OLD DOMINION EMERGENCY MEDICAL SERVICES ALLIANCE
7818 East Parham Road • Suite 911 • Henrico, VA 23294-4302
Phone: (804) 560-3300 • (804) 560-0909 • www.odemsa.net

Performance Improvement Committee

February 11, 2026, 02:00 pm to 04:00 pm
Chair: Mike Watkins, Goochland Fire
Vice-Chair: Kelley Rumsey, Bon Secours

Members and Guests Present: N/A
Virtual Attendees: Craig Bride, Beth Broering, Whitney Cipriani, Diana Jewett, Hannah Lawrence, Daniel Linkins, Amanda Loreti, Tom Ludin, Connie Moore, Greg Neiman, Melissa Sampson, Kate Schulz, Emma Spruill, Rebecca Szeles, Abby Touch, Chris Walls, and Allen Yee
ODEMSA Staff: Heidi Hooker and 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	• The meeting was called to order at 2:02 PM by Chair Mike Watkins. Introductions were conducted. • Due to an initial lack of quorum, the meeting proceeded as a working session. • A quorum was later established with the addition of attendees, allowing for official business to continue.	Motion to approved meeting minutes from the 11/12/2025 meeting made by Tom Ludin, Second by Craig Bride. **Motion passed.** Ryan Scarbrough to update the membership list and reach out to agencies for representation with a primary and

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
		secondary representative.
Agency Reports		
Goochland County Fire-Rescue	**Mike Watkins** • No major EMSQI items to report. • The agency is working with the National Emergency Response Information System (NERIS), a new fire reporting system that includes additional EMS fields for reporting to the U.S. Fire Administration. • Working with the ImageTrend critical care module to incorporate documentation of blood administration and ventilator settings. • Noted that these changes raise questions about how that information will appear downstream through ESO and other reporting platforms.	Agencies to ensure primary representatives attend or send alternates for future meetings. Ryan Scarbrough to rerun call volume reports filtered specifically for region 6.
Richmond Ambulance Authority	**Rebecca Szeles** • Updated protocols have been published and now include the new American Heart Association guidelines. • A recent ESO update created multiple reporting issues affecting the agency. • Current work is focused on resolving those ESO issues and bringing NEMSIS reporting compliance back up to 98 percent. • Some fields were being flagged as missing even when the required information had been entered.	
Richmond Fire and Emergency Services	**Tom Ludin** • Richmond Fire is struggling with the transition to NERIS and described the implementation as problematic. • The department is replacing jump bags on apparatus. • The department is also moving away from its long standing practice of carrying the entire state required equipment list on every call, noting that this approach has proven inefficient.	

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	• The statewide trauma hypothermia data presented at the state meeting raised concern and prompted review of whether Richmond Fire should adopt active warming measures, particularly given that fire apparatus do not have a patient compartment. • Lt. Betty Migliaccio was promoted to Deputy Fire Marshal. • Lt. Charles Gowen will serve as Richmond Fire's alternate representative moving forward.	
New Kent Fire-Rescue	**Travis Jenkins** • Nothing to report.	
Chesterfield Fire and EMS	**Dr. Allen Yee** • Discussed trauma registry data presented at the Governor's Advisory Board showing that approximately twenty percent of patients statewide with an Injury Severity Score greater than twenty were identified as hypothermic, while the ODEMSA region was closer to ten percent. • Noted that the state dataset used a threshold of 35.5 degrees Celsius, while use of 35 degrees Celsius or lower changes the interpretation and makes the numbers look less severe. • Chesterfield is reinforcing hypothermia prevention in trauma care through use of blankets and Mylar blankets, particularly for sicker trauma patients. • Chesterfield is also updating its traumatic cardiac arrest protocol. After hemorrhage control, the revised approach may again allow consideration of epinephrine and chest compressions. • The discussion referenced emerging literature and a draft American College of Surgeons Committee on Trauma publication. • Additional protocol updates are expected to include eliminating routine cervical collar use and instead using towel rolls and head blocks to limit cervical motion.	
Planning District 13 (PD13):	**Connie Moore** • Rejoined the committee after not serving on it for several years. • Shared that the region is pleased to now have LifeEvac stationed at VCU CMH, which improves access to helicopter transport for the area.	

