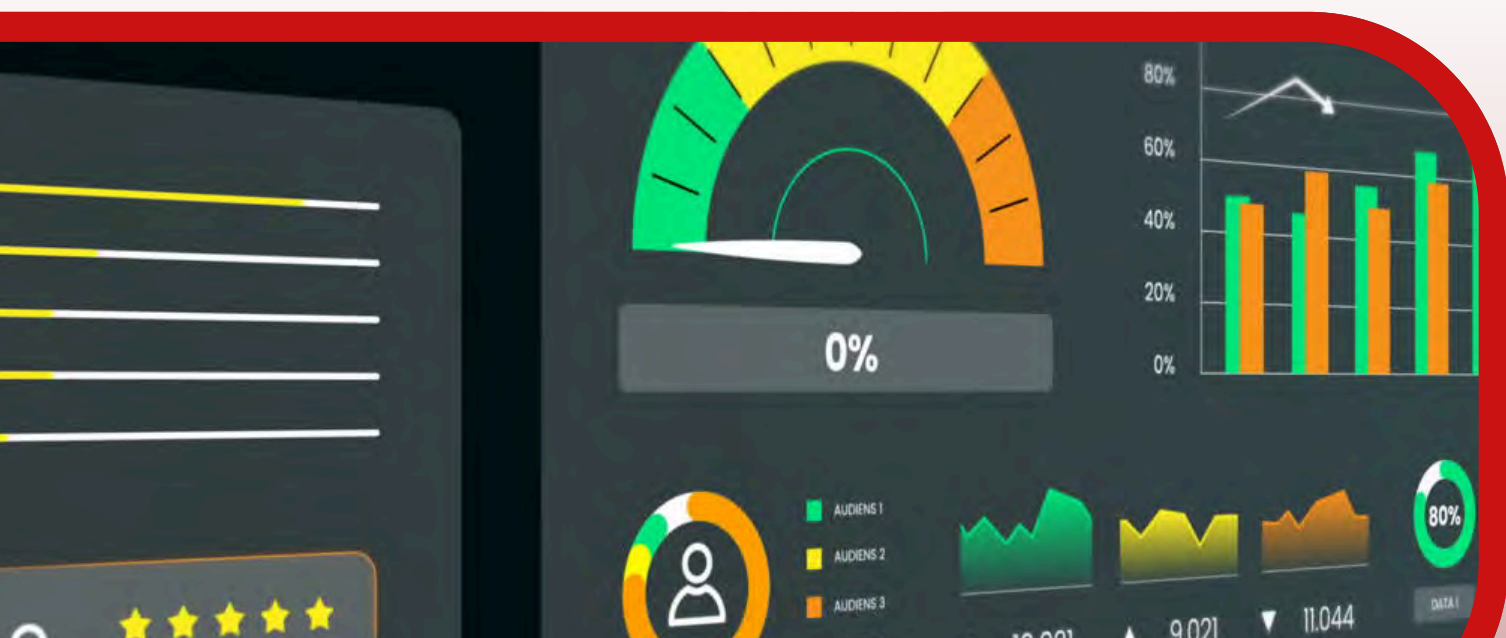
2025

The accuracy of the data within this report is limited by system performance and the accuracy of data submissions from EMS agencies. Data summarized in this report represent EMS responses that occurred during the specified quarter and were entered into the ESO State Repository as of the date of this report.



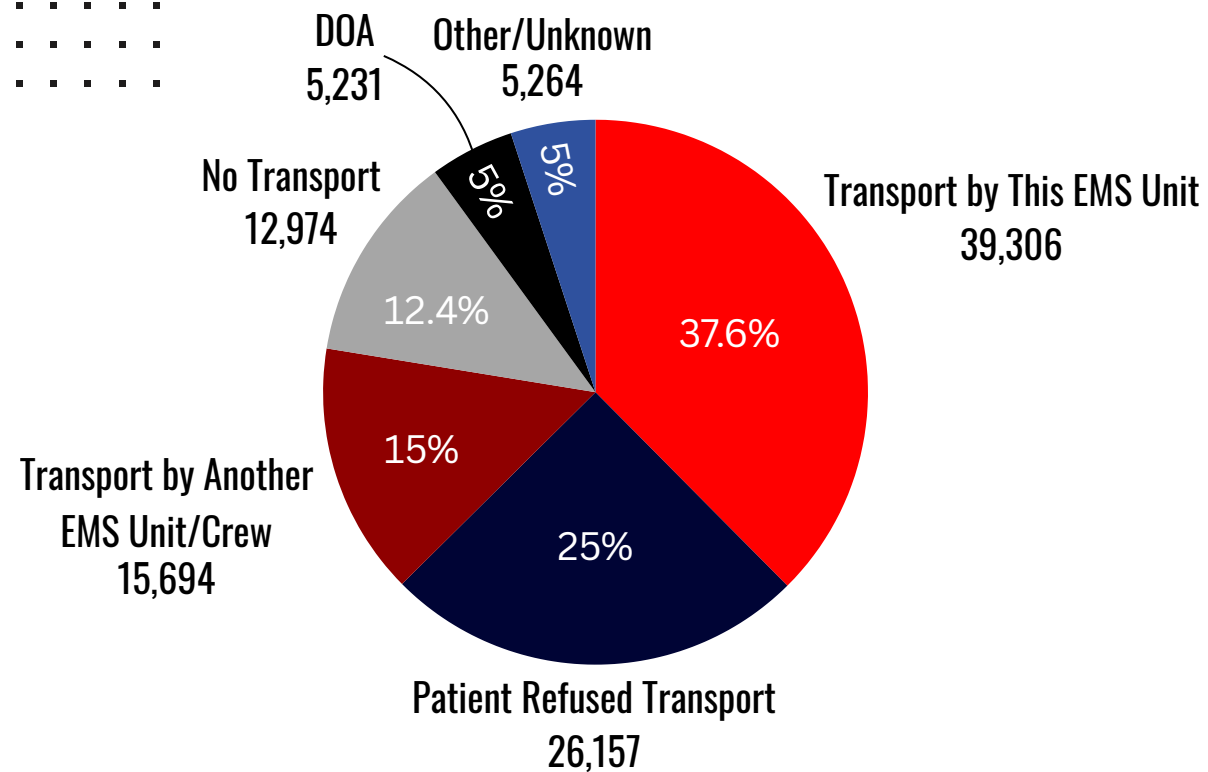
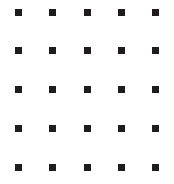
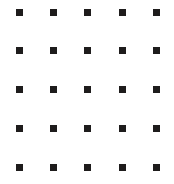
Scope of this Report

This report examines key NEMSQA-aligned performance metrics from Q4 2025 (October-December), supporting the committee's review of PI project data, EMS System, Trauma System, and General EMS. It covers aggregated data from 75 agencies across Planning Districts 13, 14, 15, and 19, focusing on call volumes, impressions, and outcomes to identify strengths and opportunities for standardization and quality enhancement. Data sourced from ESO/State Repository; limitations include submission accuracy and system performance.



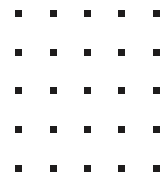
EMS Call Summary

EMS agencies in the region responded to a total of **104,626** EMS calls for service during the quarter. A total of **75** agencies submitted records to the state repository. Of these records, **73,258** had a Type of Service Requested (eResponse.05) documented as Emergency Response (Primary Response Area), Emergency Response (Intercept), Emergency Response (Mutual Aid), Public Assistance, Standby, or Support Services.



This pie chart breaks down transport dispositions for 104,626 total EMS calls in Q4 2025 across Region 6. 'Transport by This EMS Unit (This Crew Only)' was the most common at 37.6% (39,306 cases), highlighting efficient primary response. Data from ESO reports; based on eDisposition.01 (Destination Type). Opportunities: Review high refusal rates (25.0%) for patient education or follow-up protocols.

	Emergency Response						Total
	Intercept	Mutual Aid	Prim Resp Area	Public Assist	Standby	Support Srvs	
No Transport	4	16	7,470	185	182	43	7,900
Non-Patient Transport (Not Otherwise Listed)	0	0	11	0	0	0	11
Patient Refused Transport	17	12	7,247	25	10	0	7,311
Transport by Another EMS Unit	0	7	4,503	14	12	8	4,544
Transport by Another EMS Unit, with a Member of This Crew	0	2	389	0	0	0	391
Transport by This EMS Unit (This Crew Only)	21	87	39,169	14	12	3	39,306
Transport by This EMS Unit, with a Member of Another Crew	0	0	1,098	0	0	3	1,101
N/A	4	70	12,048	271	229	72	12,694
Total	46	194	71,935	509	445	129	73,258

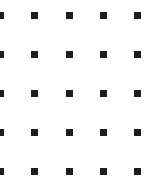
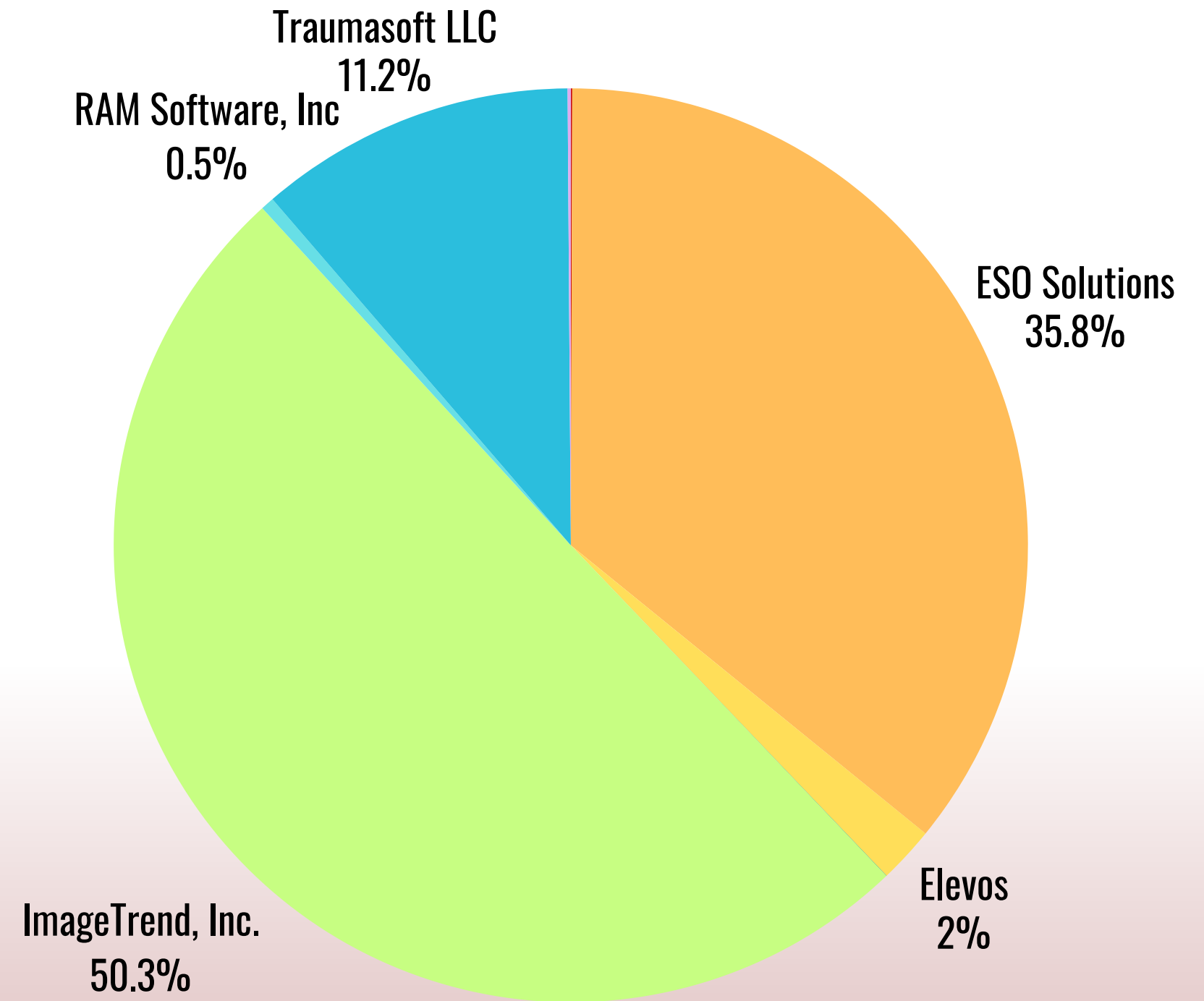


Submissions by Vendor

Record Submissions by Vendor

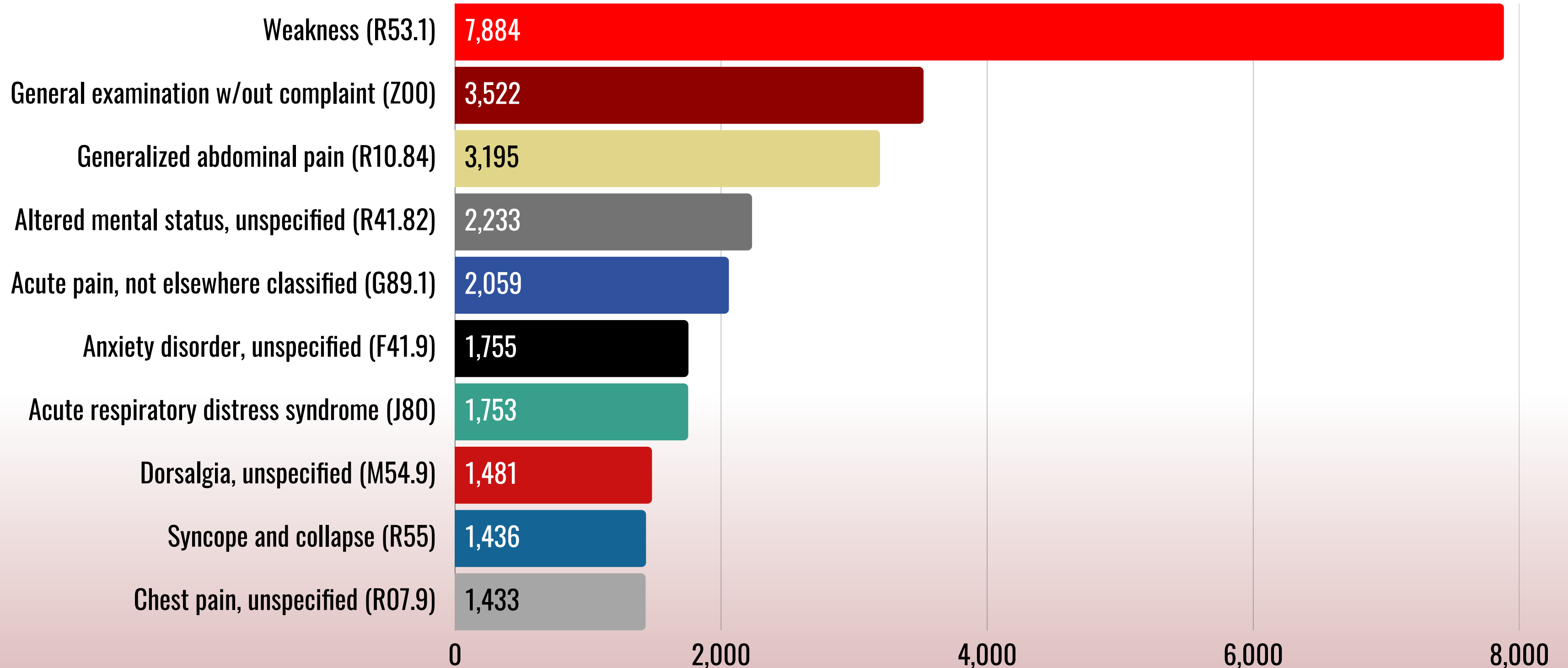
Software Vendor	# of Records			
	Fail	Pass	Pending	Total
AngelTrack LLC	0	53	0	53
ESO Solutions	486	36,980	0	37,466
Elevos	2,084	6	1	2,091
First Due Size Up	0	13	0	13
ImageTrend, Inc.	20	52,633	3	52,656
RAM Software, Inc	4	488	1	493
Traumasoft LLC	0	11,723	2	11,725
ZOLL	0	118	0	118
Total	2,594	102,014	7	104,615

Total Submissions by Vendor



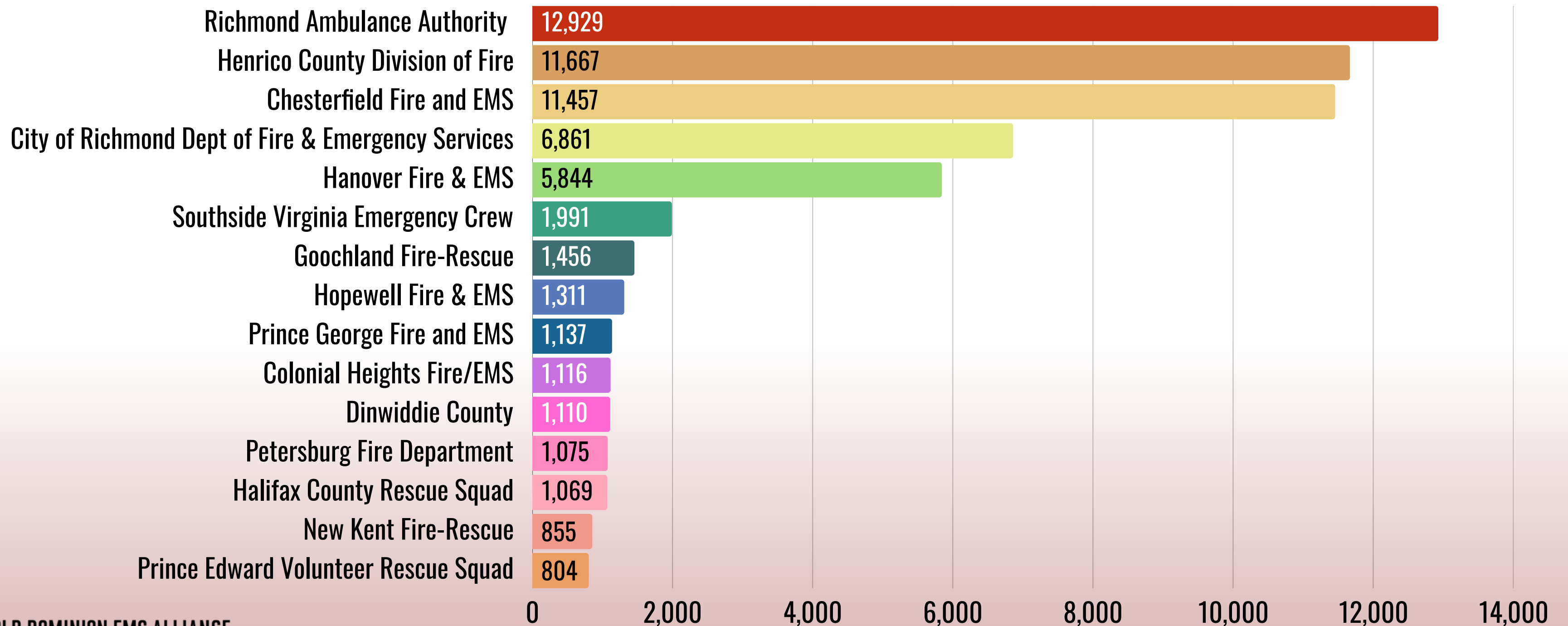
Top 10 Primary Impressions

This slide shows the Top 10 Primary Impressions across our region based on aggregated patient care data pulled by the Provider Primary Impression (eSituation.11). These represent the most common conditions encountered by EMS providers.



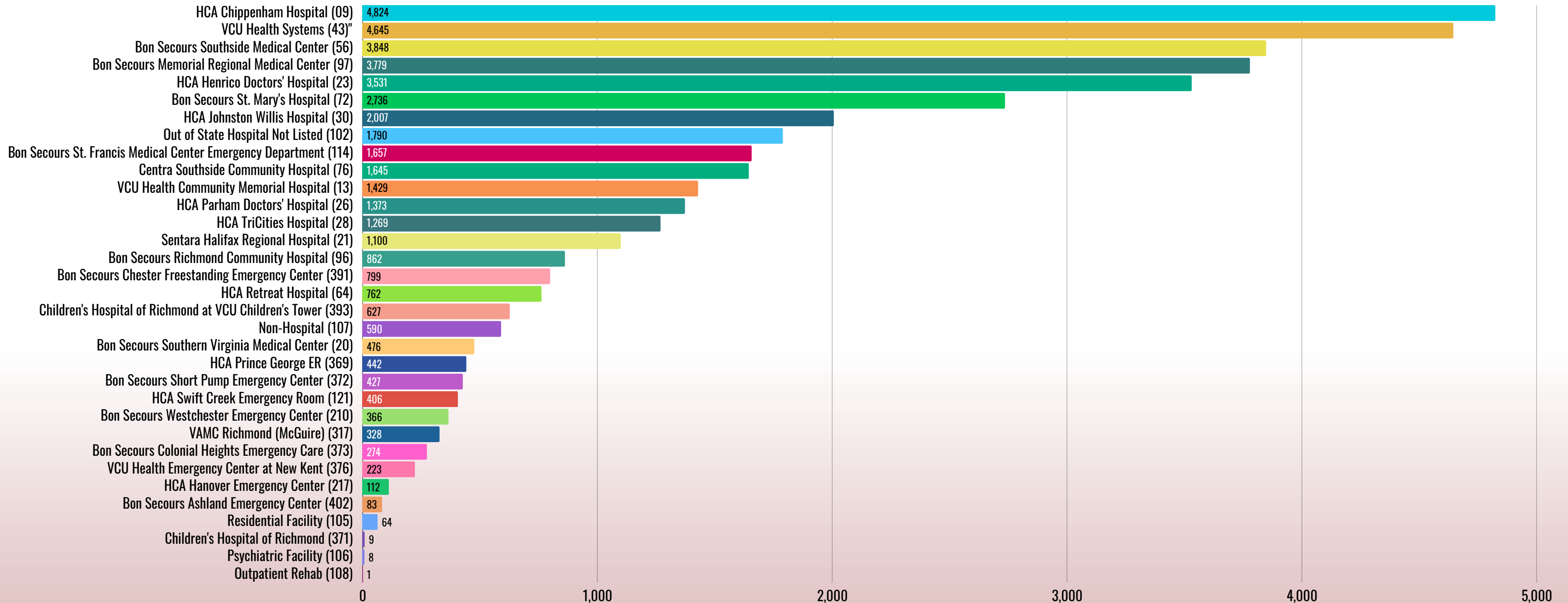
Call Volume by Agency (Top 15)

This chart displays the Top 15 agencies in the region by call volume. It provides an overview of the total number of calls run by agencies over the past quarter.



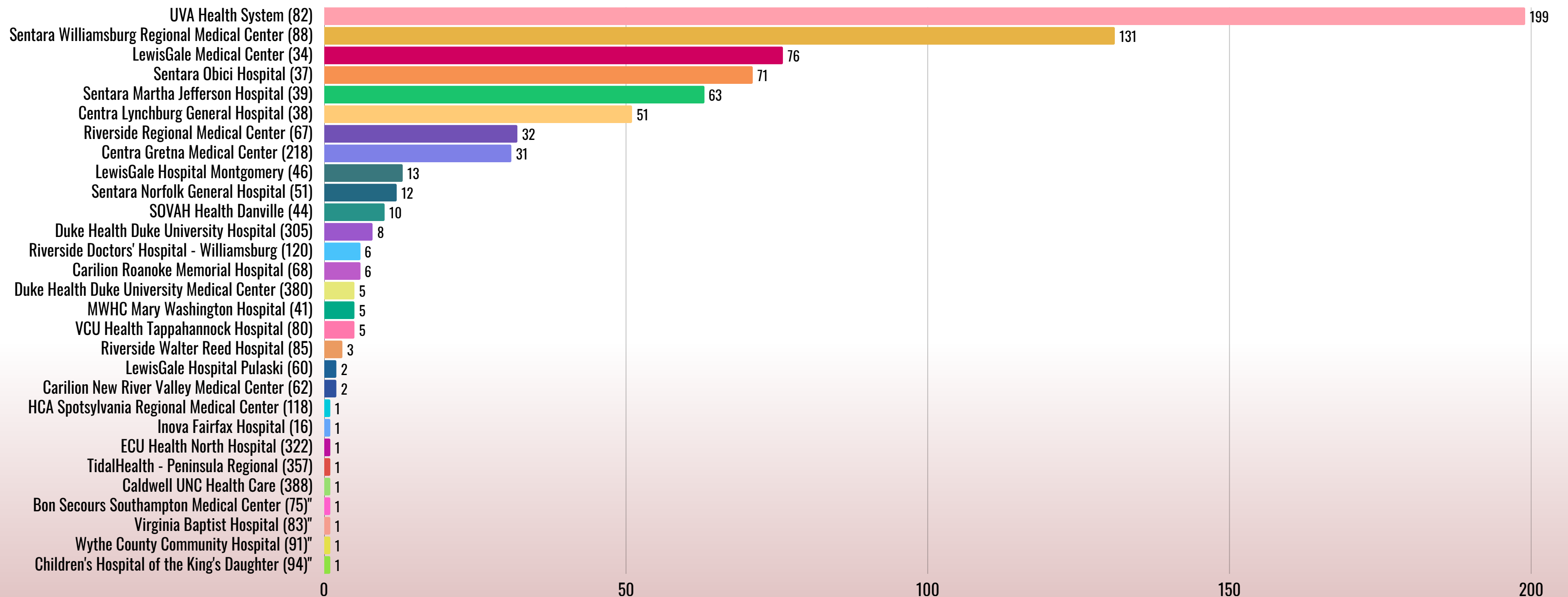
Patients Transported to Destinations Within the Region

Out-of-State Hospital Not Listed (102), Residential Facility (105), Psychiatric Facility (106), Non-Hospital (107), and Outpatient Rehabilitation (108) were selected due to the codes associated with provider entries. In these cases, the receiving facility may have been manually entered. Facilities listed under these categories included hospitals both within and outside of the region. This raises concerns about providers' ability to select these options and manually enter a facility name without an associated state NEMESIS location code. Additionally, some interfacility transport (IFT) or non-emergency agencies may be selecting options that classify these responses as "Response Incidents," potentially skewing the reported data.