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	• Noted that over a recent weekend the aircraft was not available at the time it was needed, although a helicopter was ultimately obtained. • Identified rural medicine as a significant challenge in the area, including frequent calls and recurring patients. • Also identified ongoing diversion status at one of the hospitals in the area as a recurring concern.	
VDH Virginia Office of EMS		

	Dr. Allen Yee
	• State Medical Direction is reviewing several major initiatives related to trauma care and resuscitation practices.
	• One area of focus is prehospital and hospital hypothermia. The currently available data relies on the first temperature documented at the trauma center, and because that value may be entered up to thirty minutes after arrival, the exact timing and source of the hypothermia cannot always be determined.
	  o Despite those limitations, the data still shows that a meaningful number of trauma patients are arriving hypothermic.
	  o There is a push to improve the quality of the data and to place greater emphasis on keeping patients warm in the out-of-hospital phase while also preventing hypothermia in the trauma bay.
	• Another major initiative is prioritizing resuscitation over airway management and reinforcing a true CAB approach.
	  o Noted that some patients who might previously have been intubated early may improve with resuscitation using fluids, and preferably whole blood, before airway intervention is pursued.
	• Reducing large volume IV fluid administration is also a priority.
	• Expansion of whole blood programs in the prehospital setting remains another major focus area for the coming year.
	
	Amanda Loreti
	• No updates were provided at this time.	

Hospital Reports		

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person

Bon Secours (Southern)	**Craig Bride** *(Southern Facilities)*
	• Nothing to report for the southern Bon Secours facilities.
	
	Kate Schulz *(Bon Secours Southside Medical Center)*
	• Trauma bay renovations are underway.
	  o During construction, only one trauma bay may be available for a short period of time.
	  o The renovation work is expected to take less than one month from start to finish.
	• Kelley plans to rotate off and asked Kate to attend in her absence.	

HCA	**Diana Jewett** • No updates were provided and other HCA colleagues were invited to add anything further if needed. **Whitney Cipriani & Emma Spruill** *(*Chippenham Hospital) • No updates were provided. **Hannah Lawrence** *(Henrico Doctors' Forest Campus)* • No updates were provided at this time.	
VCU Medical Center	**Beth Broering** • Shared that the annual trauma symposium will be held later this year. • The call for abstracts and registration are currently open. • Information on abstract submission and registration will be sent out for distribution with the minutes. • Karen Shipman was identified as the lead coordinator for the symposium.	
OEMS Region 6 / Old Dominion EMS Alliance Report		
ODEMSA	**Ryan Scarbrouhg** • This was Ryan's first time facilitating the Performance Improvement Committee meeting.	

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person

	• ODEMSA is in the process of hiring a Training Director and a Field Coordinator. Interviews have been completed and conditional job offers have already been extended.
	• ODEMSA is also looking at the development of a regional whole blood program, which should move forward later this year.
	• Invited committee members to identify any performance metrics that may have been missed so they can be reviewed at a future meeting.
	
	Heidi Hooker
	• As part of the statewide restructuring, the Commonwealth moved from eleven regional EMS councils to seven.
	• Members will begin seeing the region referred to as EMS Region 6 or VDH OEMS Region 6 in future communications and contract-related documents.
	• No committee requirement changes are anticipated for this committee as a result of the restructuring.
	• Existing standing ODEMSA committees will remain in place, though deliverables may need clarification.
	  o A Health and Wellness Committee will be added.
	  o The Pharmacy Committee has been disbanded because the regional drug box program has ended.
	  ▪ Medication and pharmaceutical guidance moving forward will be addressed through the Medical Direction Committee, which will include pharmacist participation.	

Old Business		
PI Quarterly Report Overview	• Ryan Scarbrough presented the quarterly regional Performance Improvement report summarizing EMS data submitted to the Virginia State EMS Repository. • Explained that the report provides a system-level overview of EMS activity, documentation patterns, and clinical performance measures across agencies in the region. • Noted that the intent of the report is to help identify opportunities for improvement in both patient care and documentation practices. • Requested feedback from the committee regarding additional data elements or ways the report could be improved for future meetings.	None identified during this section.

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	Mike Watkins • Commented that the report contains a significant amount of information and committee members may need additional time to review some of the measures more thoroughly. **Allen Yee** • Expressed appreciation for the effort involved in compiling the report and noted that the information is useful for understanding trends in regional EMS performance.	
EMS Call Summary	**Destinations** • Reviewed destination patterns for patient transports and noted that some transports appear to be going to facilities outside typical regional patterns. **Committee Discussion** • Noted that some facilities listed in the data appear unusually far from the agencies normally operating within the ODEMSA region. • Members discussed the possibility that some interfacility transport agencies may be contributing incidents that appear as 911 transports within the dataset. **Amanda Loreti** • Noted that definitions and data element descriptions used within the EMS dataset are defined within the NEMSIS data dictionary. • Shared the reference document containing the NEMSIS 3.5 extended data definitions with the committee. o All NEMSIS data element definitions and documentation requirements can be found in the NEMSIS data dictionary: https://nemsis.org/media/nemsis_v3/release-3.5.0/DataDictionary/PDFHTML/EMSDEMSTATE/Extended%20Data%20Definitions.pdf	• Review incidents where interfacility transport agencies may be configured within their ePCR systems as 911 response agencies, which may be causing IFT transports to appear within 911 response data and skew destination reporting. Responsible Person: Ryan Scarbrough
Cardiac Measures	**Regional Cardiac Measures** **Tom Ludin** • Explained that some agencies have historically documented DOA patients as cardiac arrest events by selecting "Yes" in the cardiac arrest field.	Provide education to EMS agencies on the correct documentation

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	• Noted that under the NEMSIS specification the cardiac arrest field is actually asking whether a cardiac arrest resuscitation effort was performed. • Clarified that the intent of the field is to document whether the arrest was worked rather than simply indicating that the patient was found deceased. Indicated that his agency will be changing their documentation practices so that DOA cases are not marked as cardiac arrest events. • Added that the Virginia State EMS Repository will reject records where the cardiac arrest field is selected but the primary impression does not indicate cardiac arrest. **Committee Discussion** • Members discussed the need for clearer guidance to agencies on how cardiac arrest documentation fields should be completed to ensure consistency across the region. **AED Use Prior to EMS Arrival** • Reviewed AED application prior to EMS arrival and during EMS response. **Amanda Loreti** • Noted in the meeting chat that changes between NEMSIS 3.0 and NEMSIS 3.5 updated how AED application is documented, particularly regarding who applied the AED. **Committee Discussion** • Noted that Planning District 15 includes a large rural area where public access AEDs may be less available due to fewer public buildings and greater geographic spread. • Asked about the number of cardiac arrest incidents occurring in Henrico County and whether the dataset could identify those numbers specifically. • Greg commented that agencies may benefit from developing heat maps of cardiac arrest locations to better understand where arrests occur and where AED placement may be most beneficial. • Members discussed confusion regarding which documentation field should be selected when documenting who applied the AED. • Clarified that documentation options include EMS Responder (transport EMS) and First Responder (EMS), and providers may be selecting incorrect fields.	fields for identifying who applied an AED, including clarification of the NEMSIS 3.5 fields for EMS Responder (transport EMS) versus First Responder (EMS). Responsible Person: Ryan Scarbrough

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
Pediatric Measures	**Allen Yee** • Commented on pediatric patient management considerations, noting that EMS providers must evaluate whether it is appropriate to remain on scene for treatment or rapidly transport depending on the patient's condition. • Emphasized that pediatric patients may require rapid transport in certain circumstances rather than prolonged on-scene interventions, but data show better outcomes when the arrest is worked on scene.	None identified during this section.
Stroke Measures	**Overview of Stroke Scale Performance** **Committee Discussion** • Mike discussed the regional stroke scale used within the ODEMSA region and the importance of proper documentation when assessing suspected stroke patients. • Dr. Yee noted that providers must ensure the regional stroke scale is documented correctly to support appropriate triage and patient destination decisions. • Tom discussed the importance of consistent stroke scale documentation when evaluating stroke patients. • Members discussed the use of the VAN stroke assessment and how proper documentation of stroke scale findings supports stroke system activation and hospital preparation. **Pre-Arrival Alert or Activation** • Reviewed documentation of pre-arrival alerts or activations for suspected stroke patients. **Committee Discussion** • Members discussed that some alerts documented in the dataset may reflect trauma activations rather than stroke alerts depending on how the data fields were completed.	None identified during this section.
Trauma Measures	**Pain Management** • Tom asked whether a GCS filter had been applied to the dataset to account for patients who may be unconscious or otherwise unable to report a pain score.	• Evaluate applying a GCS or mental status filter