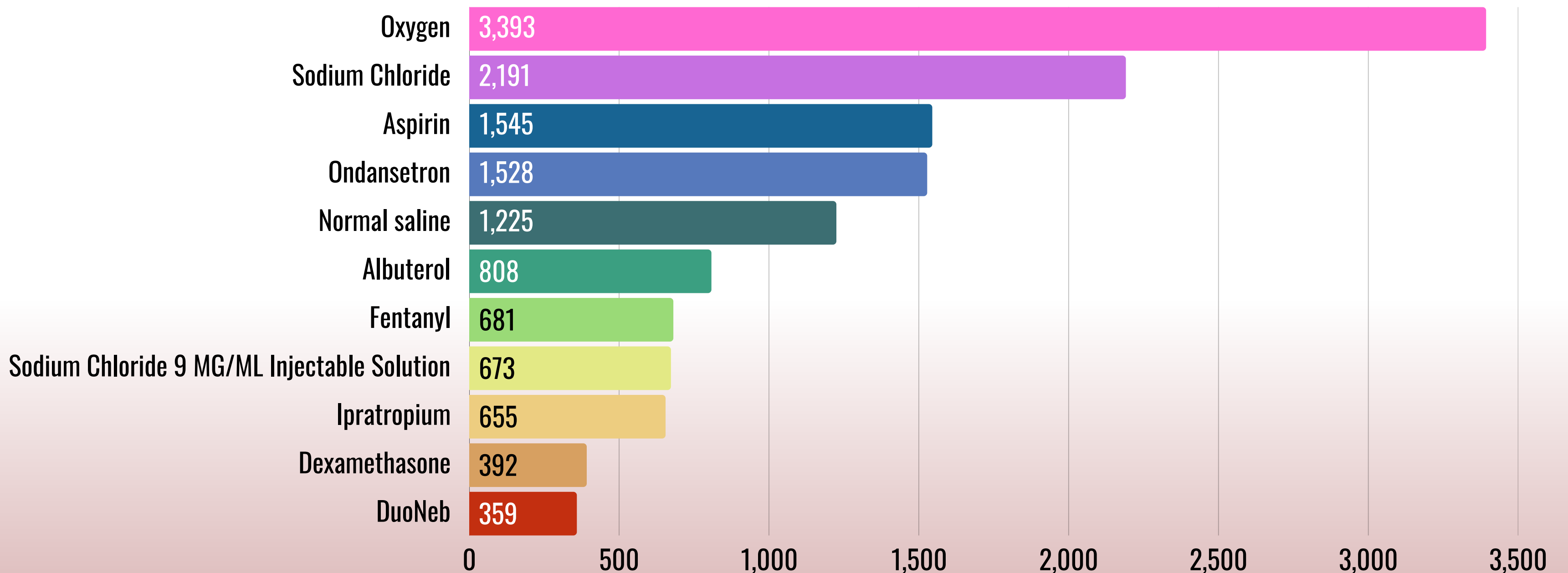
Patients Transported to Destinations Outside the Region

This slide displays all facilities selected that are located outside of the region. This further supports the likelihood that some interfacility transport (IFT) and non-emergency transport agencies may be selecting inclusion criteria that skew regional response data. In addition, some of these facilities may also serve as transport destinations for ground or air medical services. While a portion of these entries may be attributable to helicopter emergency medical services (HEMS) operating within the region, the volume of transported patients suggests that the data more likely reflects activity from non-emergency ground transport agencies rather than HEMS alone.



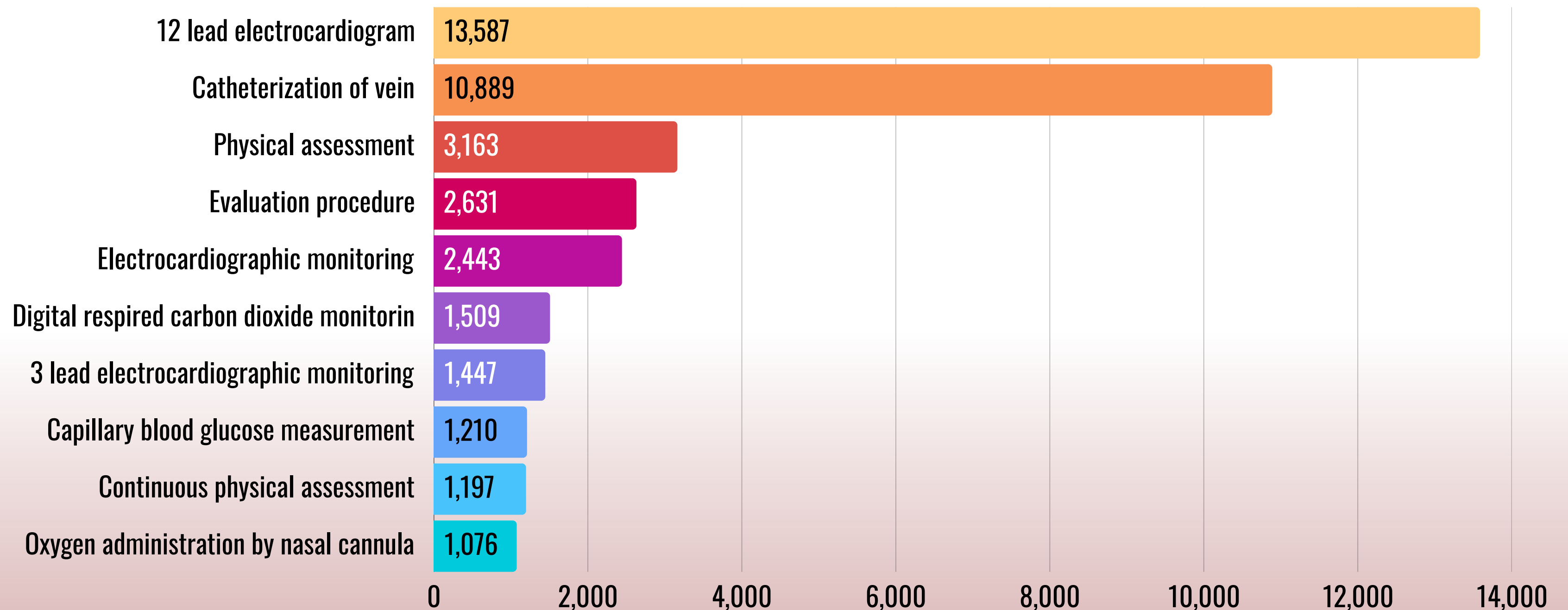
Top 10 Medications Administered

DuoNeb administration counts may be overreported, as some providers may select the trade name rather than documenting the individual components (albuterol and ipratropium) when both medications are administered together. Additionally, it is possible that Sodium Chloride 9 mg/mL Injectable Solution (only in ESO tenants) or Sodium Chloride is being selected when administering IV fluids or flushing IV locks, which may be affecting reported medication top-tier totals.



Top 10 Procedures Performed

This slide presents the 10 most frequently documented procedures. The most frequently documented procedure was "N/A," with a total of 47,988 entries, and was omitted from the chart.





OEMS REGION 6 CARDIAC MEASURES

There were **136** incidents with a “Provider Primary Impression” documented as STEMI or acute myocardial infarction.

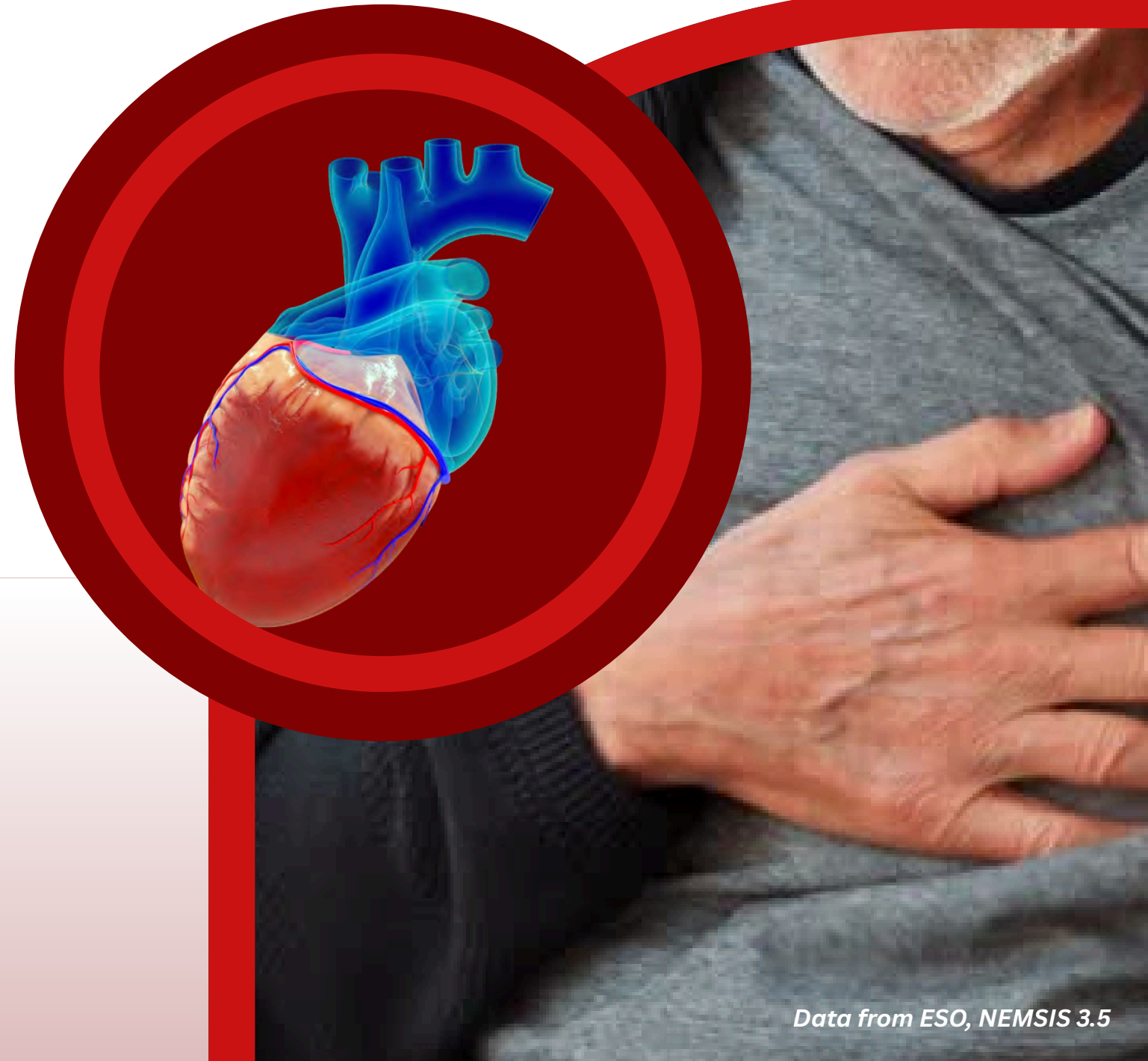
79 Non-ST elevation (NSTEMI) myocardial infarction

91 ST elevation (STEMI) myocardial infarction of **unspecified site**

26 ST elevation (STEMI) myocardial infarction of **anterior wall**

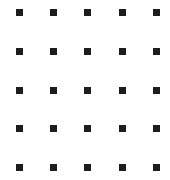
19 ST elevation (STEMI) myocardial infarction of **other sites**

0 ST elevation (STEMI) myocardial infarction of **inferior wall**





OEMS REGION 6 CARDIAC MEASURES



There were 594 incidents with a Provider Primary Impression documented as cardiac arrest and 14 incidents documented as respiratory arrest. There were 75 incidents with a Provider Secondary Impression of cardiac arrest and 44 incidents documented as respiratory arrest. There were 859 records with “Yes” selected for the Cardiac Arrest field (eArrest.01).

“Yes” Cardiac Arrest (eArrest.01)

753 Yes, Prior to Any EMS Arrival

106 Yes, After Any EMS Arrival



PROVIDER PRIMARY IMPRESSION

594 Cardiac Arrest (I46/I46.9)

14 Respiratory Arrest (R09.2)

PROVIDER SECONDARY IMPRESSION

75 Cardiac Arrest (I46/I46.9)

44 Respiratory Arrest (R09.2)

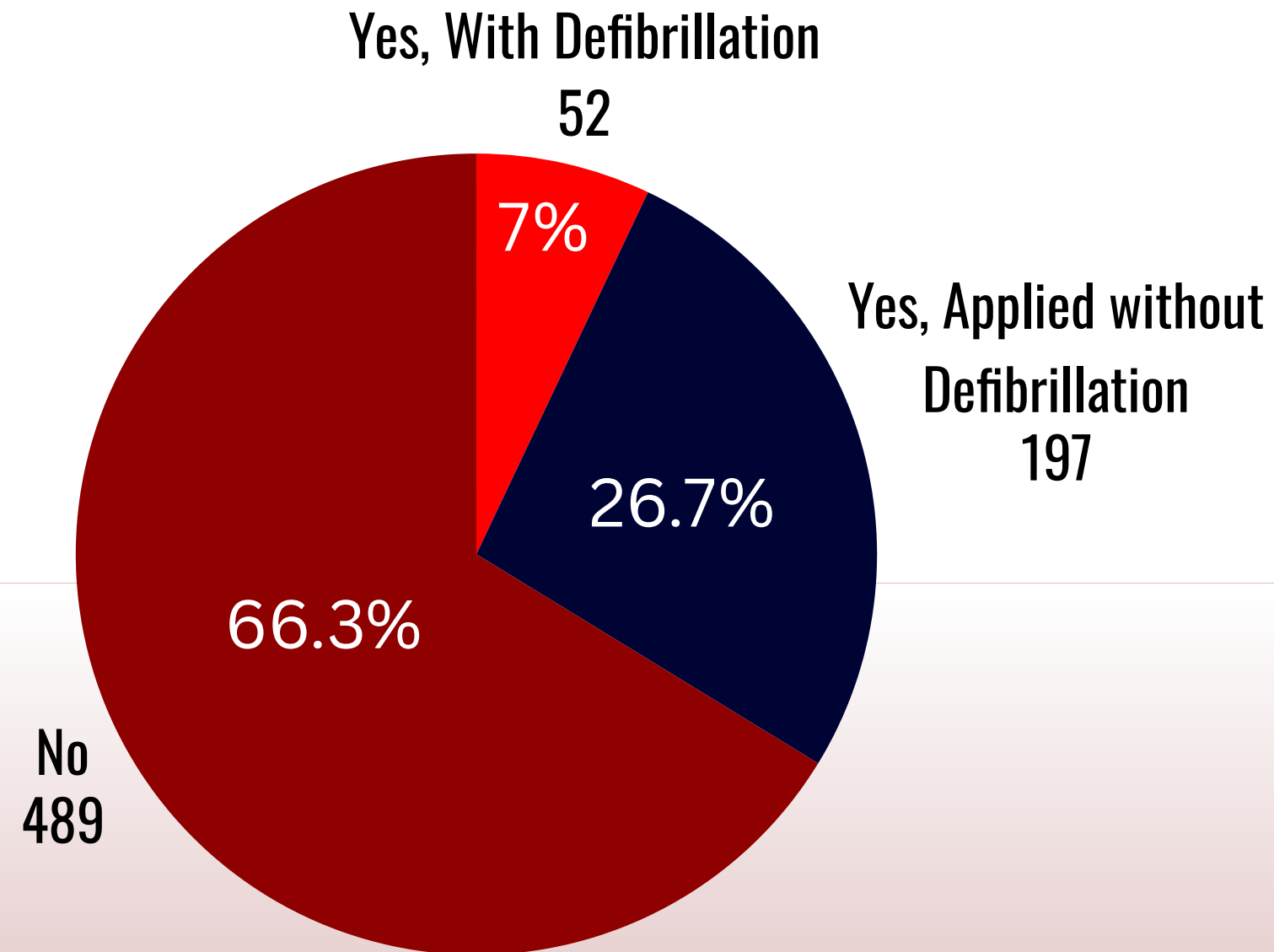


OEMS REGION 6 CARDIAC MEASURES

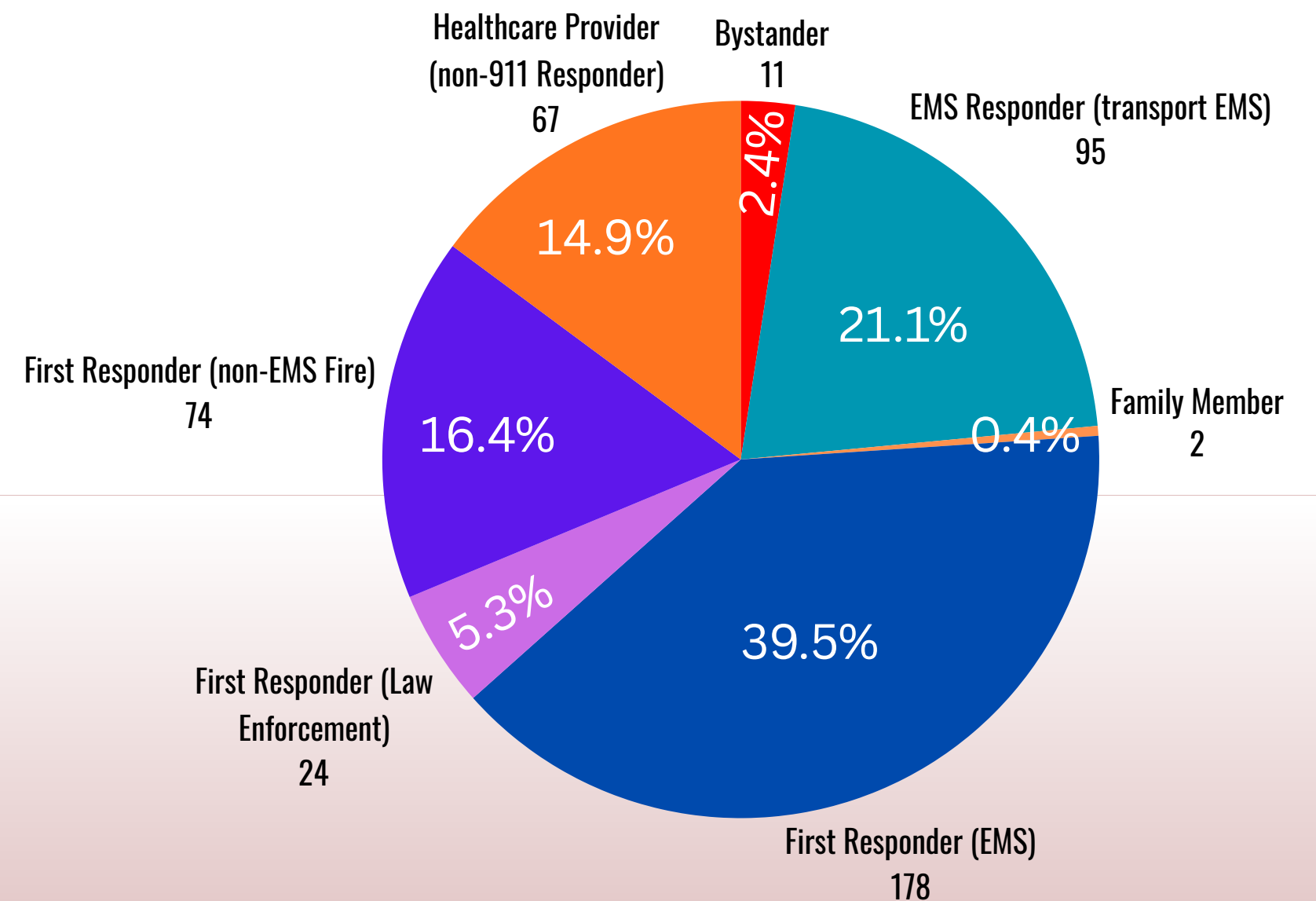
The chart on the left summarizes AED use prior to EMS arrival. In 66.3% of cases, an AED was not applied before EMS arrived. Of the remaining incidents, 7% involved the delivery of a shock, while 26.7% involved AED application without defibrillation.

The adjacent chart identifies the individual or group who first applied the AED. The data suggest a potential need for targeted provider education to ensure accurate reporting, particularly in light of the terminology changes introduced with the NEMSIS 3.5 transition.

AED Use Prior to EMS Arrival



Who First Applied the AED?



405 selected N/A

Data from ESO, NEMSIS 3.5

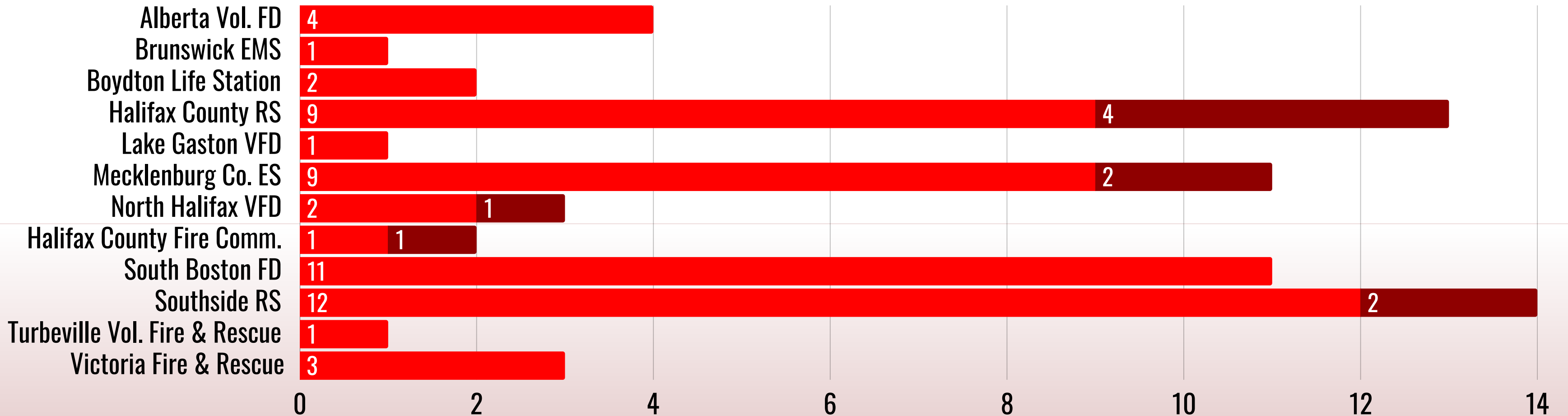


OEMS REGION 6 CARDIAC MEASURES

Planning District 13 Southside

This data reflects incidents within Planning District 13 Southside. During the previous quarter, there were **66 cardiac arrest incidents** in which “Yes” was selected for the Cardiac Arrest field (eArrest.01).

● Prior to Any EMS Arrival ● After Any EMS Arrival



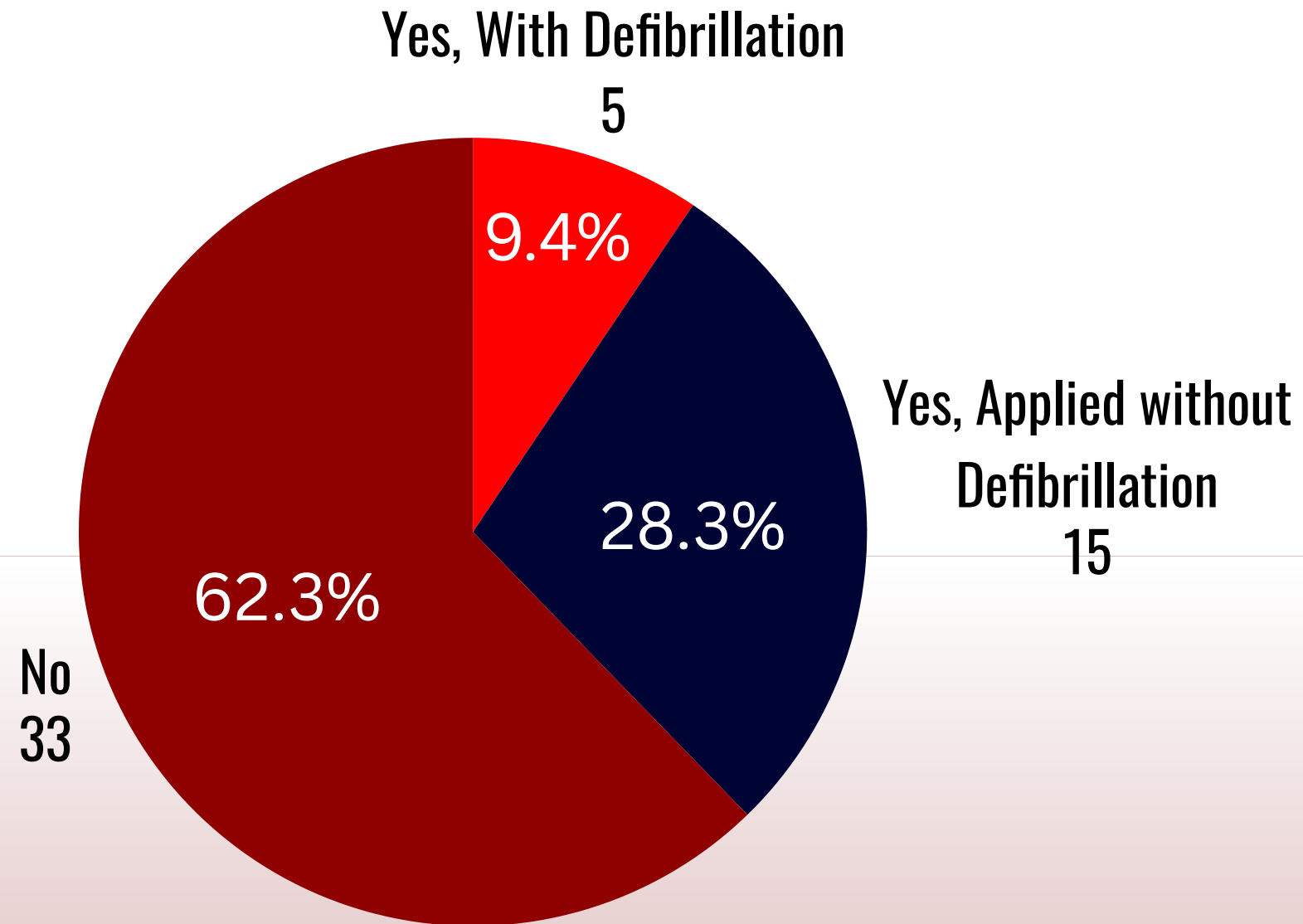


OEMS REGION 6 CARDIAC MEASURES

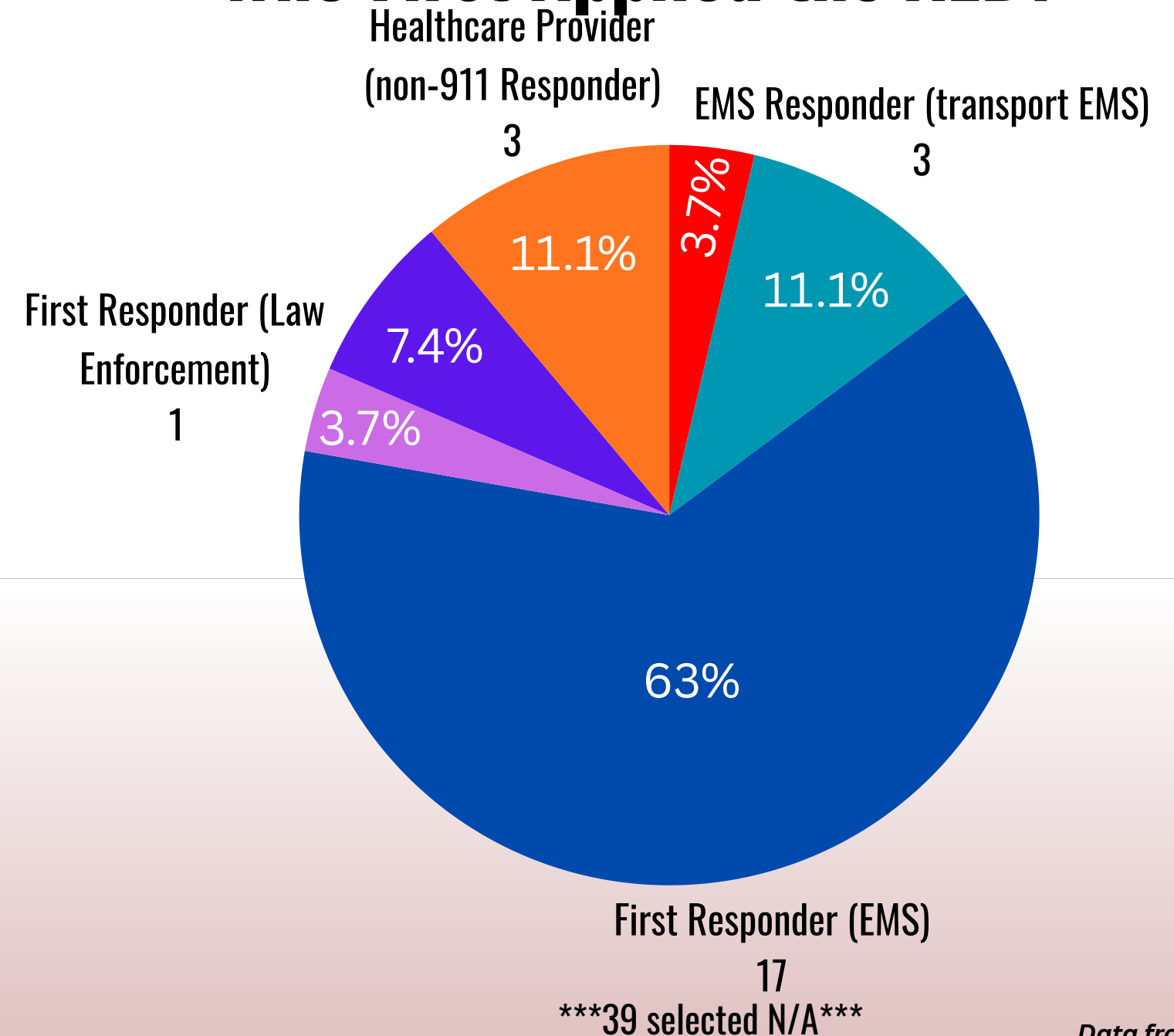
This data reflects incidents within Planning District 13 Southside. The left chart shows that in 62.3% of cases, an AED was not applied prior to EMS arrival. A shock was delivered in 9.4% of cases, and in 28.3% of cases the AED was applied without defibrillation.

The adjacent chart indicates that in 63% of cases (17 patients), the AED was applied by a "First Responder (EMS)." This may reflect some confusion in reporting and suggests a need for continued provider education following the NEMSIS 3.5 terminology changes.

AED Use Prior to EMS Arrival



Who First Applied the AED?



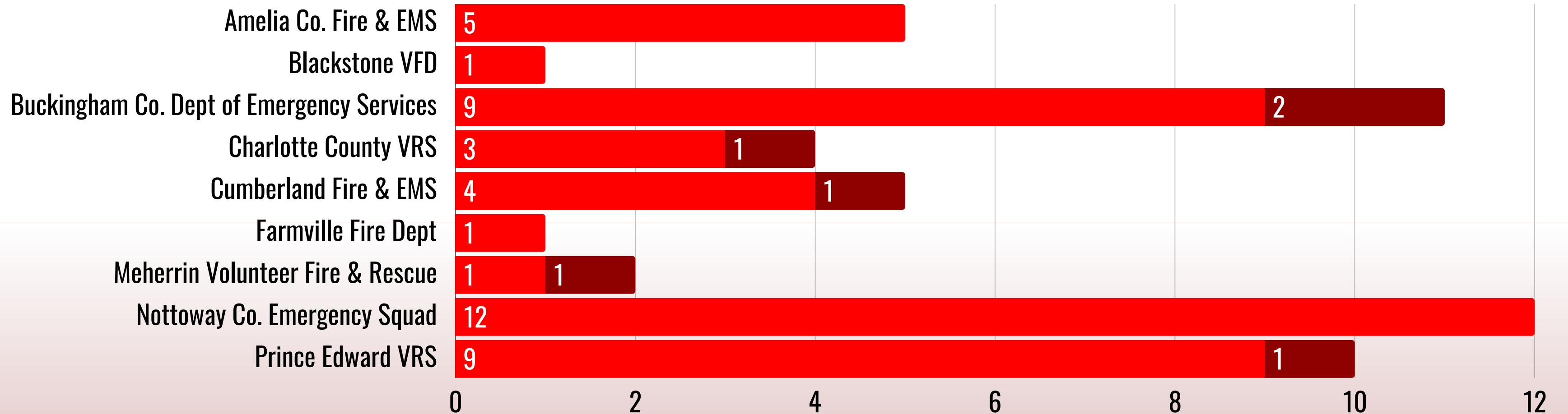


OEMS REGION 6 CARDIAC MEASURES

Planning District 14 South Central

This data reflects incidents within Planning District 14 South Central. During the previous quarter, there were **51 cardiac arrest incidents** in which “Yes” was selected for the Cardiac Arrest field (eArrest.01).

● Prior to Any EMS Arrival ● After Any EMS Arrival



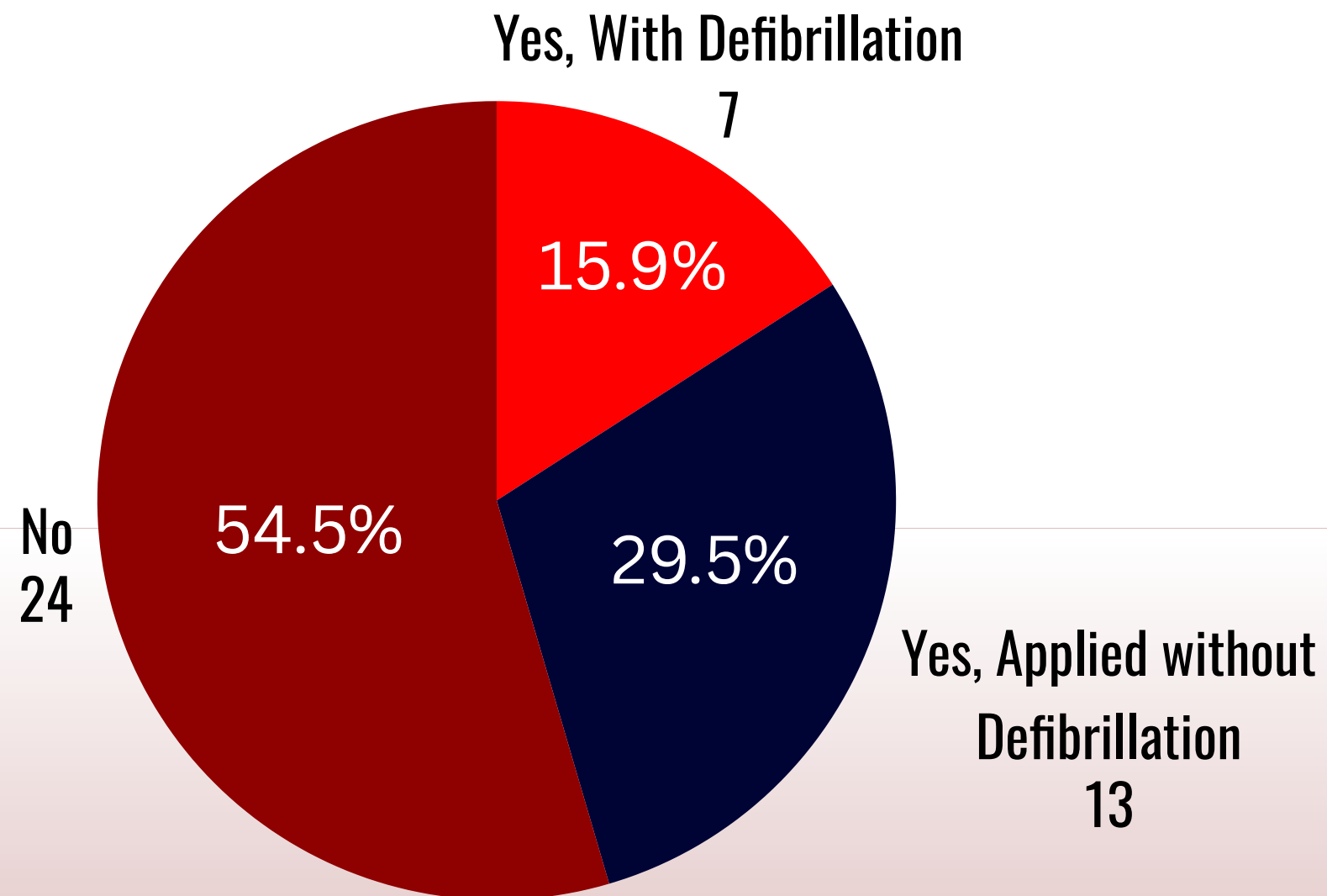


OEMS REGION 6 CARDIAC MEASURES

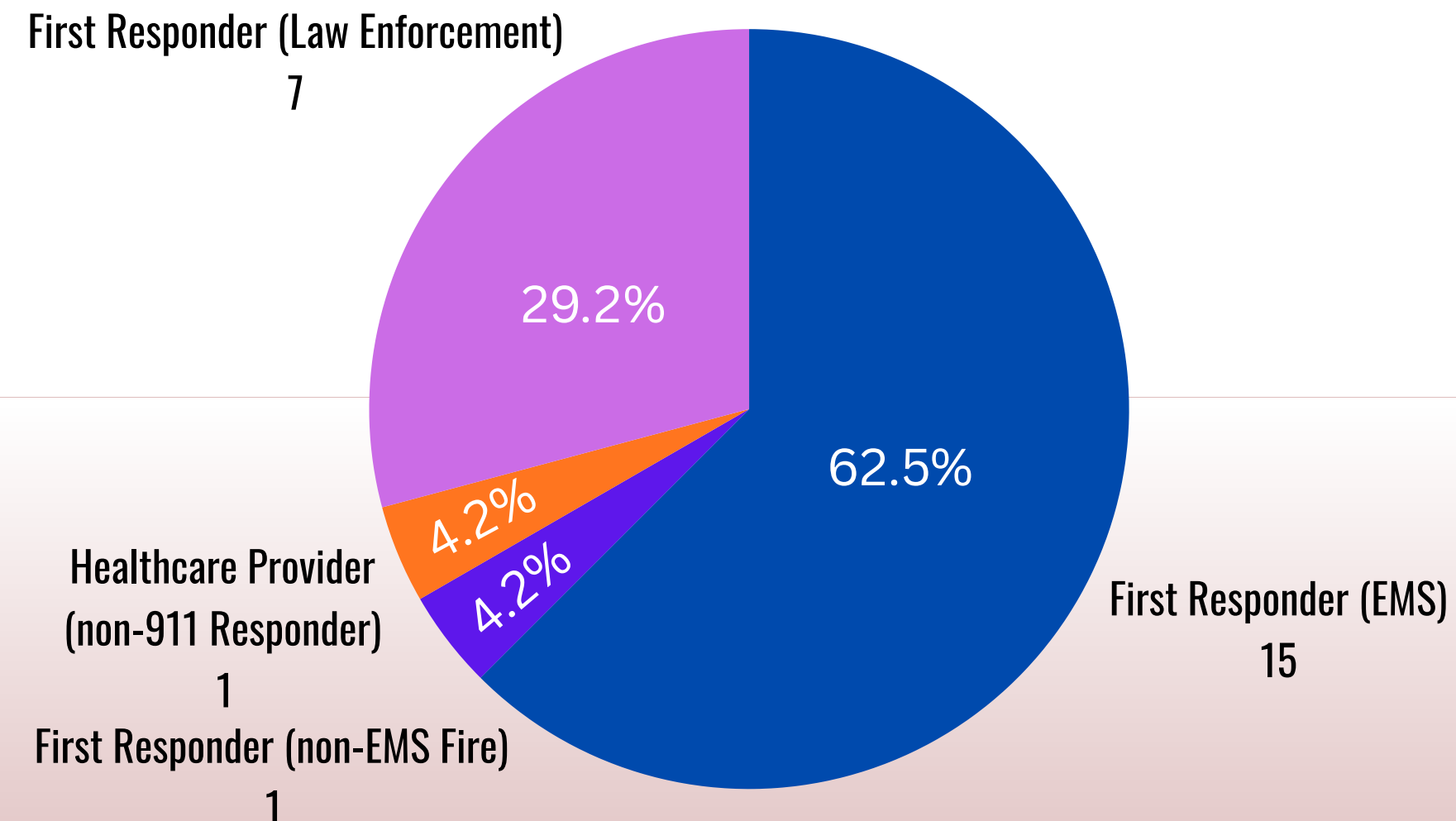
This data reflects incidents within Planning District 14 South Central. The left chart shows that in 54.5% of cases, an AED was not applied prior to EMS arrival. A shock was delivered in 15.9% of cases, and in 29.5% of cases the AED was applied without defibrillation.

The adjacent chart indicates that in 62.5% of cases (15 patients), the AED was applied by a "First Responder (EMS)." This may reflect some confusion in reporting and suggests a need for continued provider education following the NEMSIS 3.5 terminology changes.

AED Use Prior to EMS Arrival



Who First Applied the AED?



27 selected N/A

Data from ESO, NEMSIS 3.5

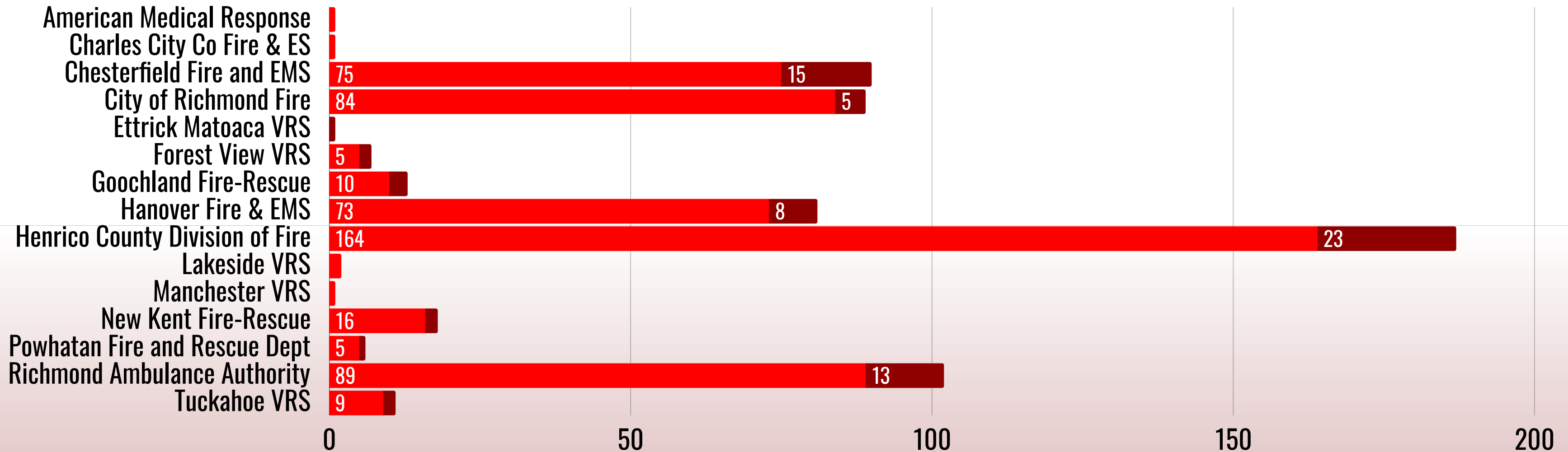


OEMS REGION 6 CARDIAC MEASURES

Planning District 15 Metro Richmond

This data reflects incidents within Planning District 15 Metro Richmond. During the previous quarter, there were **610 cardiac arrest incidents** in which “Yes” was selected for the Cardiac Arrest field (eArrest.01).

● Prior to Any EMS Arrival ● After Any EMS Arrival



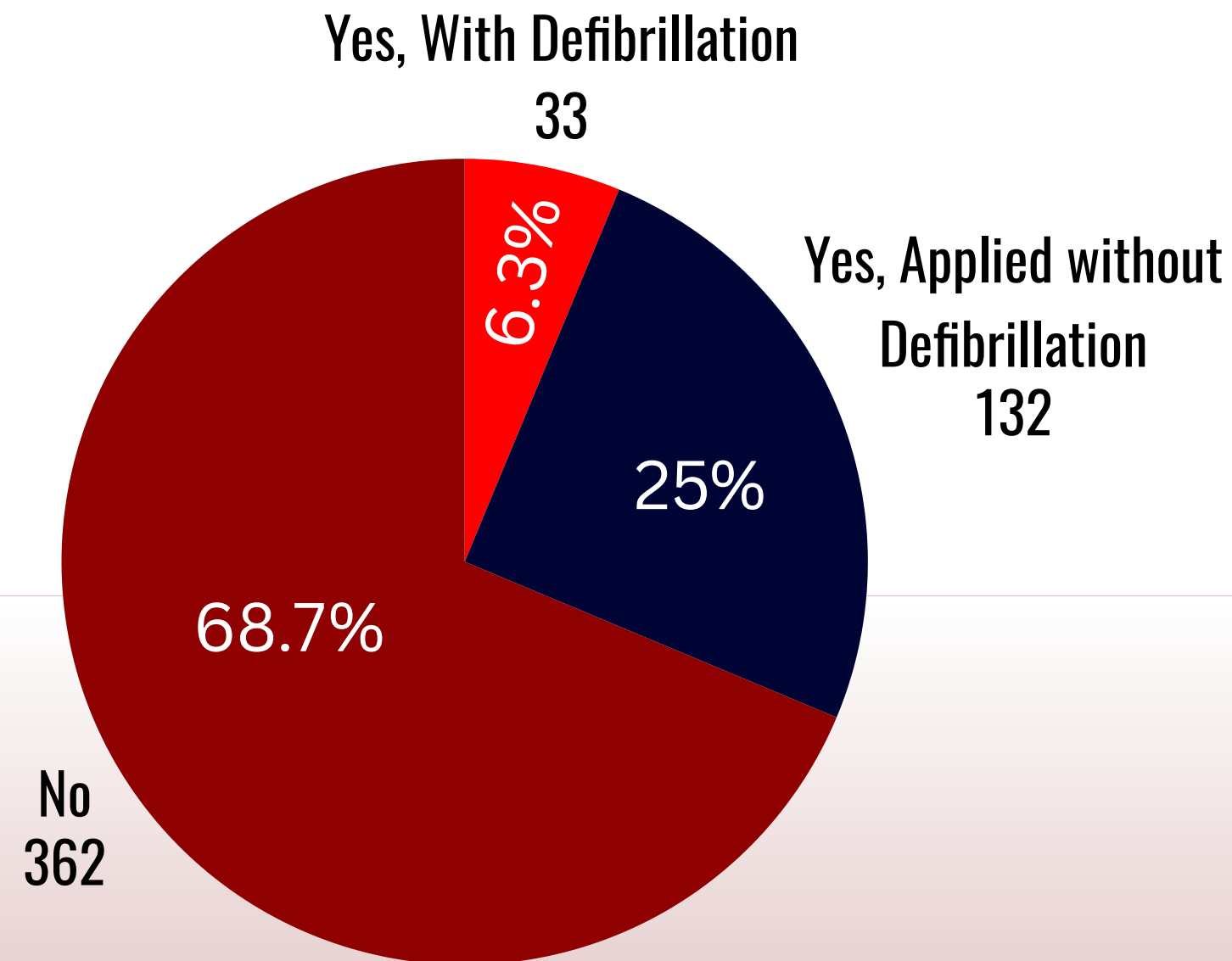


OEMS REGION 6 CARDIAC MEASURES

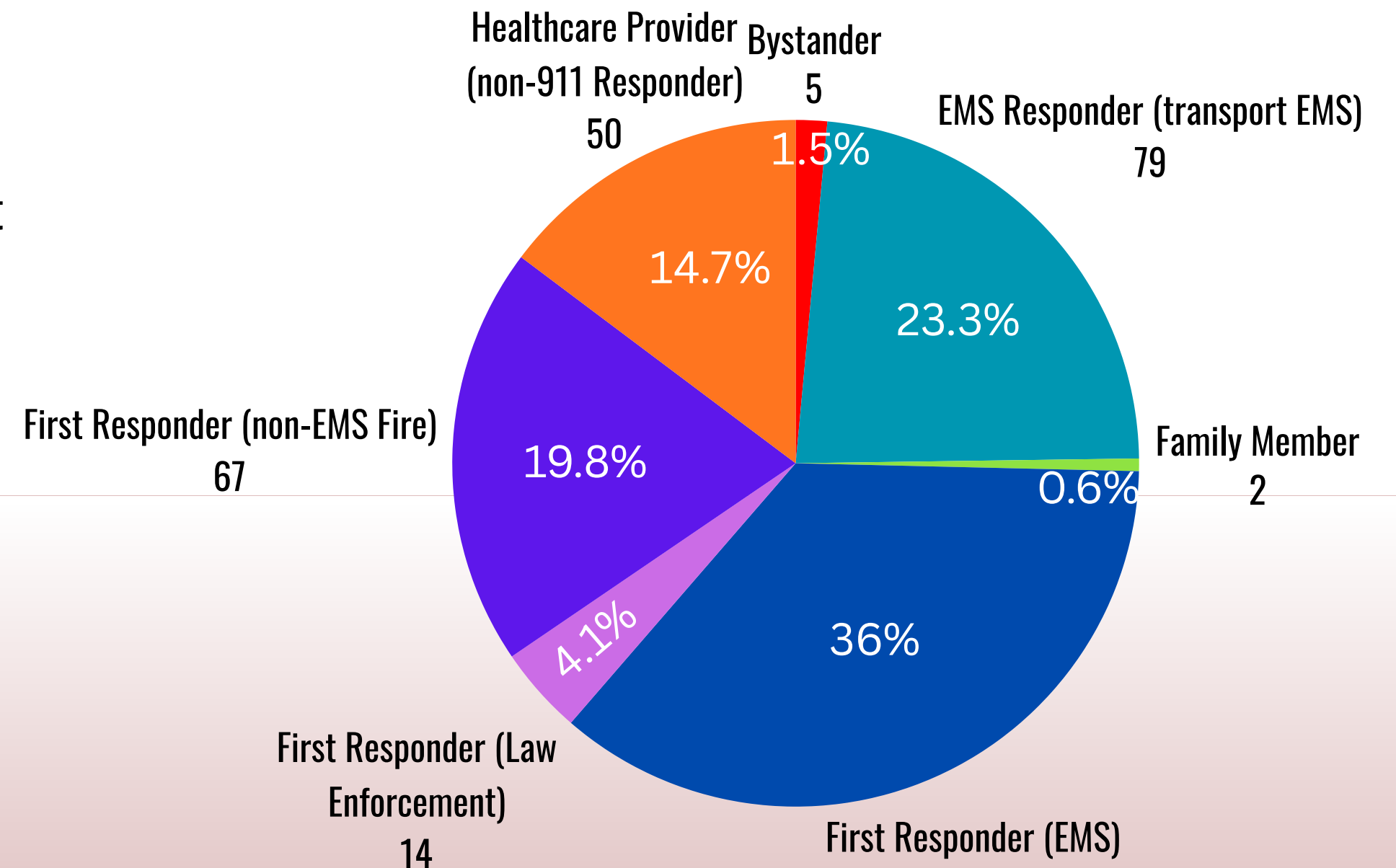
This data reflects incidents within Planning District 15 Metro Richmond. The left chart shows that in 68.7% of cases, an AED was not applied prior to EMS arrival. A shock was delivered in 6.3% of cases, and in 25% of cases the AED was applied without defibrillation.