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	• Noted that an unresponsive patient cannot report a pain level using a standard pain scale. • Mike recommended breaking out the data in future reports to account for patients who cannot provide a pain score due to altered mental status. **Overview of Pain Management Effectiveness** • Reviewed documentation showing the effectiveness of pain management interventions. **Committee Discussion** • Members noted that accurate analysis requires documentation of at least two pain scores or change filter to be for changes, unchanged, or worsened. • Clarified that pain scores should be documented prior to medication administration and again following treatment to demonstrate effectiveness of the intervention.	in future reports when reviewing pain score documentation to account for patients who are unable to provide a pain score. Responsible Person: Ryan Scarbrough
Seizure Measures	**Overview of Seizure Intervention Performance** • Reviewed seizure-related patient care measures. **Committee Discussion** • Members discussed that patients may still be actively seizing when 911 is called but may be postictal upon EMS arrival. • Noted that in these cases the patient experienced a seizure but may not require medication administration because the seizure activity has already stopped. **Seizure Interventions by Age Group** • Dr. Yee discussed pediatric age breakpoints used in the dataset and how they may differ between medical and trauma definitions. • Kate Contributed to the discussion regarding pediatric patient classification within the dataset.	• Review pediatric age breakpoints used in seizure reporting and align definitions with Medical Direction guidance to ensure consistency between medical

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
		and trauma pediatric classifications. Responsible Person: Ryan Scarbrough
New Business		
Trauma Triage Plan Review and Approval	**Mike Watkins** • Introduced the Trauma Triage Plan for review and approval and asked Ryan Scarbrough to provide an overview. **Ryan Scarbrough** • Stated that the current plan needs review to determine what updates and revisions are required. **Beth Broering** • Reported that Appendix B and C require significant updates. • Noted that the trauma center requirements reference appears to be from 2006 and is outdated. • Stated that the map and trauma center listings likely need revision to reflect additional trauma centers, updated trauma center levels, council changes, and demographic updates. **Mike Watkins** • Asked whether the terminology in the plan should be revised to reflect Region 6 rather than ODEMSA. • Stated that the document likely requires major revisions rather than minor edits, including terminology updates, plan scope, and references. • Questioned whether the plan needs to list the entire state's trauma centers or focus on the region and adjacent centers more likely to receive patients from Region 6. • Noted that UVA and Mary Washington should likely be included because agencies may transport patients there.	• **Trauma Triage Plan approval was tabled** pending full review and revision. • **Form a work group** to review the Trauma Triage Plan in its entirety and bring recommended revisions back to the committee. **Responsible Person:** Ryan Scarbrough to coordinate with Mike Watkins and identified stakeholders. • **Update terminology throughout the plan** to reflect Region 6 rather