The adjacent chart indicates that in 36% of cases (122 patients), the AED was applied by a "First Responder (EMS)," followed by 23.3% by transport EMS. This distribution highlights the importance of continued emphasis on accurate reporting and proper role selection under the NEMSIS 3.5 standards.

AED Use Prior to EMS Arrival



Who First Applied the AED?



271 selected N/A

Data from ESO, NEMSIS 3.5

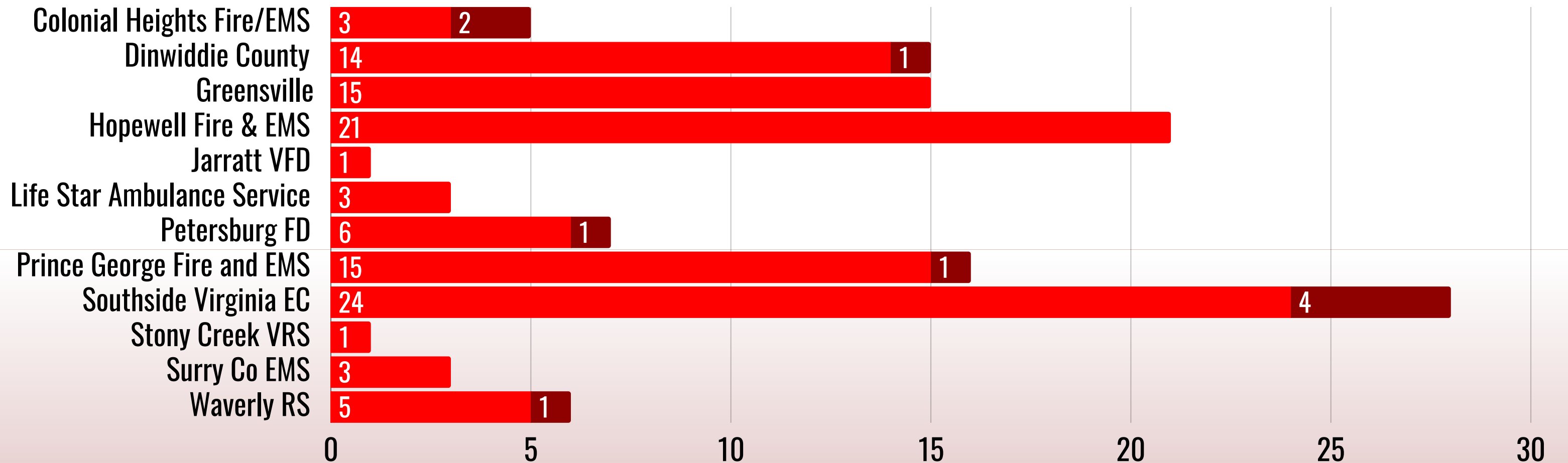


OEMS REGION 6 CARDIAC MEASURES

Planning District 19 Crater

This data reflects incidents within Planning District 19 Crater. During the previous quarter, there were **121 cardiac arrest incidents** in which “Yes” was selected for the Cardiac Arrest field (eArrest.01).

● Prior to Any EMS Arrival ● After Any EMS Arrival





OEMS REGION 6 CARDIAC MEASURES

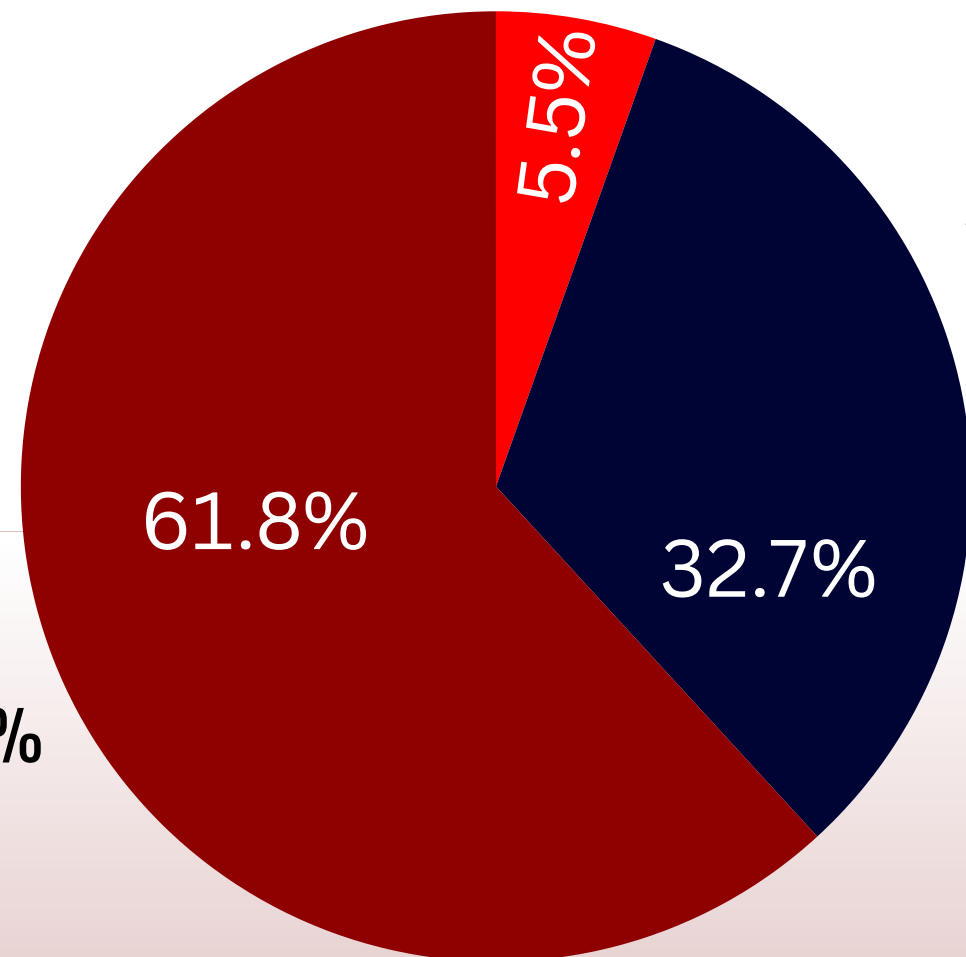
This data reflects incidents within Planning District 19 Crater. The left chart shows that in 61.8% of cases, an AED was not applied prior to EMS arrival. A shock was delivered in 5.5% of cases, and in 32.7% of cases the AED was applied without defibrillation.

The adjacent chart indicates that in 42.1% of cases (24 patients), the AED was applied by a "First Responder (EMS)," followed by 22.8% by healthcare providers. This distribution highlights the importance of continued emphasis on accurate reporting and proper role selection under the NEMSIS 3.5 standards.

AED Use Prior to EMS Arrival

Yes, With Defibrillation

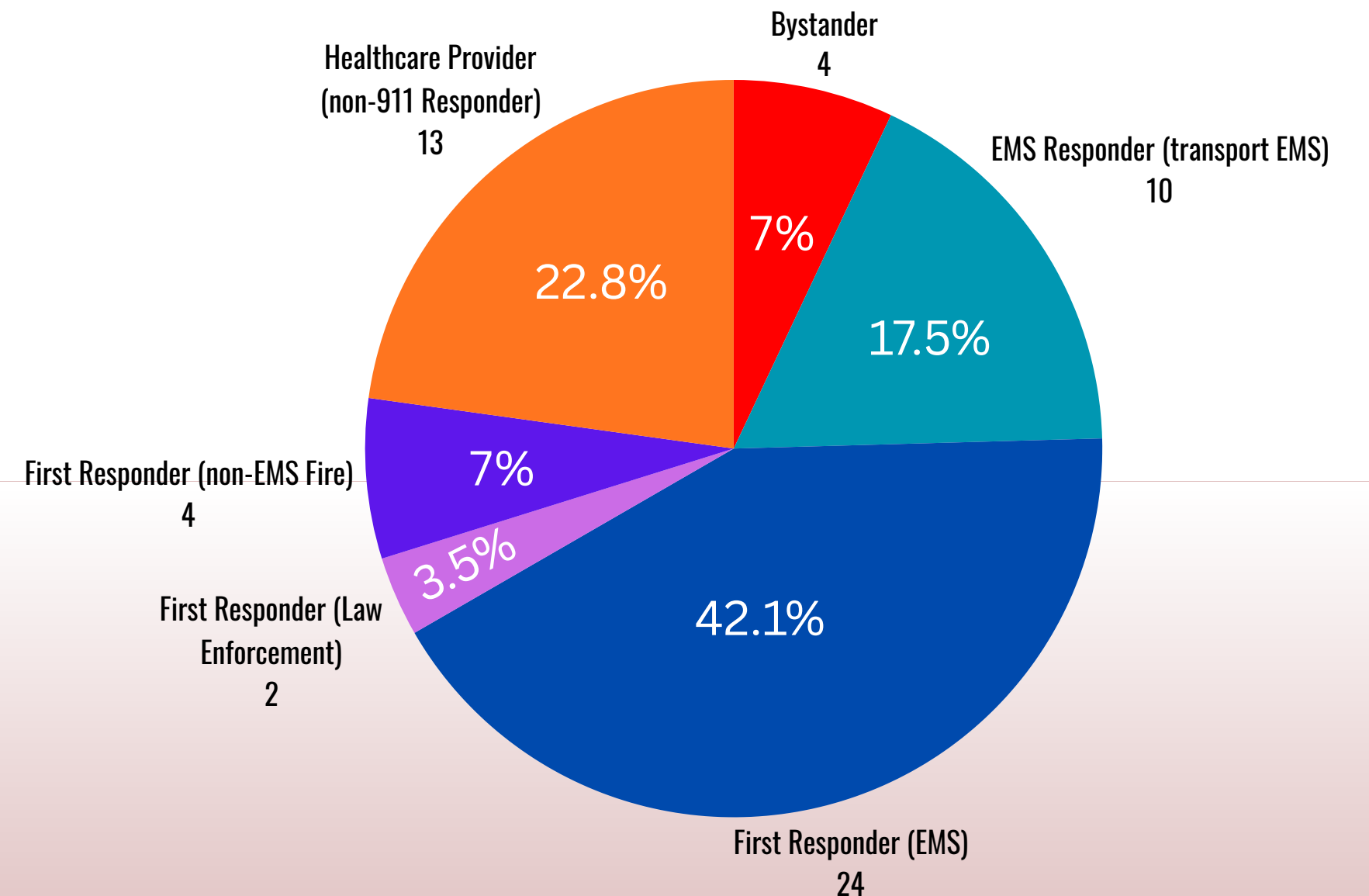
5.5%



Yes, Applied without
Defibrillation
32.7%

No
61.8%

Who First Applied the AED?



64 selected N/A

Data from ESO, NEMSIS 3.5



OEMS REGION 6 CARDIAC MEASURES

This data reflects **8 cardiac arrest incidents** involving Regional Air Medical (HEMS) responses in which “Yes” was selected for the Cardiac Arrest field (eArrest.01). Most HEMS responses occurred after ground EMS arrival, which is consistent with typical air medical activation and response patterns.

Regional Air Medical (HEMS)

● Prior to Any EMS Arrival ● After Any EMS Arrival

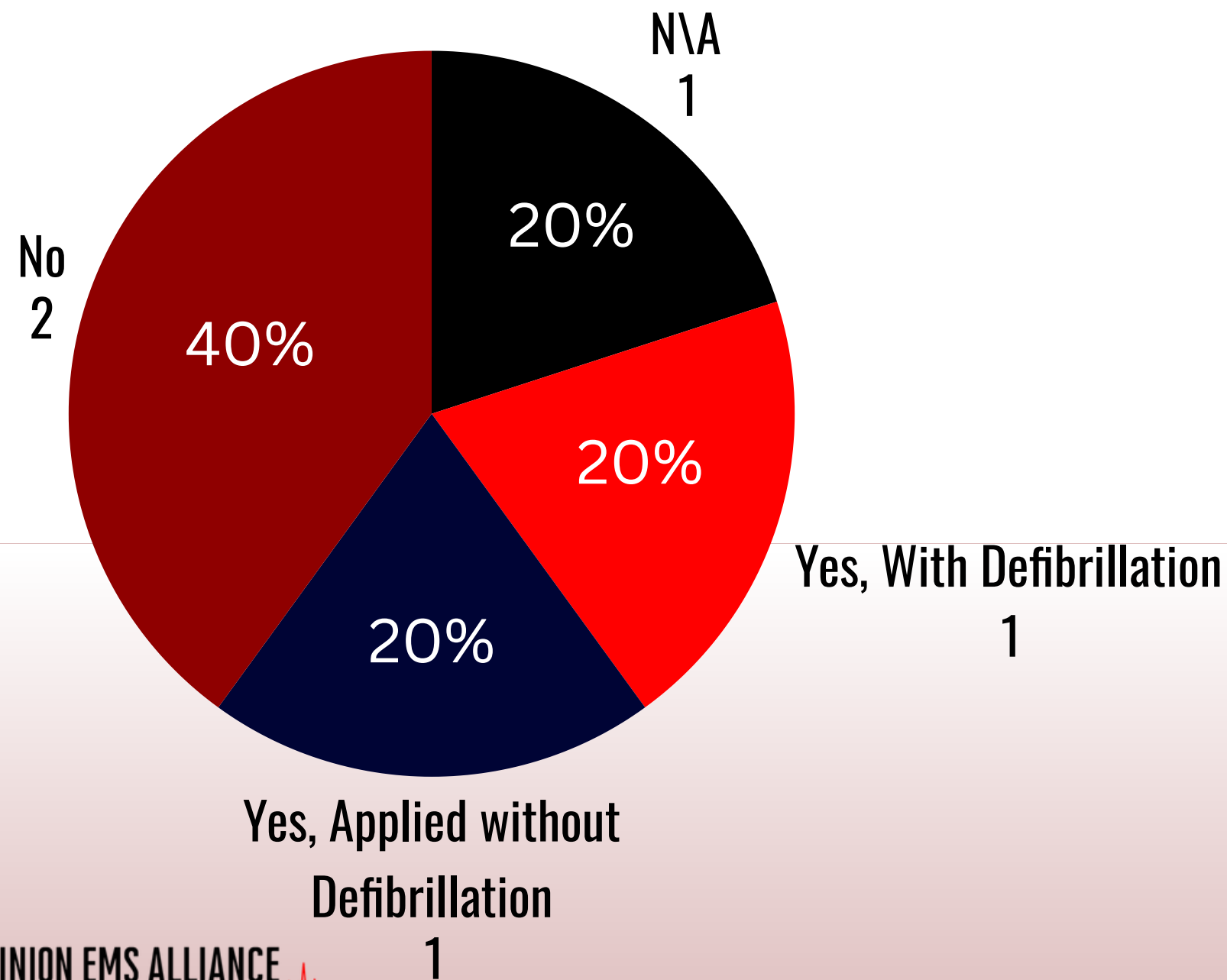




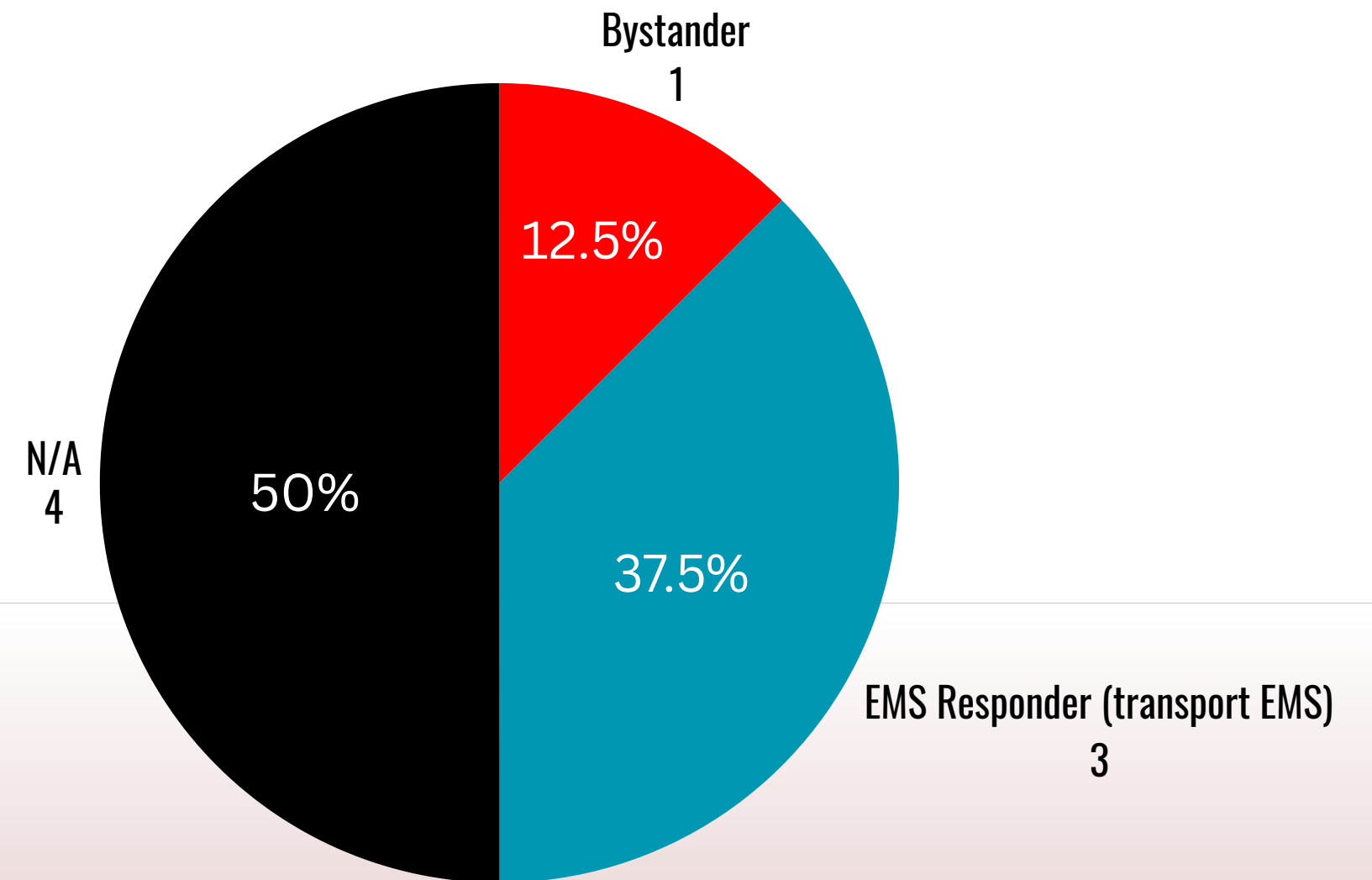
OEMS REGION 6 CARDIAC MEASURES

This data reflects incidents involving HEMS (Air Medical) responses. The left chart shows that in 40% of cases, an AED was not applied prior to EMS arrival. A shock was delivered in 20% of cases, and in 20% of cases the AED was applied without defibrillation. An additional 20% of records were documented as not applicable. The adjacent chart indicates that in most cases, AED application was either performed by transport EMS (37.5%) or appropriately marked as not applicable (50%). This suggests that HEMS providers are generally documenting AED involvement accurately, consistent with their role in later phases of patient care.

AED Use Prior to EMS Arrival



Who First Applied the AED?



271 selected N/A



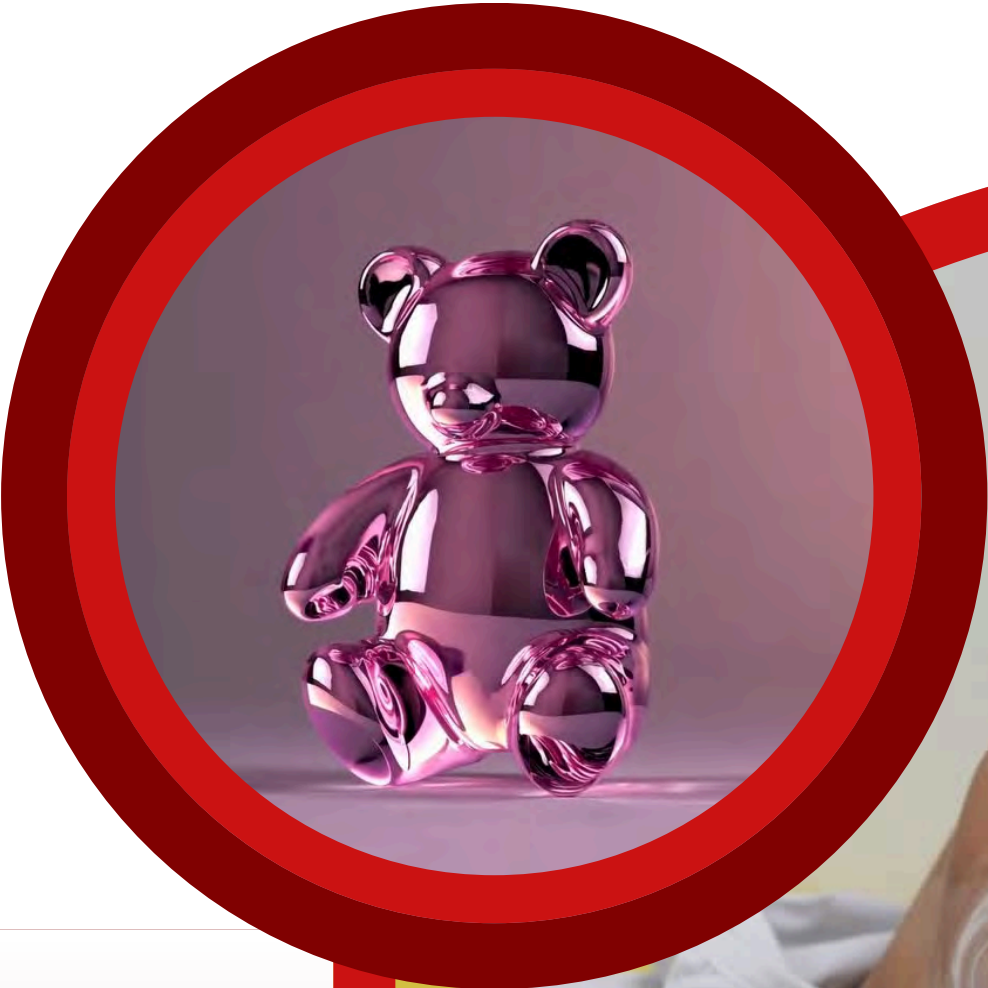
OEMS REGION 6 PEDIATRIC MEASURES

2,425
Total Pediatric Calls for Service

7
There were a total of Pediatric
Cardiac Arrests

17 minutes 11 seconds
Average Pediatric Cardiac Arrest Onscene to
Transport Time

10 minutes
Average Pediatric Cardiac Arrest On Scene to
First Epinephrine Administration





OEMS REGION 6 STROKE MEASURES

This slide highlights the most frequently documented primary and secondary provider impressions for suspected stroke patients in the previous quarter. Cerebral infarction and transient ischemic attack remain the most common impressions, emphasizing the importance of early recognition and rapid transport to appropriate stroke centers. Data from ESO reports; based on eSituation.11/12 (Provider Impressions) across 928 unique incidents. These align with NEMSQA Stroke-01 criteria for identifying suspected strokes, supporting better triage in ODEMSA Region 6 (Planning Districts 13, 14, 15, 19).
Opportunities: Improve secondary impression documentation to reduce blanks and capture comorbidities.



PROVIDER PRIMARY IMPRESSION

685 Cerebral Infarction, unspecified

87 Transient Cerebral Ischemic Attack, Unspecified

21 Nontraumatic Intracranial Hemorrhage, Unspecified

PROVIDER SECONDARY IMPRESSION

122 Cerebral Infarction, Unspecified

31 Transient Cerebral Ischemic Attack, Unspecified

2 Nontraumatic Intracranial Hemorrhage, Unspecified

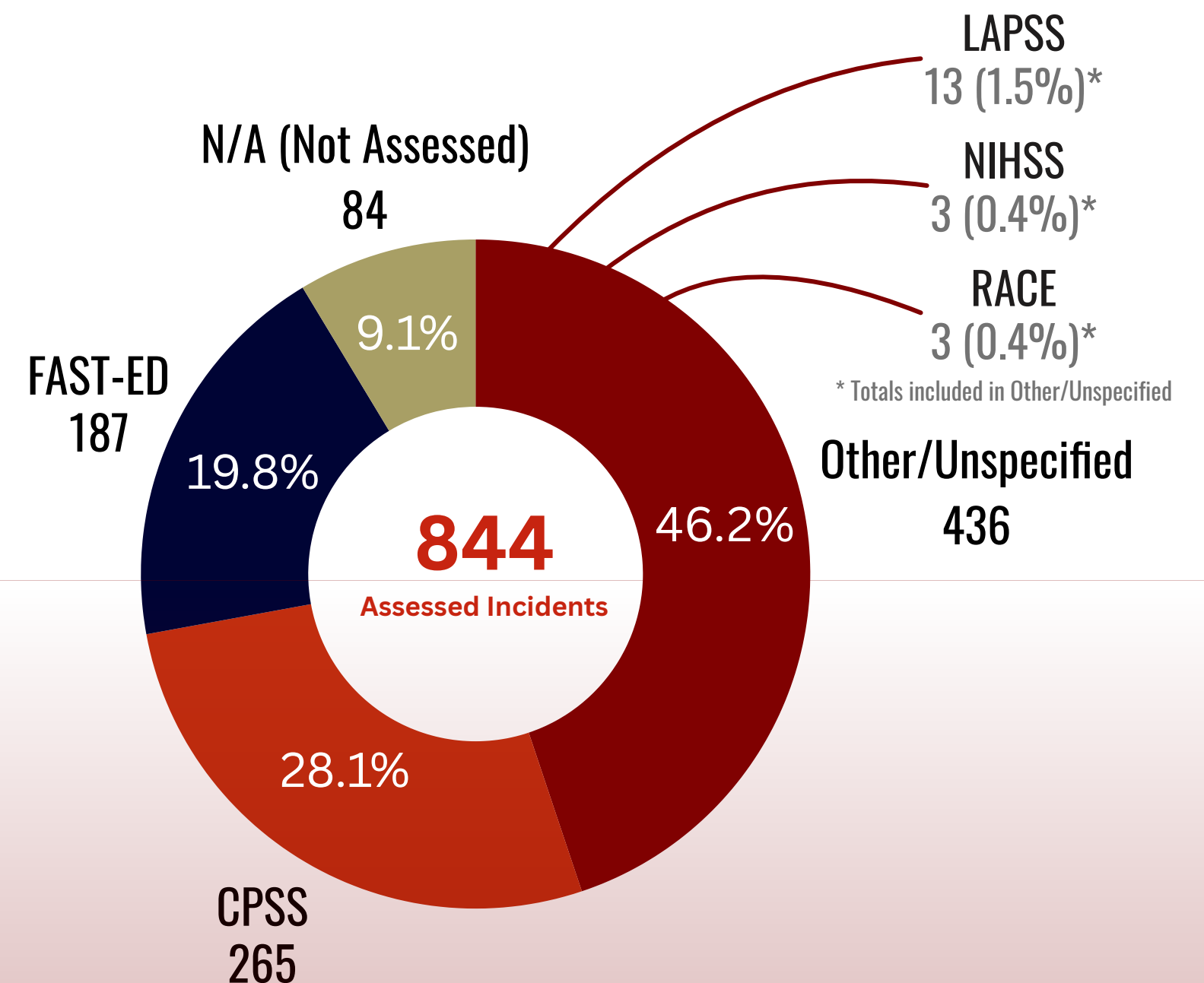


OEMS REGION 6 STROKE MEASURES

Overview of Stroke Scale Performance (Stroke-01)

This chart summarizes the types of stroke scales used by EMS agencies in Planning Districts 13, 14, 15, and 19 for suspected stroke patients in Q4 2025 (928 total incidents). Other/Unspecified scales dominate at 46.2% (436 cases, including sub-types like LAPSS 13/1.5%, NIHSS 3/0.4%, RACE 3/0.4%), followed by CPSS at 28.1% (265 cases). Only 9.1% (84 cases) were not assessed (N/A), indicating strong compliance (90.9%) with NEMSQA Stroke-01 (Suspected Stroke Receiving Prehospital Stroke Assessment). Data sourced from ESO analytics, aligned with NEMSIS 3.5 elements like eVitals.29 (Stroke Scale Score) and eVitals.30 (Stroke Scale Type). Higher 'Other' usage may reflect agency preferences – opportunities for standardization to improve outcomes and reduce non-assessments.

Stroke Scale Performed

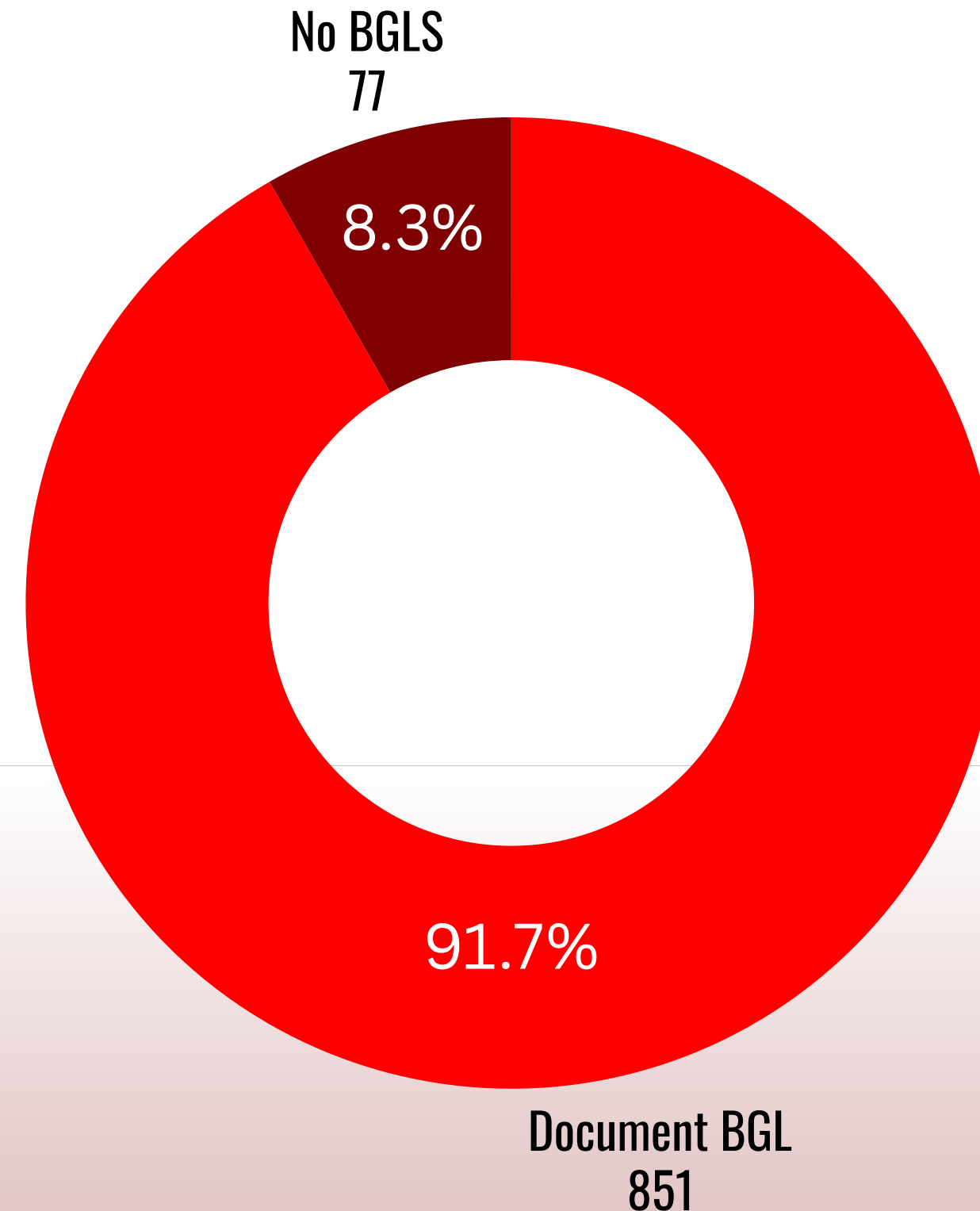




OEMS REGION 6 STROKE MEASURES

This chart shows documented blood glucose levels for suspected stroke patients in the previous quarter. In 91.7% of cases (851 incidents), a blood glucose level was recorded, while 8.3% (77 incidents) had no documented value. Overall, documentation compliance remains high, aligning with NEMSQA Stroke-04 (Suspected Stroke with Blood Glucose Measurement) to rule out low BGL as a cause for altered mental status (AMS). Continued opportunity to reinforce consistent assessment and reporting in all stroke-related encounters. Data from ESO reports; based on eVitals.18 documentation across 928 total incidents.

Documented Blood Glucose Level (Stroke-04)

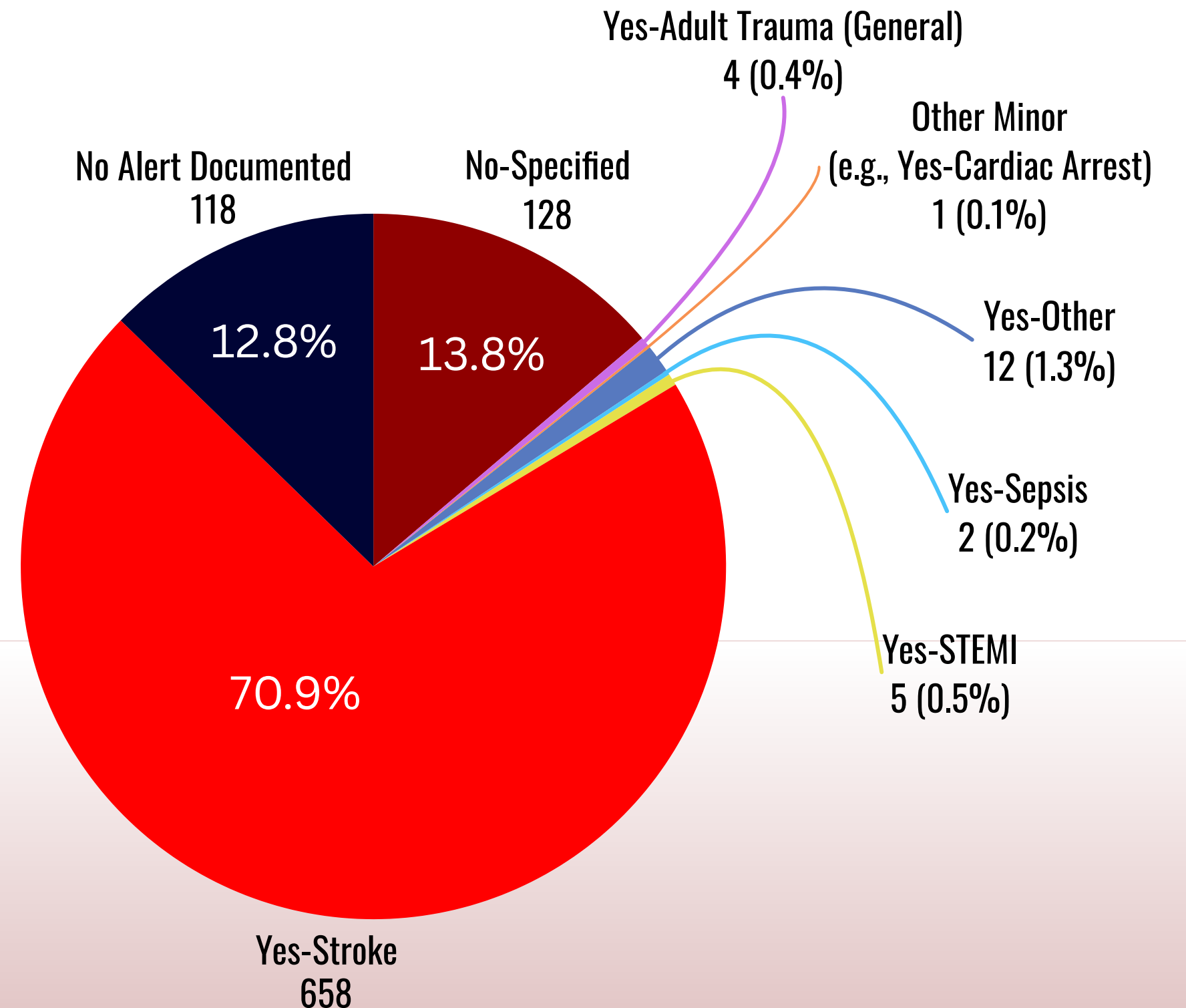




OEMS REGION 6 STROKE MEASURES

Documented Pre-Arrival Alert or Activation (Stroke-06)

This chart reflects pre-arrival alerts for 928 patient care reports related to transient ischemic attack, cerebral infarction, or nontraumatic intracranial hemorrhage in the previous quarter, based on provider primary or secondary impressions. Only incidents in which the patient was transported by the responding EMS unit, or with a member of another crew, are included. "Yes-Stroke" alerts were activated in 70.9% (658 cases), supporting NEMSQA Stroke-06 (Suspected Stroke with Prehospital Stroke Alert). Some pre-alerts may have been recently recorded only in the narrative or not documented consistently. These findings highlight opportunities to improve standardized documentation and reinforce timely stroke alert activation. Data from ESO; based on eDisposition.24.

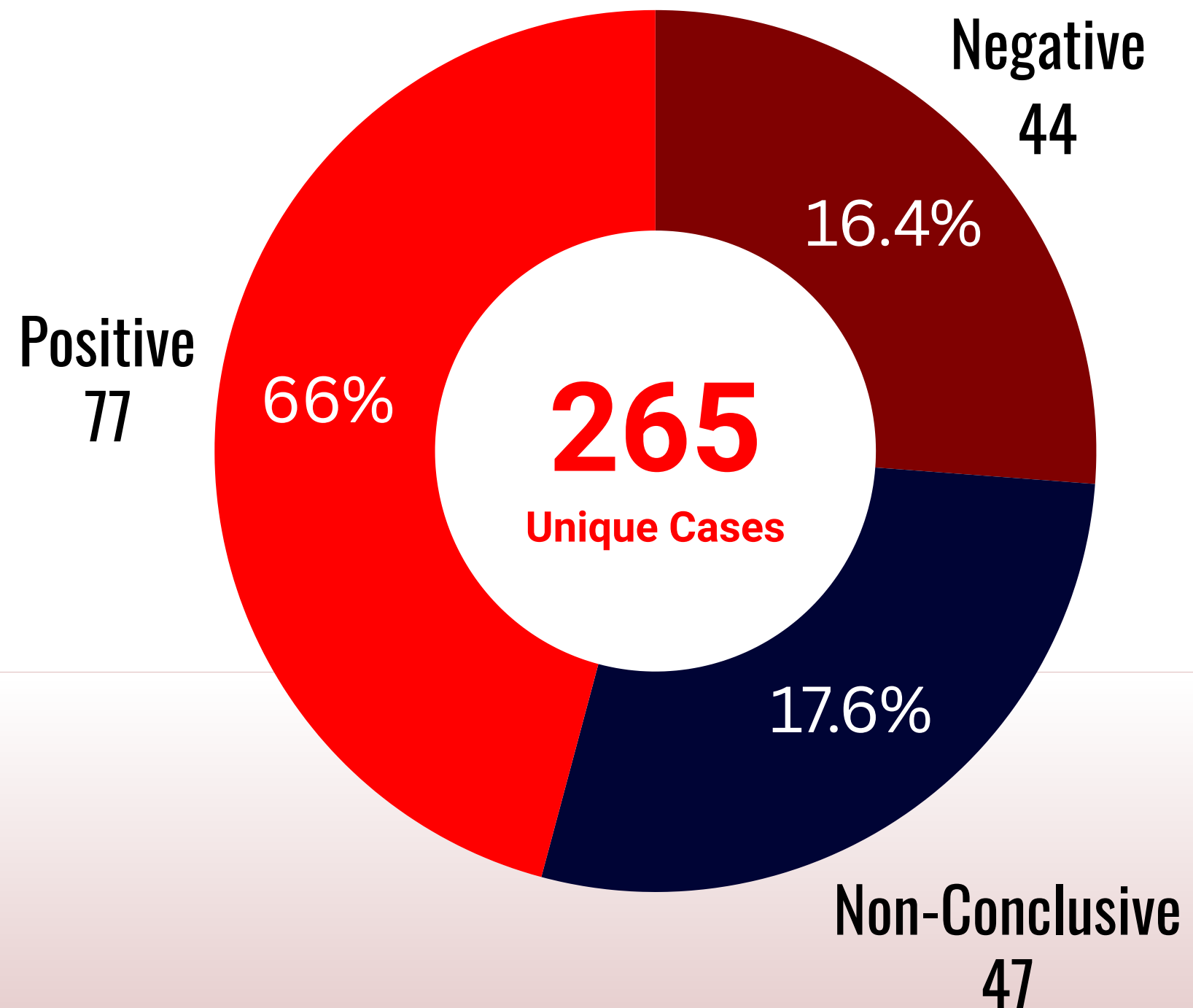




OEMS REGION 6 STROKE MEASURES

Among the 265 unique cases where CPSS was used in the previous quarter, 66.0% (177 cases) scored positive, suggesting a high suspicion of stroke. This aligns with NEMSQA Stroke-02 (Stroke Scale Positive) and Stroke-03 (Suspected Stroke with Positive Prehospital Stroke Scale), emphasizing early identification for time-sensitive interventions. Positive scores trigger protocols like large vessel occlusion (LVO) routing. In Region 6, this rate may indicate effective triage but warrants review for false positives via hospital feedback. Data from ESO reports; total based on eVitals.29 documentation.

Cincinnati Prehospital Stroke Scale (CPSS) Outcomes (Stroke-02/03)



Total CPSS Cases: 268 assessments (265 unique incidents; percentages are of 268 for outcomes).

Data from ESO, NEMSIS 3.5

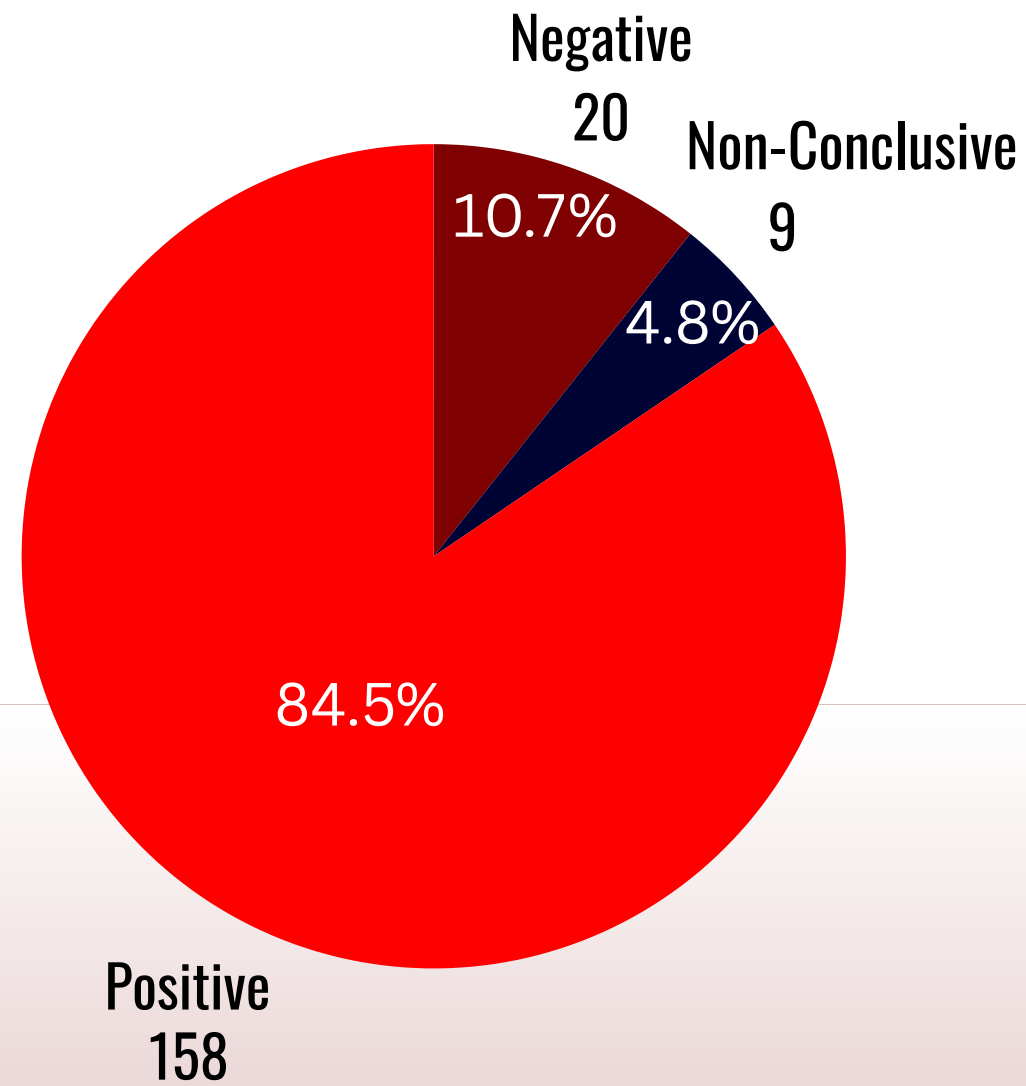


OEMS REGION 6 STROKE MEASURES

FAST-ED and Other Stroke Scale Outcomes (Stroke-02/03)

FAST-ED (19.8% of assessed incidents) had an 84.5% (158 cases) positive rate across 187 cases, demonstrating high sensitivity for large vessel occlusions (LVOs) and supporting NEMSQA Stroke-02/03. The 'Other' category (46.2%, 436 cases) includes LAPSS (13), NIHSS (3), RACE (3), and unspecified tools, with outcomes more balanced at 56.9% (248 cases) positive. In Region 6, high 'Other' reliance highlights protocol variations across agencies — recommend transitioning to validated scales like CPSS/FAST-ED per NEMSQA guidelines for improved stroke detection and outcomes. Data aggregated from ESO; based on eVitals.29/30.

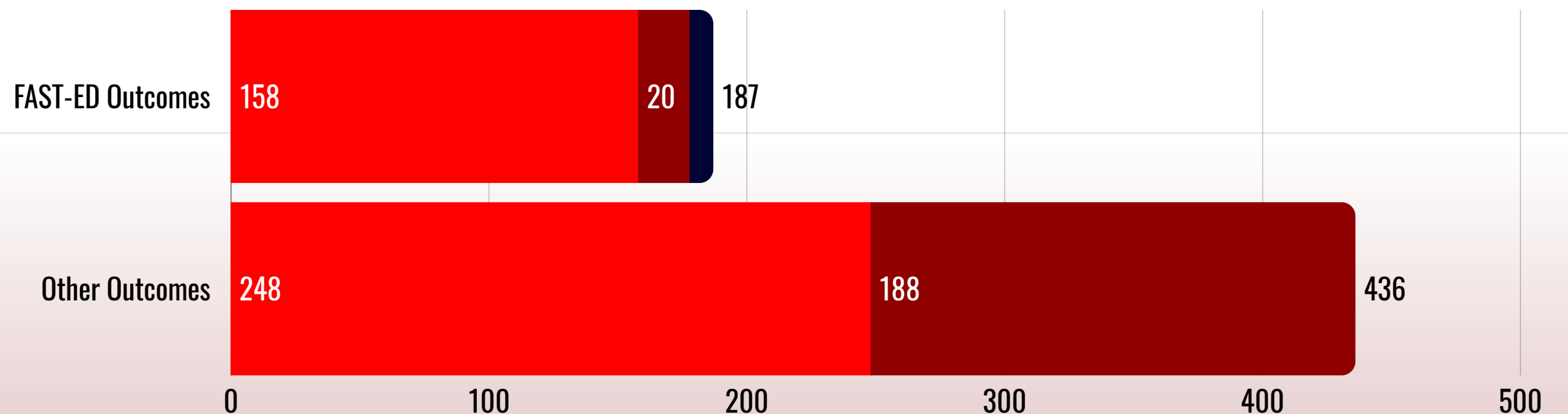
FAST-ED Outcomes



Total FAST-ED Cases: 187 (percentages are of this total).

FAST-ED Outcomes

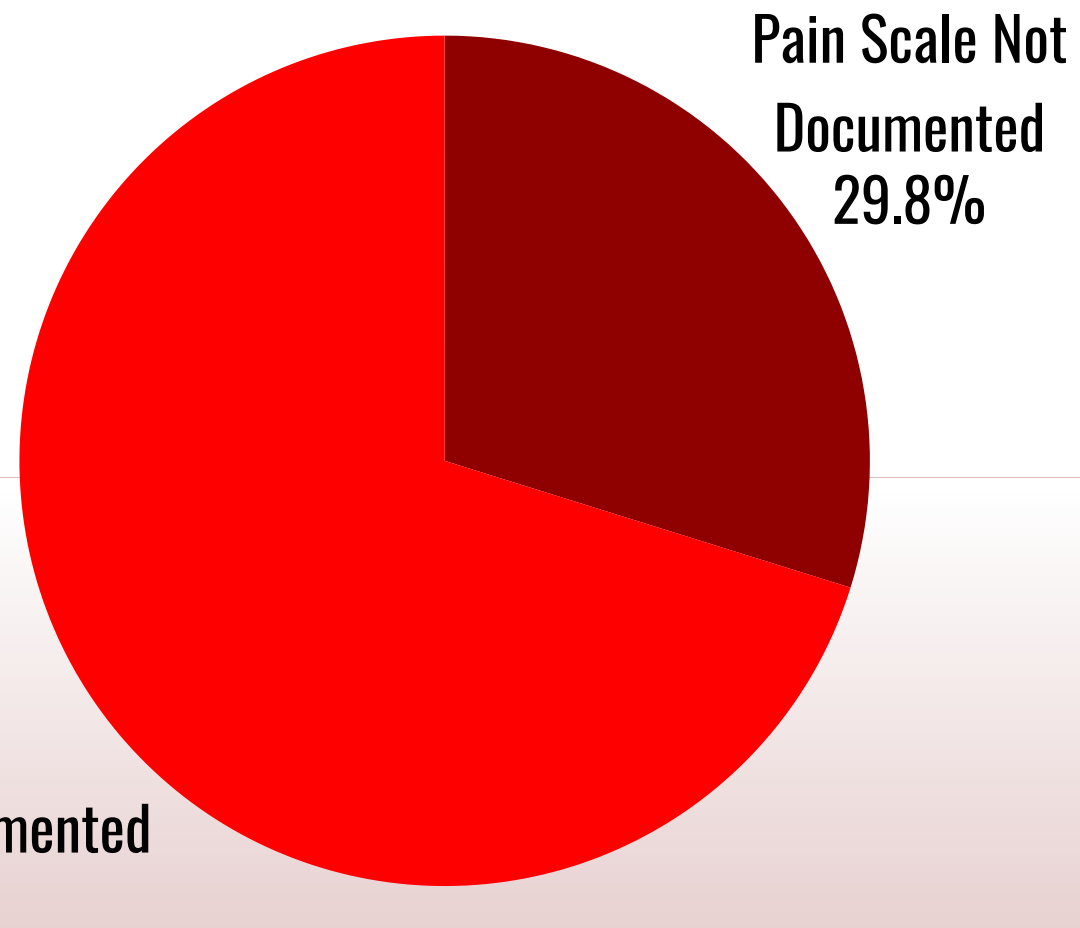
● Positive ● Negative ● Non-Conclusive





OEMS REGION 6 TRAUMA MEASURES

This chart shows pain scale documentation for trauma patients based on provider impression. 70.2% (5,573 cases) had a documented pain scale, aligning with NEMSQA Trauma-03 preparation. Opportunity to reduce the 29.8% undocumented via training.