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	• Stated that air medical transport criteria should be reviewed to ensure consistency with current air medical program expectations. • Noted that Johnston-Willis is no longer a Level III trauma center and that the relevant page will need to be updated. • Stated that whole blood should be incorporated into the plan, particularly given the regional whole blood initiative and agencies already carrying blood products. • Suggested that trauma alert criteria and other key decision points should also be reviewed. • Asked whether language related to mass casualty incidents and natural disasters should remain in the trauma triage plan or be more clearly tied to the separate MCI plan. • Stated that providers would benefit from clearer expectations regarding patient destination determination, especially during large scale incidents. • Noted that air medical representation should be included in the review process to ensure the plan reflects current expectations. **Beth Broering** • Recommended keeping the focus on the region rather than recreating a statewide trauma center reference within the plan. **Allen Yee** • Noted that ACS released updated guidance in 2021 and that the committee is still using an outdated document and graphic. • Suggested including each individual trauma center's criteria as an appendix so EMS agencies can reference them in planning and local protocol development. **Kate Schulz** • Noted that the region already has a separate MCI plan and suggested the trauma triage plan should default to the MCI plan when appropriate. **Travis Jenkins** • Recommended forming a work group to review the trauma triage plan in its entirety and bring proposed revisions back to the committee.	than ODEMSA where appropriate. **Responsible Person:** Ryan Scarbrough. • **Revise outdated trauma center references, maps, trauma center levels, and appendices**, including review of ACS and state updates and council boundary changes. **Responsible Person:** Work group with input from trauma center representatives. • **Review inclusion of whole blood, air medical criteria, and trauma center-specific criteria** within the plan and appendices.

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	Ryan Scarbrough • Stated that he could compile proposed edits if members sent revisions and could also support a work group process.	**Responsible Person:** Work group with trauma center and air medical representation. • **Schedule a work group meeting in March or late April** and return an updated draft to the committee for review at the May meeting. **Responsible Person:** Ryan Scarbrough and Mike Watkins.
Committee Representation and Bylaws Housekeeping	**Mike Watkins** • Raised the issue of committee representation from agencies answering more than 20,000 EMS calls annually under the bylaws. • Noted that he believed the current representation included Chesterfield, Henrico, and Richmond and asked for clarification. **Ryan Scarbrough** • Reported that after reviewing 2025 data, Hospital to Home and American Medical Response appeared to meet the threshold for voting representation. **Allen Yee** • Clarified that any call volume used for committee representation must reflect calls generated within Region 6, not statewide totals.	• **Rerun committee representation eligibility using Region 6 call volume only. Responsible Person:** Ryan Scarbrough. • **Correct the bylaw typo** changing 200,000 calls to 20,000 calls and

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	Ryan Scarbrough • Agreed to rerun the report and verify that only Region 6 call volume is used. • Noted that one bylaw provision contains a typo stating 200,000 calls instead of 20,000 calls. **Mike Watkins** • Stated that the 200,000 call threshold should be treated as a typo and corrected as a housekeeping item. • Reviewed the bylaw language describing voting membership categories, including agency representatives, hospital system representatives, planning district representatives, the Regional Medical Director, and representatives from ODEMSA committees. • Asked whether the Professional Development Committee still exists. **Heidi Hooker** • Clarified that the Professional Development Committee is now the Training and Certification Committee. **Mike Watkins** • Stated that the bylaw language should be updated accordingly. • Asked whether the planning district representative list is current. **Heidi Hooker** • Confirmed that the list exists but needs updating. **Allen Yee** • Stated that planning district representatives should be formally nominated by the sub-councils, not assumed based on attendance at meetings. **Mike Watkins** • Agreed that the sub-councils should identify and nominate their official representatives. • Noted that Training and Certification and Air Medical also need to designate representatives.	Professional Development Committee to Training and Education Committee as a housekeeping item. **Responsible Person:** ODEMSA staff. • **Update bylaw language** replacing Professional Development Committee with Training and Certification Committee. **Responsible Person:** ODEMSA staff. • **Update and verify committee representative lists**, including planning district, Air Medical, and Training and Certification representatives. **Responsible**