Pain Scale Documented
70.2%

Pain Scale Not
Documented
29.8%



PAIN SCORE OBTAINED BASED ON PROVIDER IMPRESSION

5,573 With a Pain Scale Obtained

2,368 With Out a Pain Scale Obtained

Total impressions: 7,941; evaluable for change (≥ 2 assessments, initial > 0): 2,972

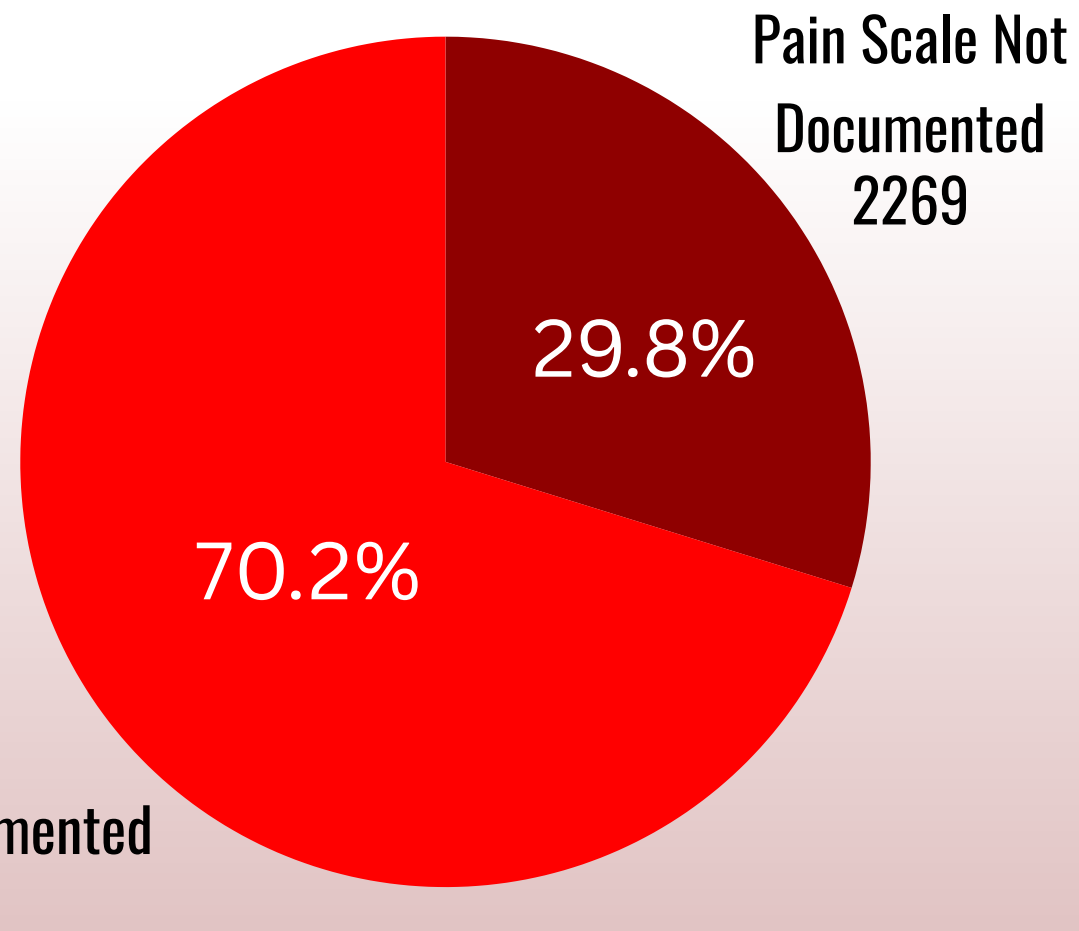
Data from ESO, NEMSIS 3.5



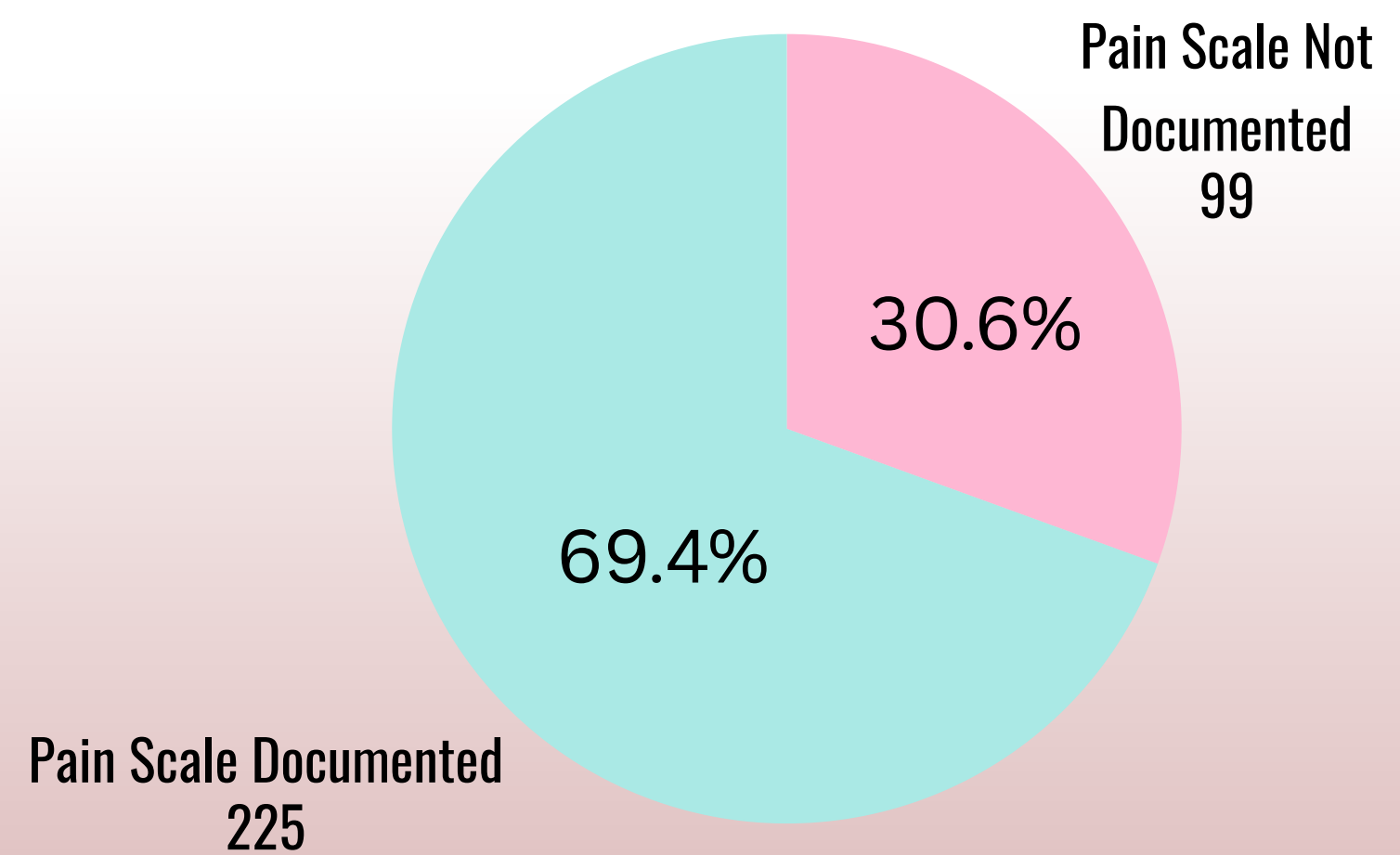
OEMS REGION 6 TRAUMA MEASURES

OEMS Region 6 All Planning Districts

Adult Pain Scales



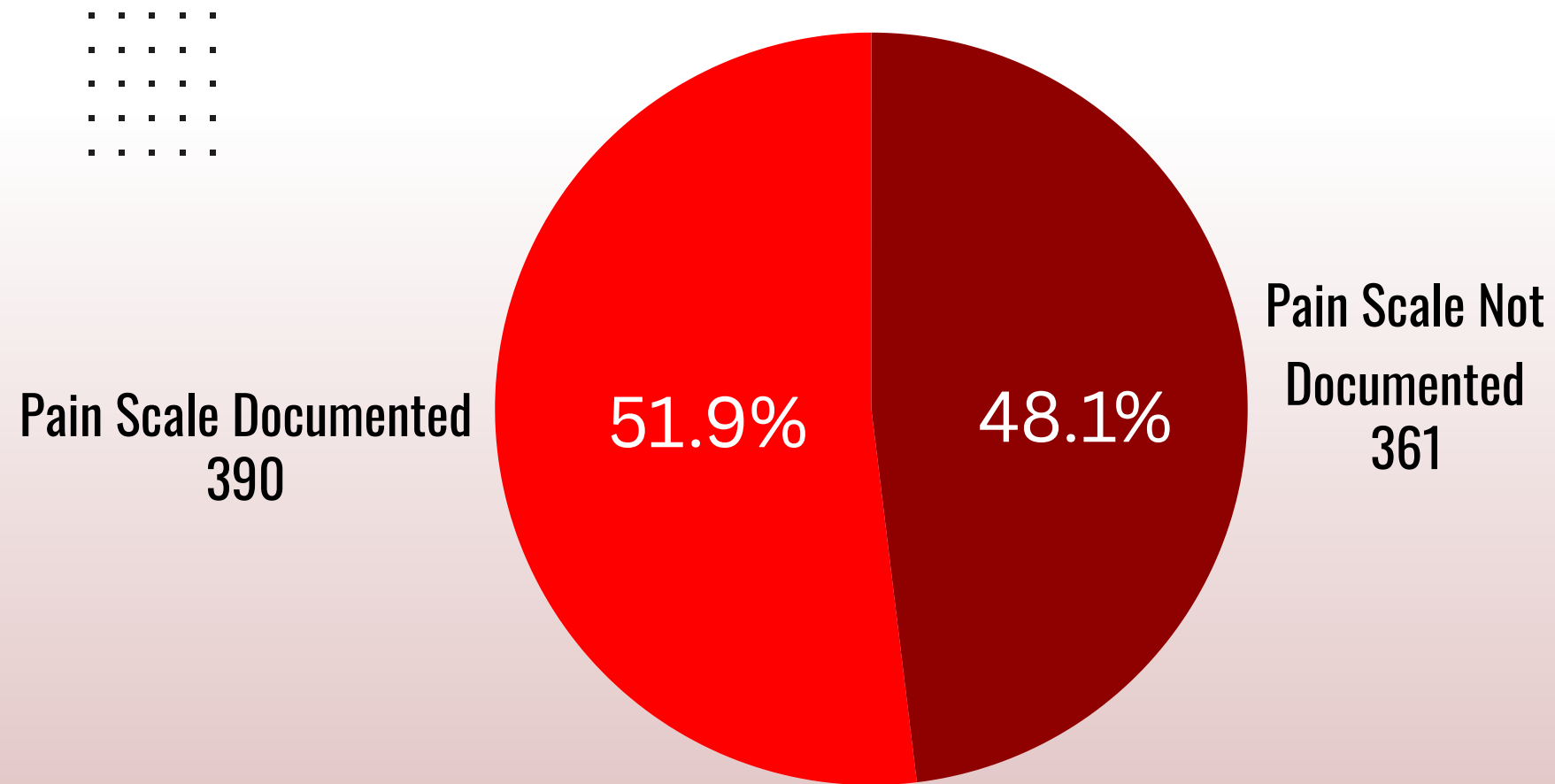
Peds Pain Scales





OEMS REGION 6 TRAUMA MEASURES

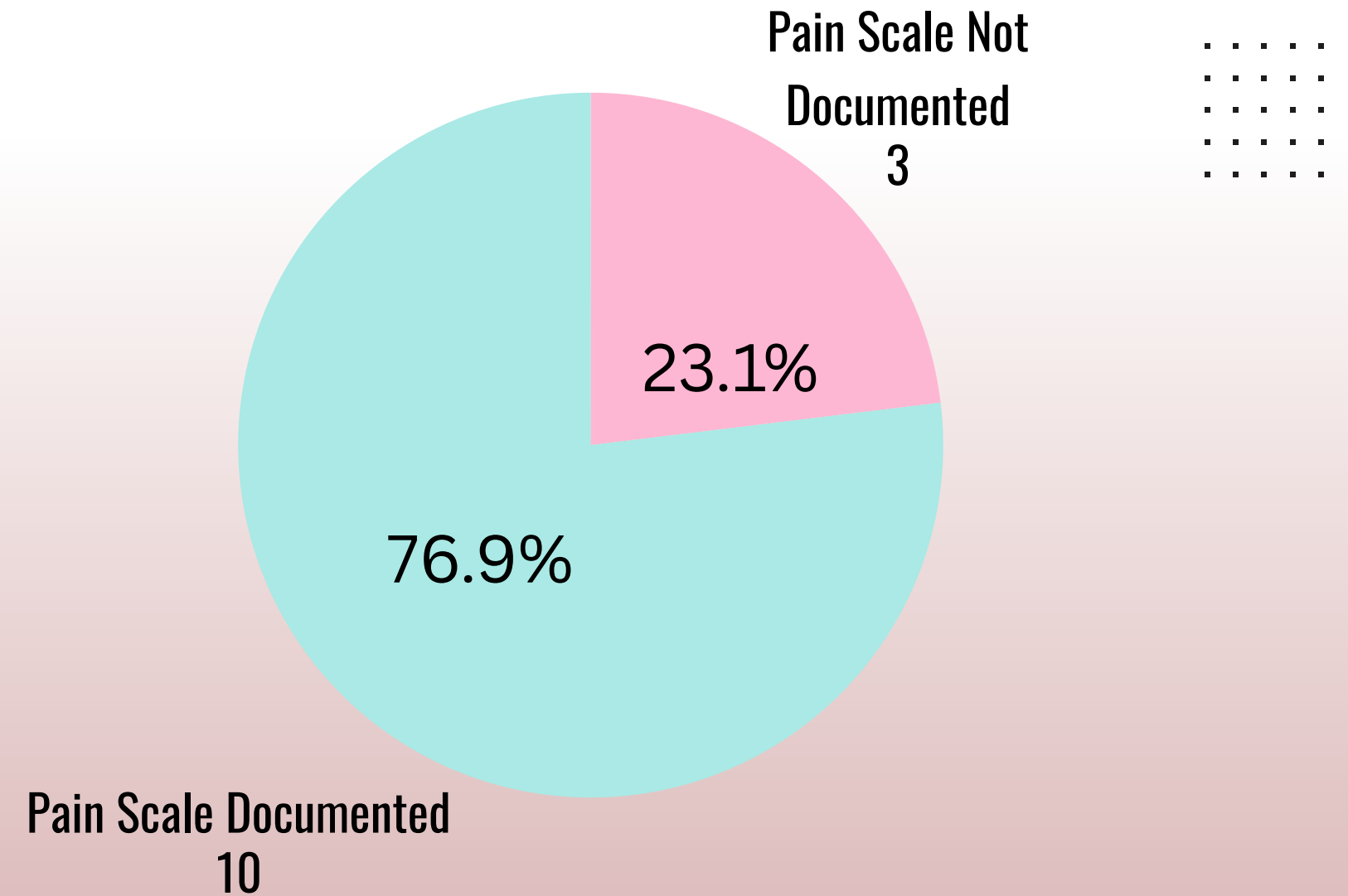
Adult Pain Scales



Planning District 13 Southside



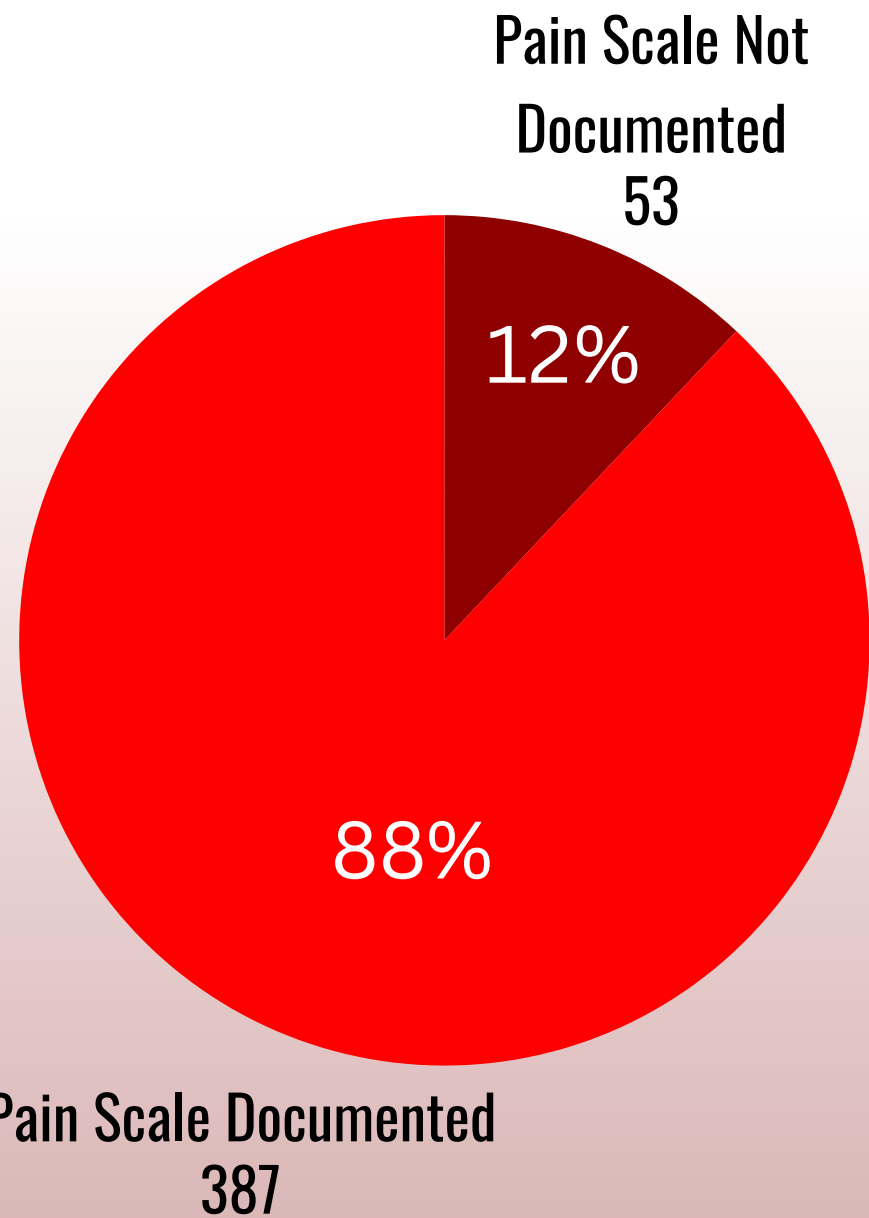
Peds Pain Scales





OEMS REGION 6 TRAUMA MEASURES

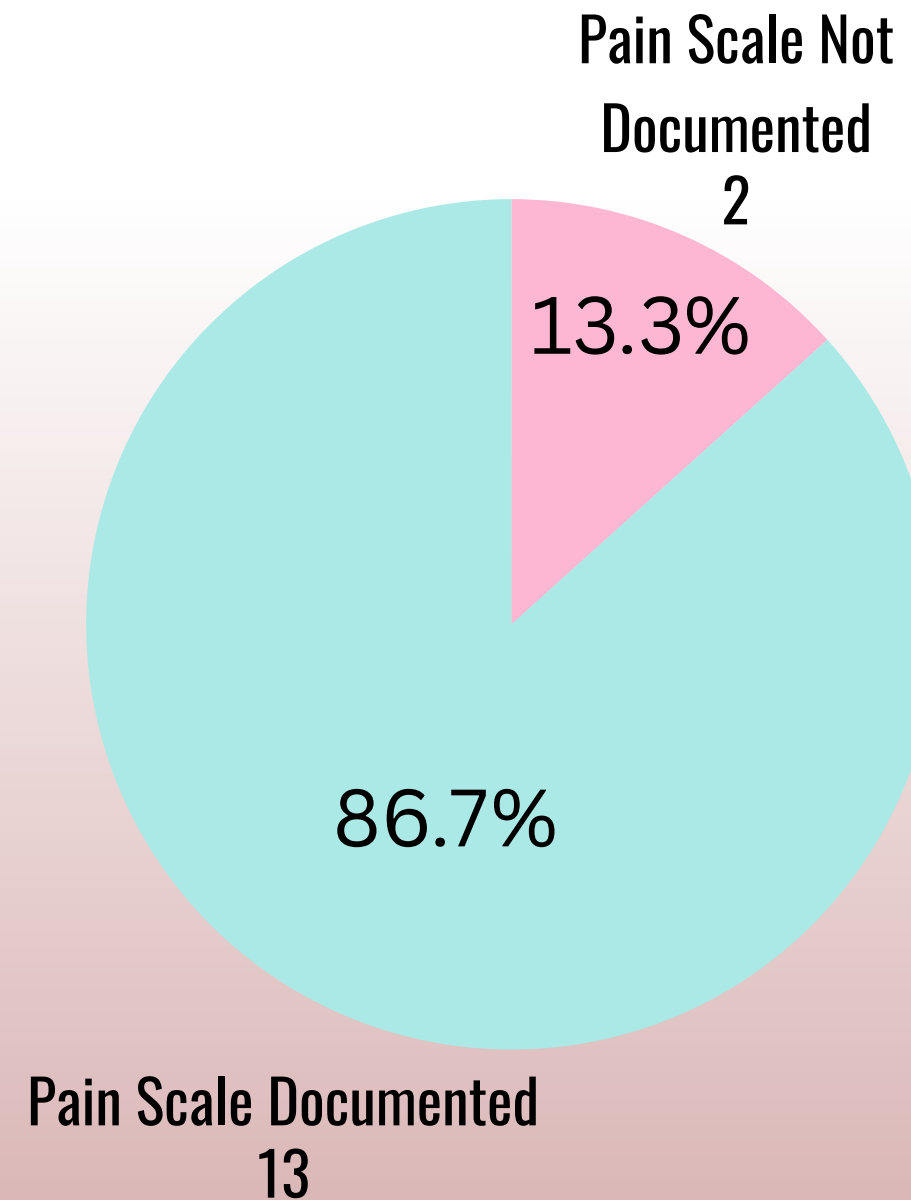
Adult Pain Scales



Planning District 14 South Central



Peds Pain Scales

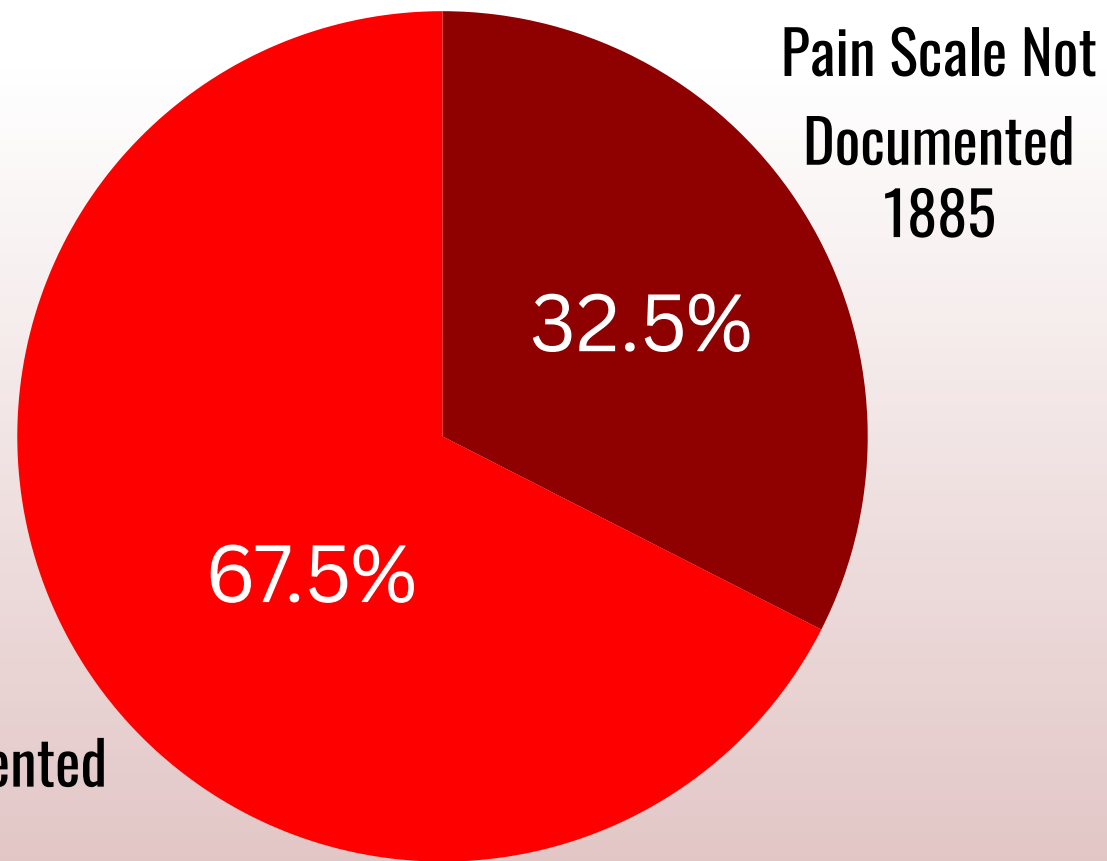
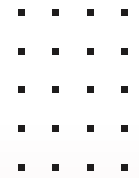




OEMS REGION 6 TRAUMA MEASURES

Planning District 15 Metro Richmond

Adult Pain Scales

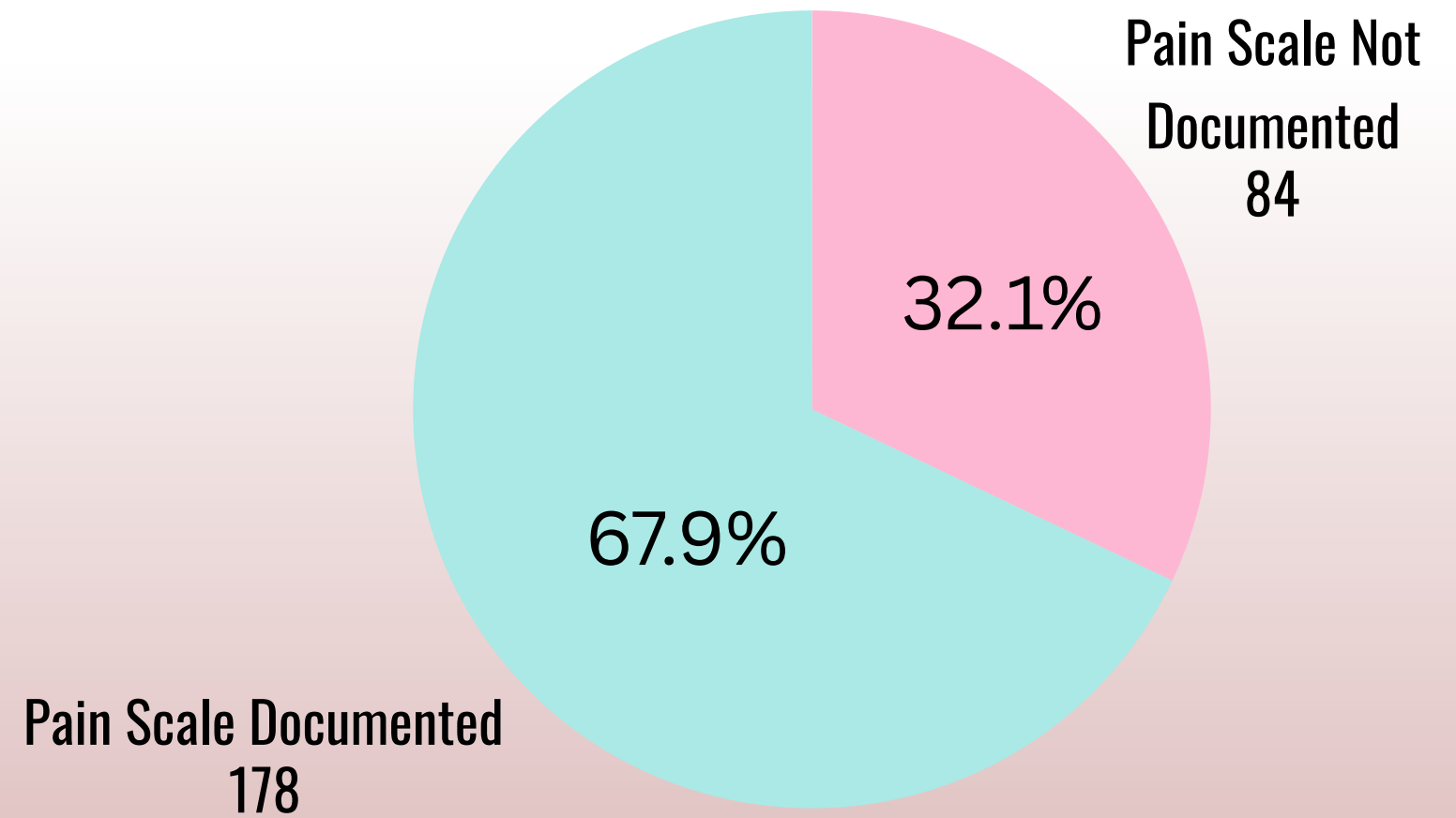
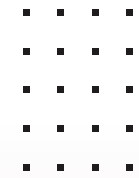


Pain Scale Documented
3914

Pain Scale Not Documented
1885



Peds Pain Scales



Pain Scale Documented
178

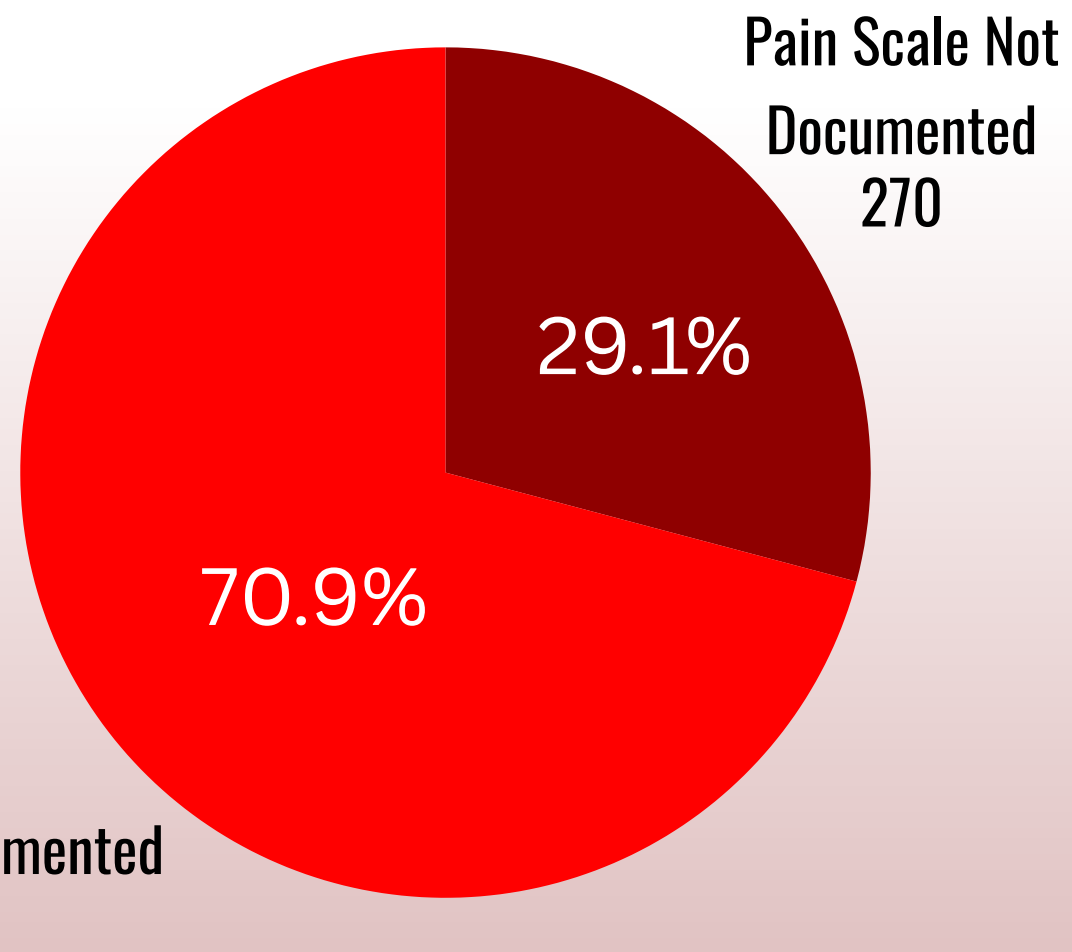
Pain Scale Not Documented
84



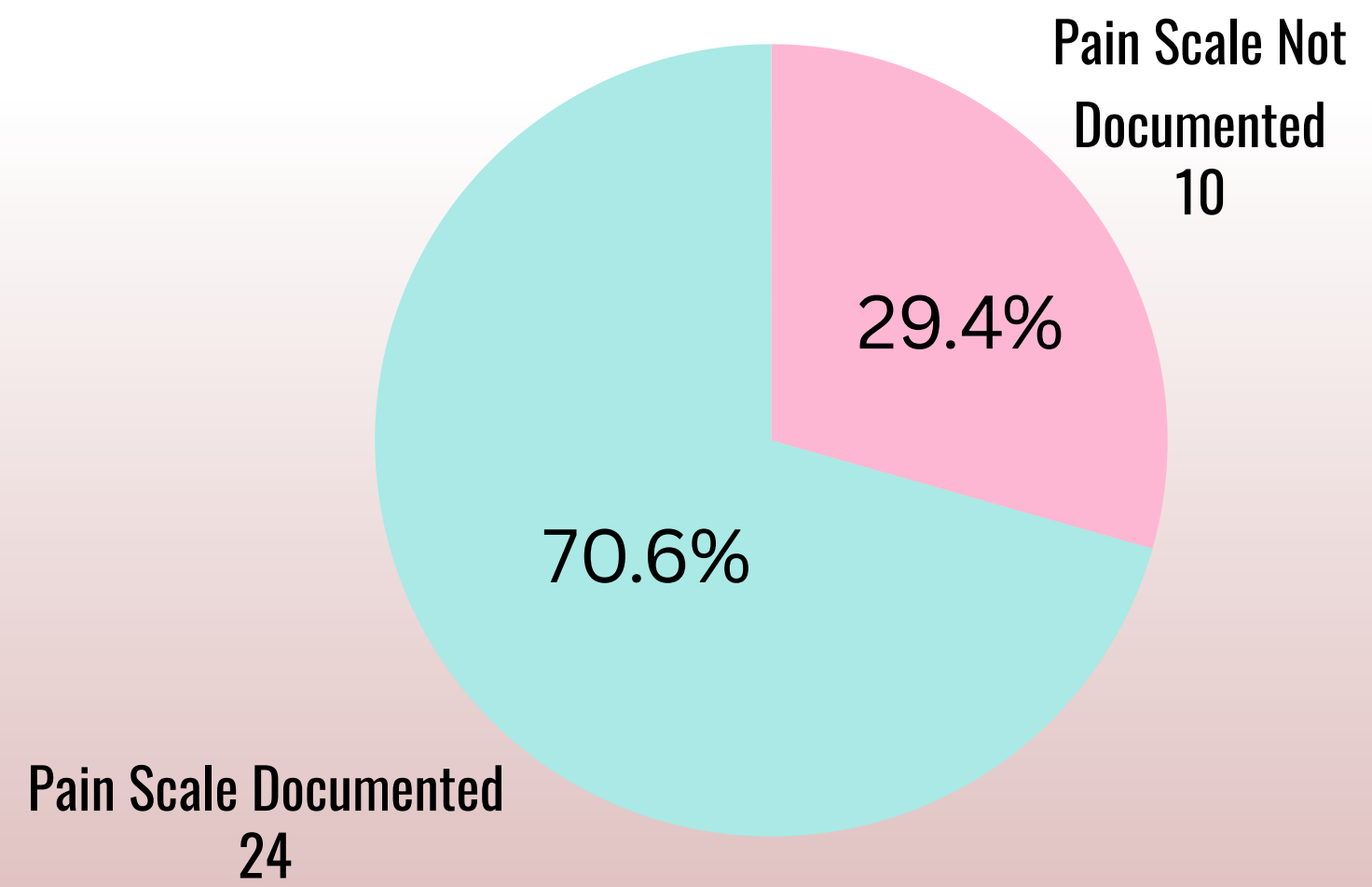
OEMS REGION 6 TRAUMA MEASURES

Planning District 19 Crater

Adult Pain Scales



Peds Pain Scales

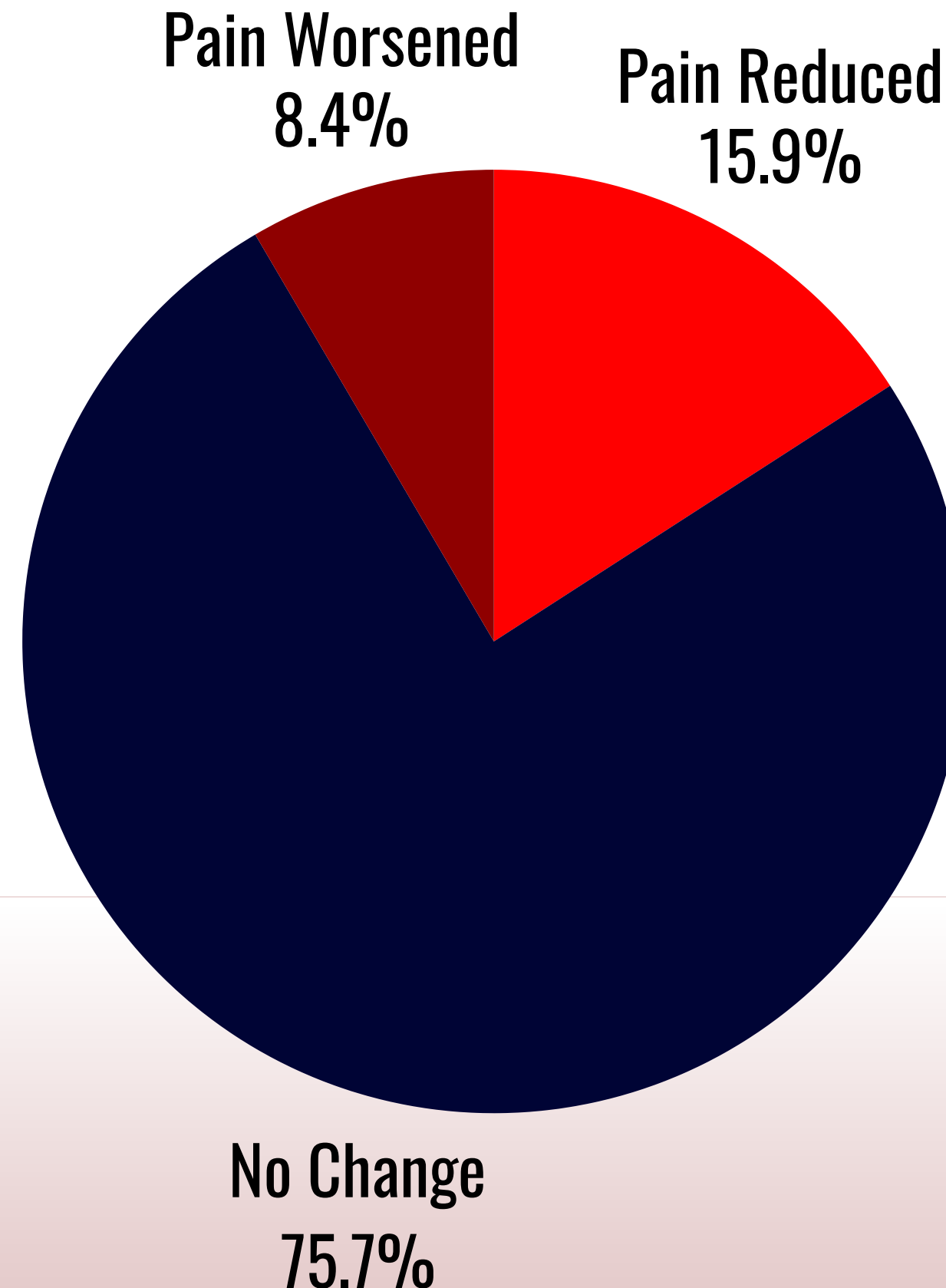




OEMS REGION 6 TRAUMA MEASURES

This chart shows the distribution of pain score changes for all injured patients in the ODEMSA Region during the previous quarter. Pain reduction was achieved in 15.88% of evaluable EMS transports, based on at least two pain assessments with an initial score >0. Data includes all call types and is derived from NEMSIS 3.5 elements like eVitals.27 (Pain Scale Score).

Overview of Pain Management Effectiveness



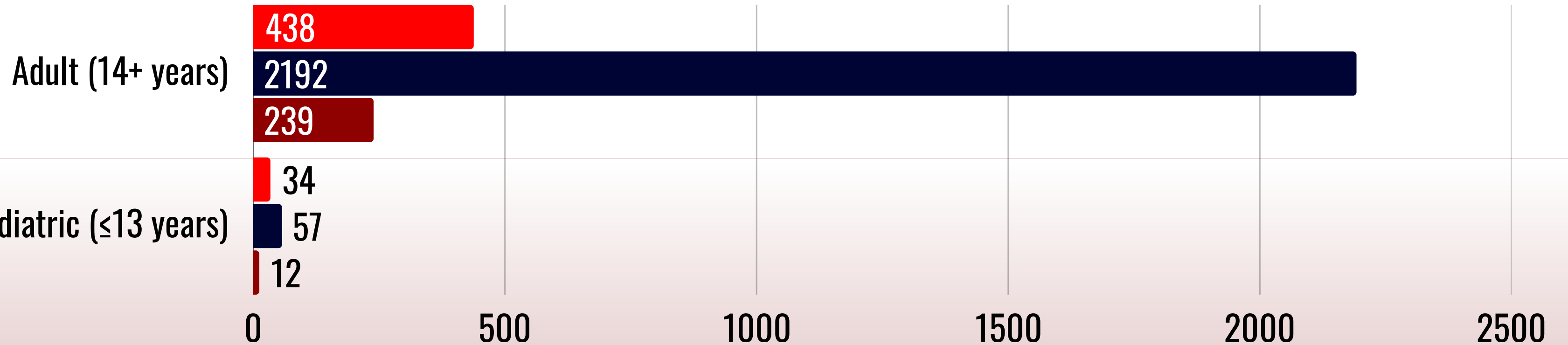


OEMS REGION 6 TRAUMA MEASURES

Pain Management by Age Group

This chart compares pain management outcomes between adult and pediatric patients in the previous quarter. Pediatric patients showed higher rates of pain reduction (33.01%) compared to adults (15.27%). Evaluable incidents required at least two pain scores, with exclusions for patients unable to report pain (e.g., altered mental status). Total incidents: 2,972.

● Pain Reduced ● No Change ● Pain Worsened



Pediatric (≤ 13 years)

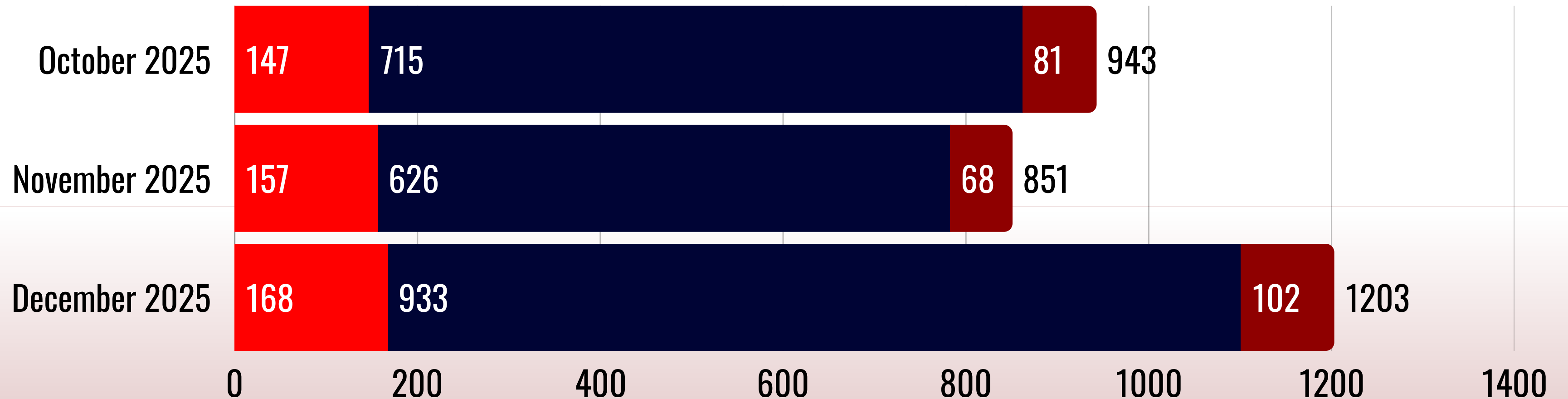


OEMS REGION 6 TRAUMA MEASURES

Monthly Trends in Pain Management Effectiveness

This chart illustrates monthly trends in pain score changes for the previous quarter across the ODEMSA Region. Pain reduction peaked in November at 18.44%. Data aggregates all planning districts and age groups, focusing on effectiveness as measured by reductions in eVitals.27 (Pain Scale Score).

● Pain Reduced ● No Change ● Pain Worsened



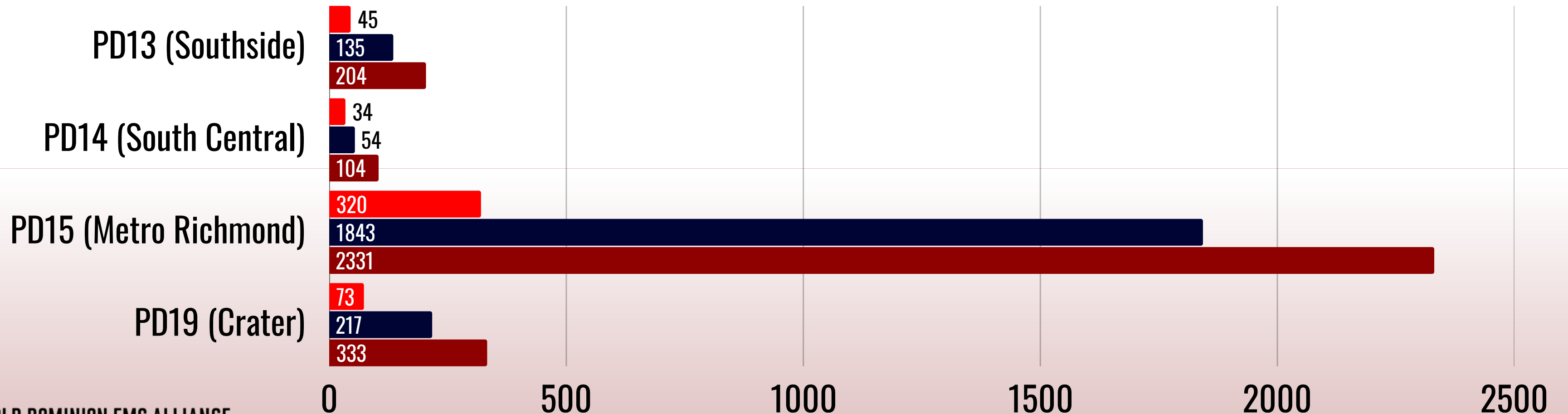


OEMS REGION 6 TRAUMA MEASURES

Pain Management by Planning District

This chart breaks down pain management outcomes by planning district in the ODEMSA Region for the previous quarter. PD14 had the highest pain reduction rate at 32.69%, while PD15 (the largest volume district) had the lowest at 13.73%. Data is based on aggregated incidents from all agencies within each PD, using NEMSIS-compliant pain assessments.

● Pain Reduced ● No Change ● Pain Worsened



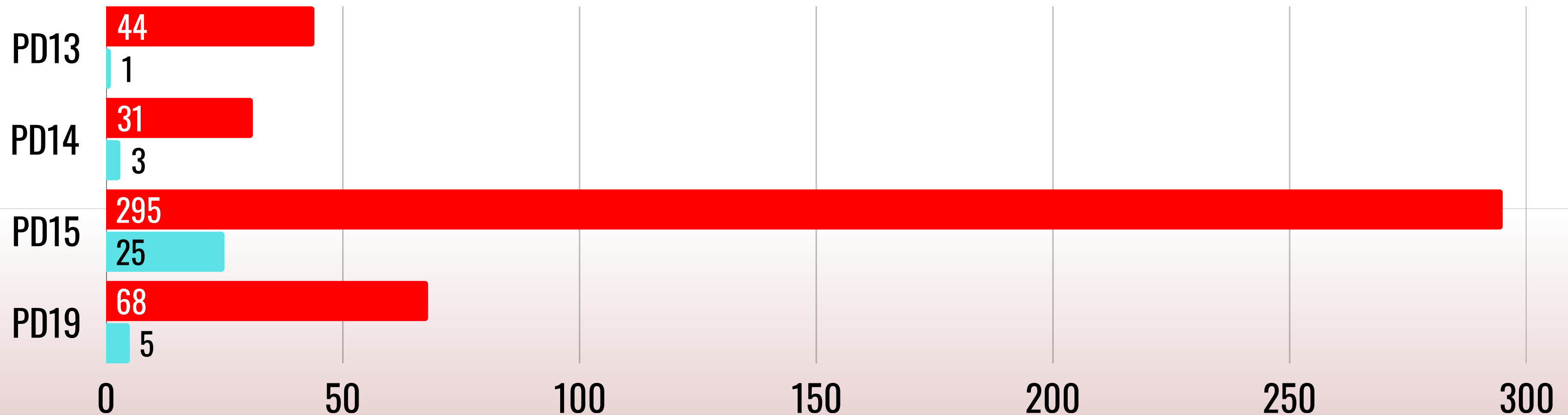


OEMS REGION 6 TRAUMA MEASURES

Pain Management by Age Group

This chart highlights pain reduction rates by planning district and age group in the previous quarter. Pediatric patients consistently showed higher reduction rates across districts, with PD14 Pediatric at 60.00%. This focuses on the key Trauma-03 metric of pain score lowering during EMS encounters.

● Adult Pain Reduced % (Cases) ● Pediatric Pain Reduced % (Cases)

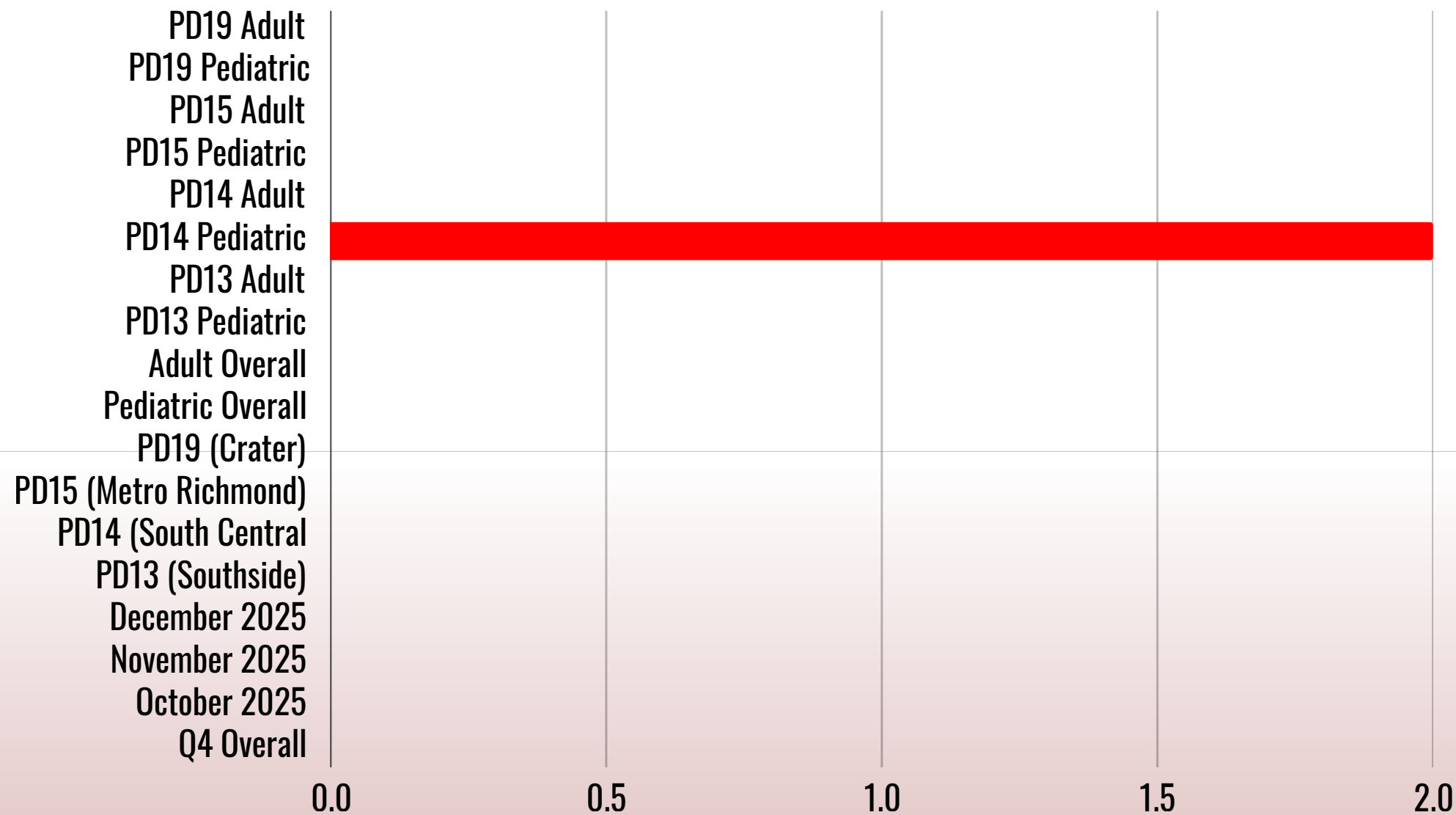




OEMS REGION 6 TRAUMA MEASURES

Median Pain Score Delta by Group

This chart displays the median change in pain scores (first to last assessment) for evaluable patients in the previous quarter. The median delta was 0 across most groups, indicating no change in pain for the typical patient. PD14 Pediatric showed a median reduction of 2 points. Data calculated from eVitals.²⁷ differences, evaluable only.



Key Metric: Median delta is the middle value of all pain score changes (initial minus final on 0-10 scale) in a group—shows "typical" relief level (positive = improved pain, 0 = no change, negative = worsened).

Why Mostly 0?: In Q4 2025 data, most groups had high "no change" rates (66-80%), keeping the median at 0 (half or more patients saw no improvement).

PD14 Pediatric Exception (Median +2): Small group (5 cases) with 60% strong improvements (≥ 2 points), shifting middle value to +2 - highlights better outcomes in pediatrics, but sample size-sensitive.

Tie to Trauma.03: Complements % improved by measuring typical change magnitude; evaluable only (≥ 2 assessments, initial > 0 , reliable reporters).



OEMS REGION 6 SEIZURE MEASURES

This slide highlights the most frequently documented primary and secondary provider impressions for eligible status epilepticus patients in the previous quarter. 'Other Seizures' and 'Epilepsy Without Status' dominate, emphasizing the need for rapid intervention per NEMSQA Seizure-02 (Patient Received Intervention for Status Epilepticus). Data from ESO reports; based on eSituation.11/12 (Provider Impressions) across 378 unique eligible incidents (911 transports, active seizing, age ≥ 2). These align with NEMSQA criteria for identifying status epilepticus, supporting better triage in ODEMSA Region 6 (Planning Districts 13, 14, 15, 19). Opportunities: Improve secondary impression documentation to reduce blanks and capture comorbidities.



PROVIDER PRIMARY IMPRESSION

228 Other Seizures

96 Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus

19 Syncope and Collapse

PROVIDER SECONDARY IMPRESSION

60 Other Seizures

33 Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus

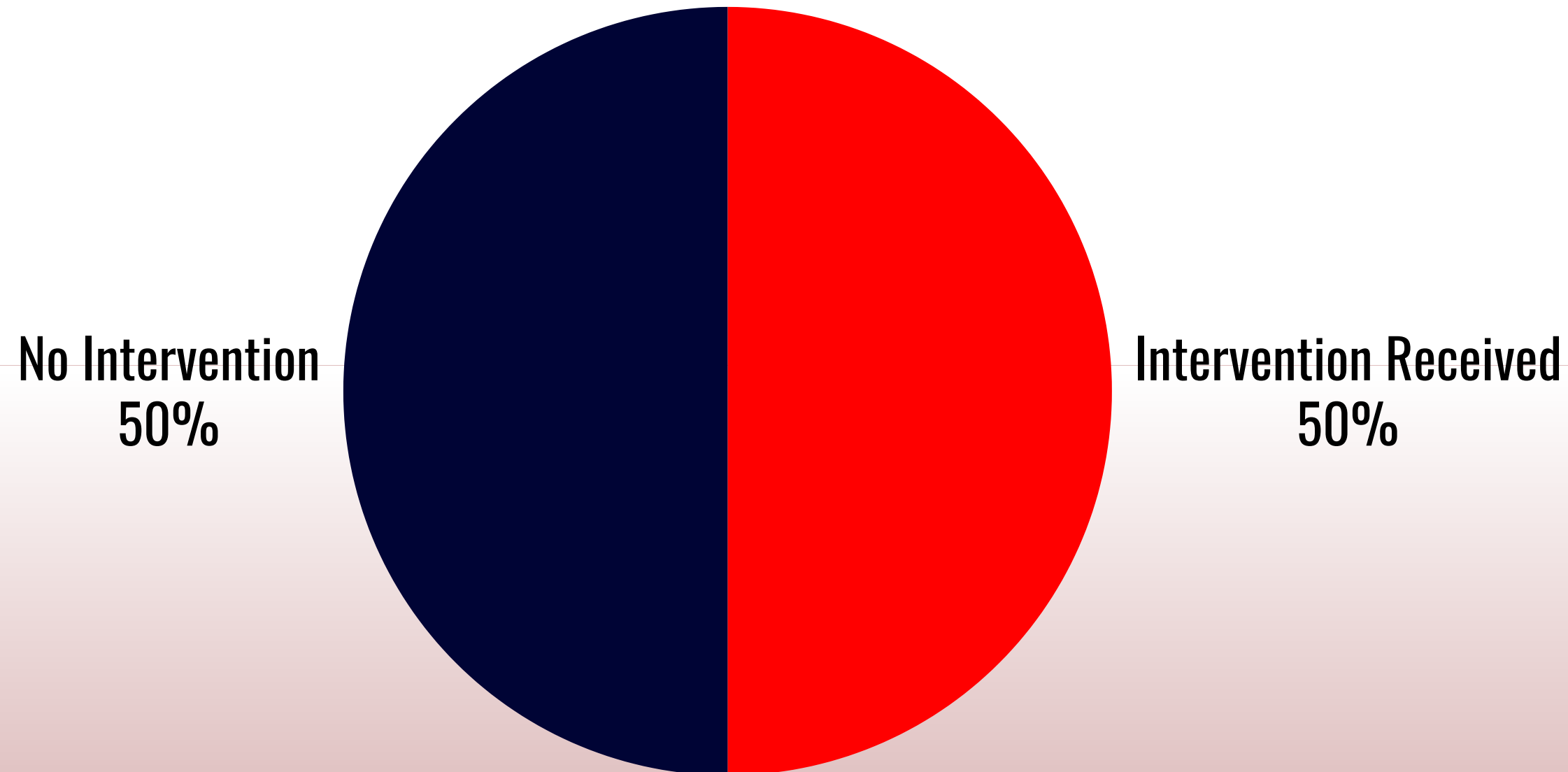
16 Weakness



OEMS REGION 6 SEIZURE MEASURES

Overview of Seizure Intervention Performance

This chart shows the percentage of EMS transports for patients in status epilepticus who received a benzodiazepine intervention during the encounter in Region 6 during the previous quarter. 50.00% of eligible patients received the intervention, based on NEMSQA Seizure-02 specifications. The measure focuses on 911 requests for patients with active seizing (inferred from impressions like 'status epilepticus' or 'other seizures'). Higher scores indicate better performance. Data derived from NEMSIS 3.5 elements like eSituation.11 (Primary Impression), eMedications.03 (Medication Given), and eDisposition.01 (Destination Type).



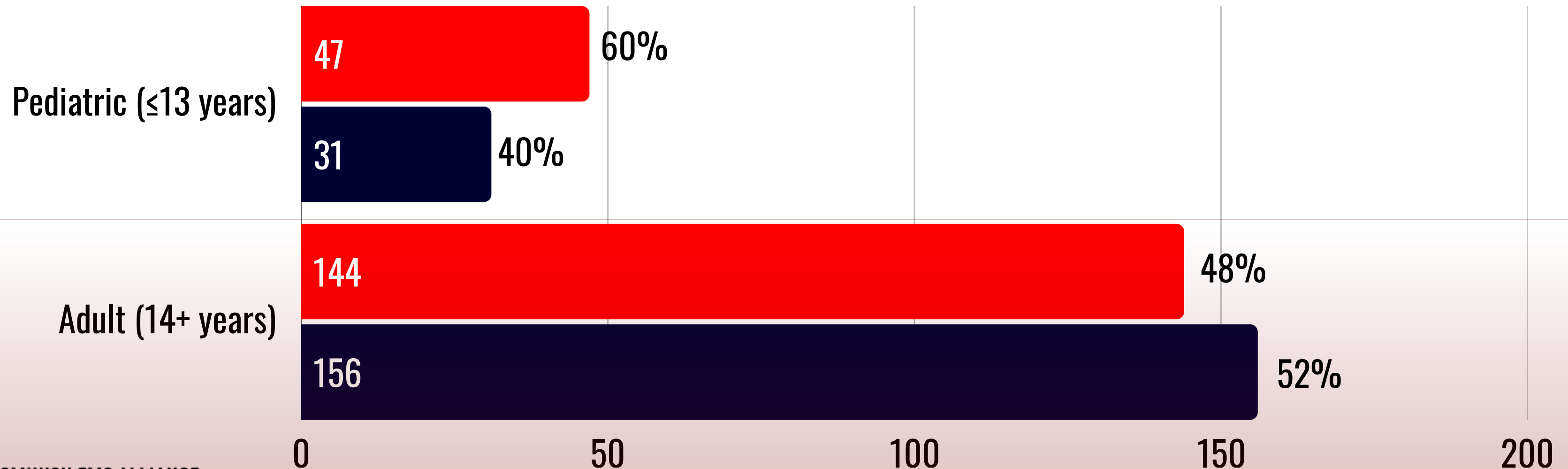


OEMS REGION 6 SEIZURE MEASURES

Seizure Intervention by Age Group

This chart compares seizure intervention rates between pediatric and adult patients in the previous quarter. Pediatric patients showed higher rates of intervention (60.00%) compared to adults (48.00%). Eligible incidents required at least active seizing documentation, age ≥ 2 , and transport. Exclusions include non- transports or age < 2 . Total eligible: 378. Data from ESO, focused on NEMSQA Seizure-02 for quality improvement.

● Intervention Received ● No Intervention

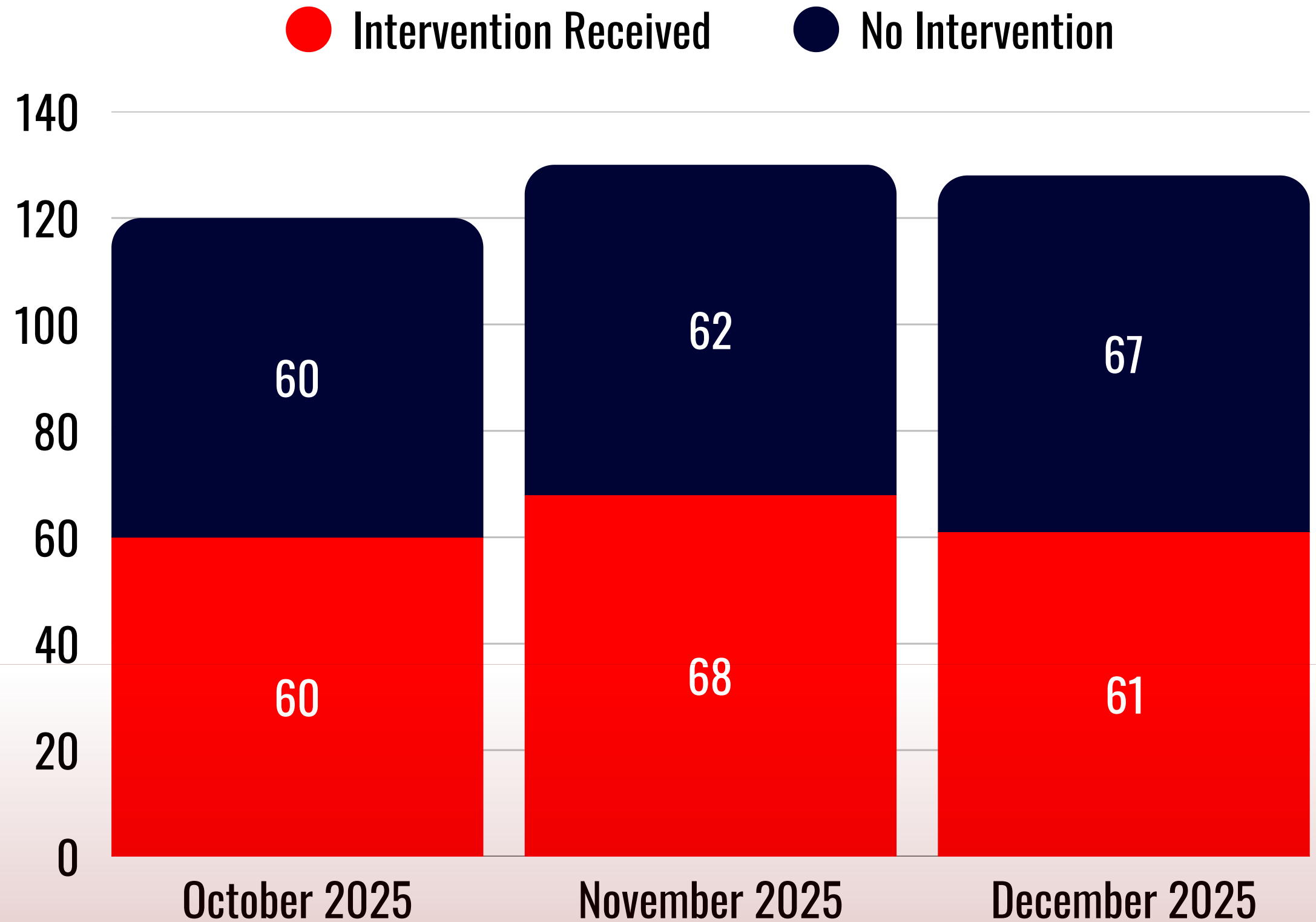




OEMS REGION 6 SEIZURE MEASURES

This stacked bar chart illustrates monthly trends in benzodiazepine intervention for status epilepticus in Q4 2025 across the ODEMSA Region. Intervention rates peaked in November at 52.00%. Data aggregates all planning districts and age groups, focusing on effectiveness as measured by NEMSQA Seizure-02. Encourage consistent protocol adherence for improvement.

Monthly Trends in Seizure Intervention Effectiveness



National ESO benchmark: >90%; opportunity for protocol review.

Data from ESO, NEMSIS 3.5

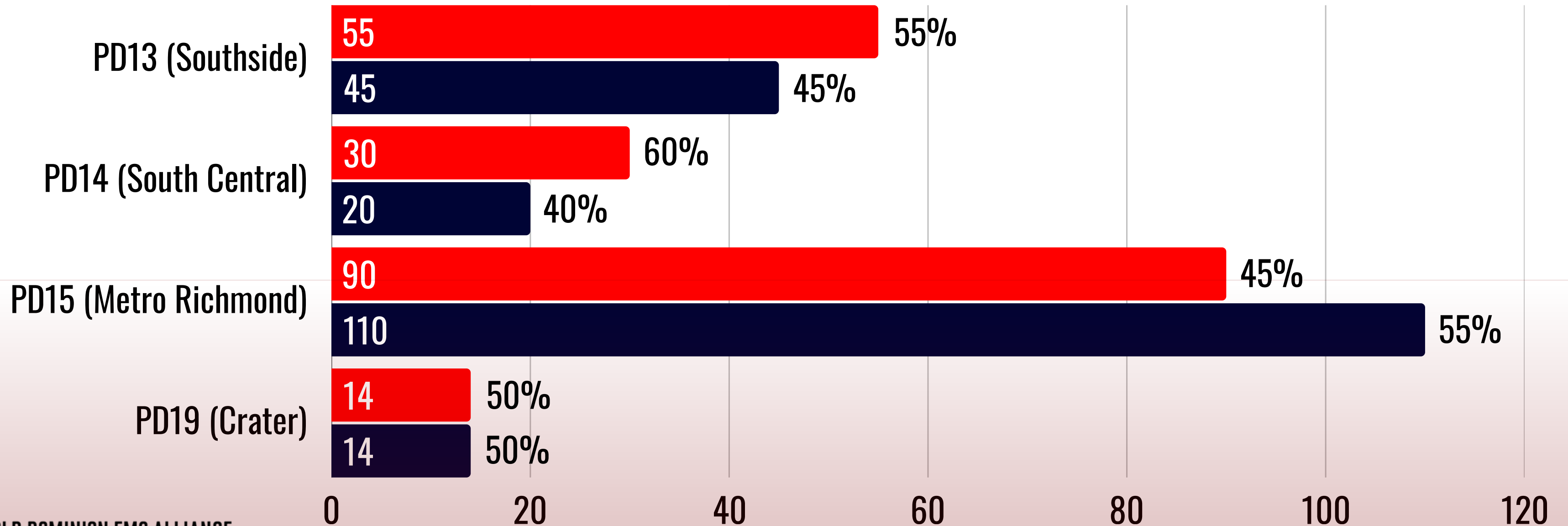


OEMS REGION 6 SEIZURE MEASURES

Seizure Intervention by Age Group

This chart breaks down seizure intervention rates by planning district in the ODEMSA Region for the previous quarter. PD14 had the highest rate at 60.00%, while PD15 (the largest volume district) had the lowest at 45.00%. Data is based on aggregated incidents from all agencies within each PD, using NEMSIS-compliant impressions and medications.

● Intervention Received ● No Intervention

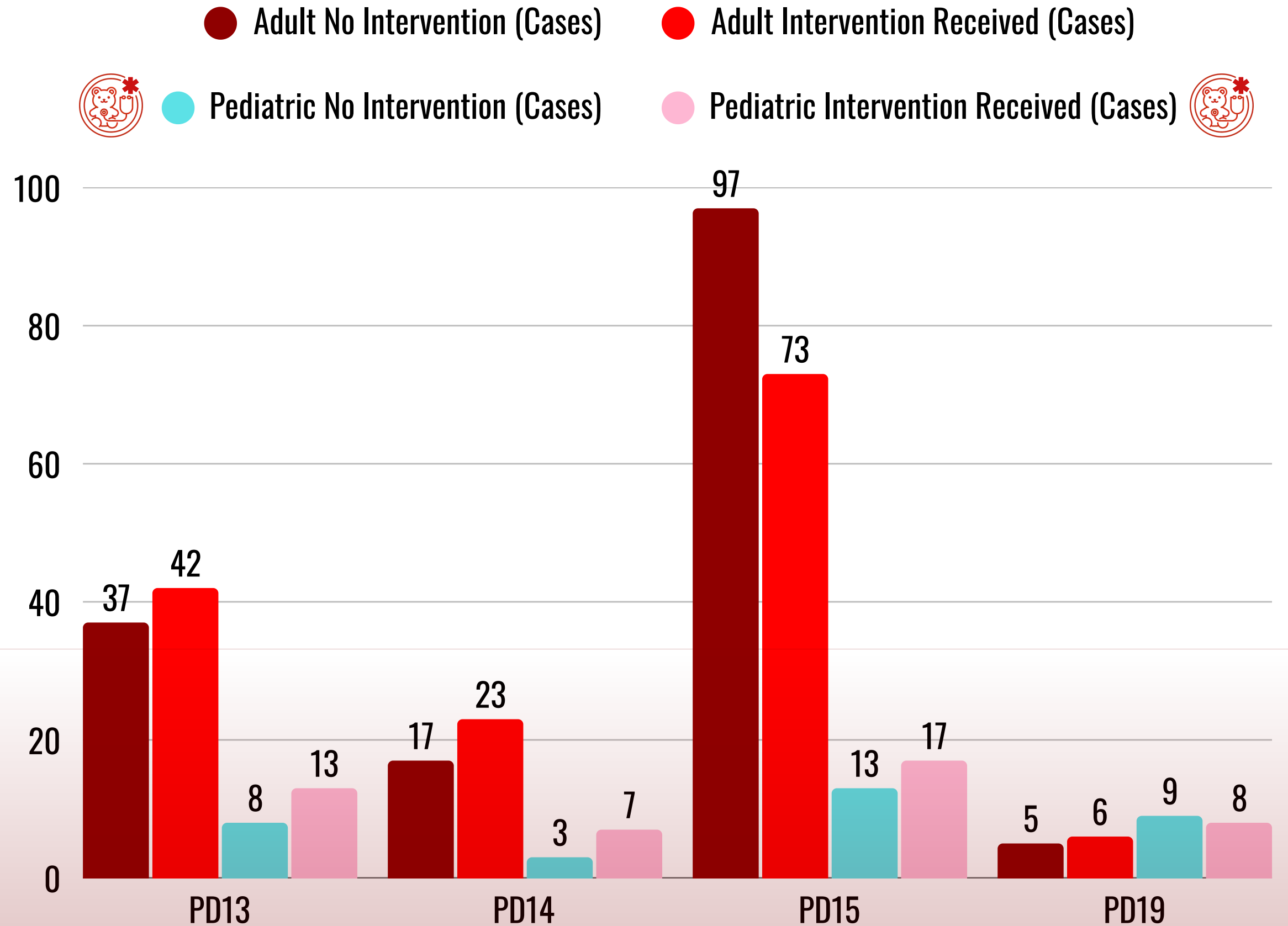




OEMS REGION 6 SEIZURE MEASURES

This chart highlights intervention rates for status epilepticus by planning district and age group in the previous quarter, with bar lengths showing total cases and stacks for 'Intervention Received' vs. 'No Intervention.' Pediatric patients consistently showed higher intervention rates across districts (e.g., PD14 Pediatric at 70.00%), while adults had lower rates and higher volumes. This focuses on the key Seizure-02 metric of benzodiazepine administration during EMS encounters, revealing opportunities for protocol reinforcement in high-volume areas like PD15.

Seizure Intervention by Planning District and Age Group



Key Insights & Next Steps

We value your expertise—share feedback, suggestions, or data ideas to refine future quarterly reports.

Summary

- Q4 2025 highlights strong EMS performance: 104,626 calls handled, with high compliance in stroke assessments (90.9%) and BGL checks (91.7%).
- Opportunities identified: Improve trauma pain reduction (15.9% achieved) and seizure interventions (50.0% received) through targeted training.
- Overall, Region 6 agencies demonstrate commitment to NEMSQA standards—data-driven improvements will enhance patient outcomes across PDs 13, 14, 15, and 19.

Thank You For Your Attention