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	• Asked for clarification regarding the current Air Medical representative. **Ryan Scarbrough** • Indicated that Greg Jones is intended to serve as the Air Medical representative. **Mike Watkins** • Noted that the 20,000 call threshold still excludes several active agencies with significant volume and stated that broader representation may need future consideration. • Suggested reaching out to Kelly Schaf or Kelly Rumsey at Henrico regarding continued participation and representation. **Tom Ludin** • Noted that he had invited another participant to help with quorum and was not aware of the call volume cutoff. **Mike Watkins** • Stated that he and Ryan could work offline to update the representation list and reach out to affected parties.	**Person:** Ryan Scarbrough and Mike Watkins. • **Request formal nominations from the sub-councils** for planning district representatives. **Responsible Person:** Sub-councils, with ODEMSA staff to coordinate outreach.
Use of Data for System Improvement	**Allen Yee** • Stated that the committee must move beyond reviewing data and should use the information to complete the full Plan, Do, Study, Act (PDSA) cycle. • Emphasized that the committee should identify a data point, implement an intervention, study the results, and then act on the findings rather than simply reviewing reports. • Suggested that if a metric such as dexamethasone use or another medication trend is identified as an issue, the committee should consider pushing out education or another system-wide intervention and then reassess the results. **Mike Watkins** • Agreed and suggested evaluating before and after comparisons related to the pharmacy change, particularly for medications such as dexamethasone and fentanyl.	• **Identify one or more priority data points for intervention** and begin using a formal PDSA cycle approach for committee quality improvement work. **Responsible Person:** PI Committee leadership with

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
	• Noted that some agencies have likely increased dexamethasone use since it became more accessible and that fentanyl use has also increased. • Stated that applying system-wide change across the region will be more challenging than doing so within progressive individual EMS agencies, but agreed the committee should move in that direction.	committee input. • **Consider medication trend review before and after the pharmacy change**, including dexamethasone and fentanyl use, for possible future PI work. **Responsible Person:** PI Committee and Ryan Scarbrough for future data review.
Adjourn		
	• Announced that the next meeting will be held on **May 13, 2026 at 1400 hours**. • Adjourned the meeting at 2:35 PM and thanked members for their participation.	**Next meeting:** May 13, 2026 at 1400 hours. Motion to adjourn made by Connie More; Seconded by Beth Broering. **Motion Passed**

www.odemsa.net
804.560.3300
ODEMSA@vaems.org

OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Quarterly Performance Improvement Report

Reporting Period

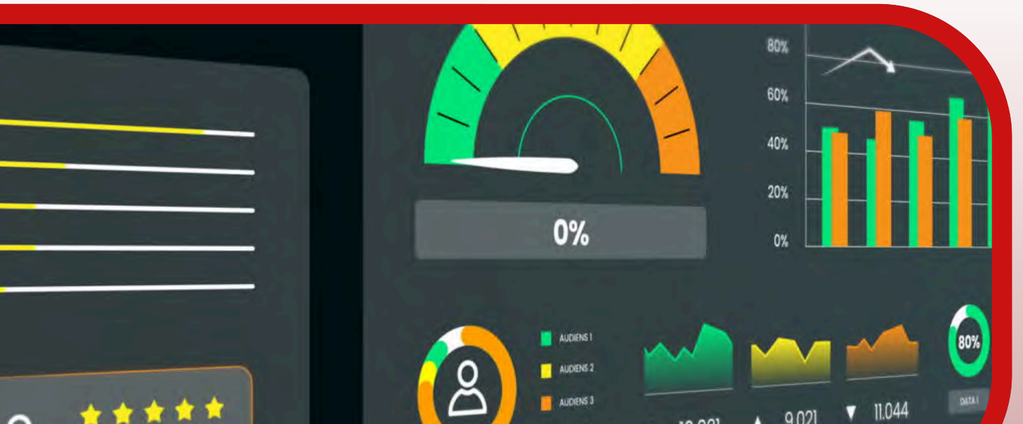
Q4 2025

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.

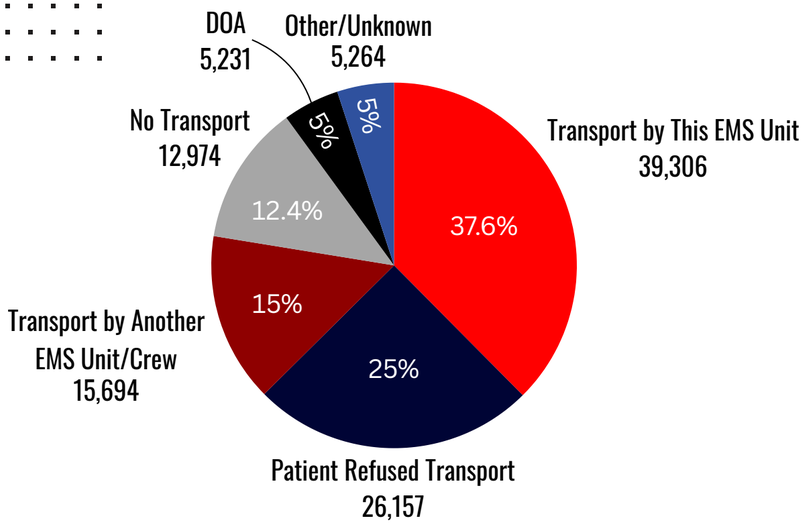


- Cardiac Measures
- Pediatric Measures
- Stroke Measures
- Trauma Measures
- Seizure Measures

OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

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						
	Intercept	Mutual Aid	Prim Resp Area	Public Assist	Standby	Support Srvs	Total
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**

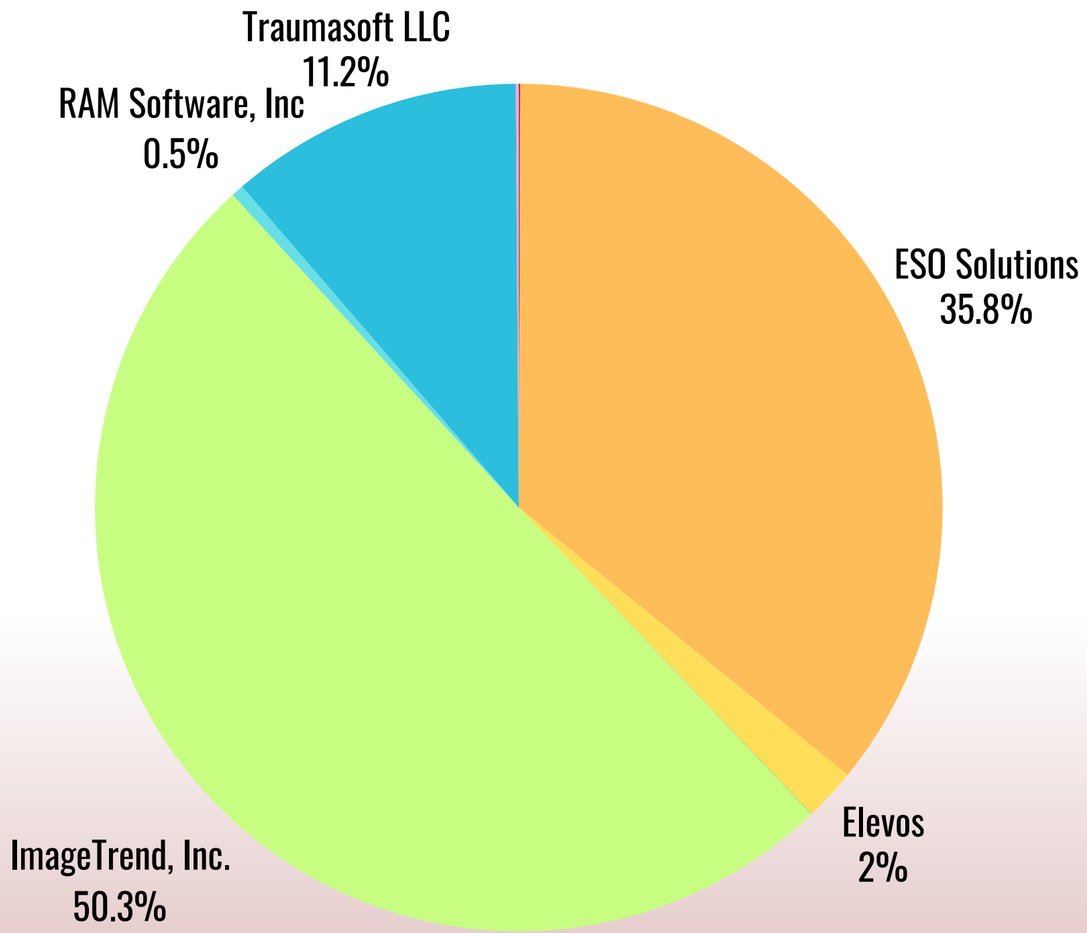
Data from ESO, NEMSIS 3.5

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**

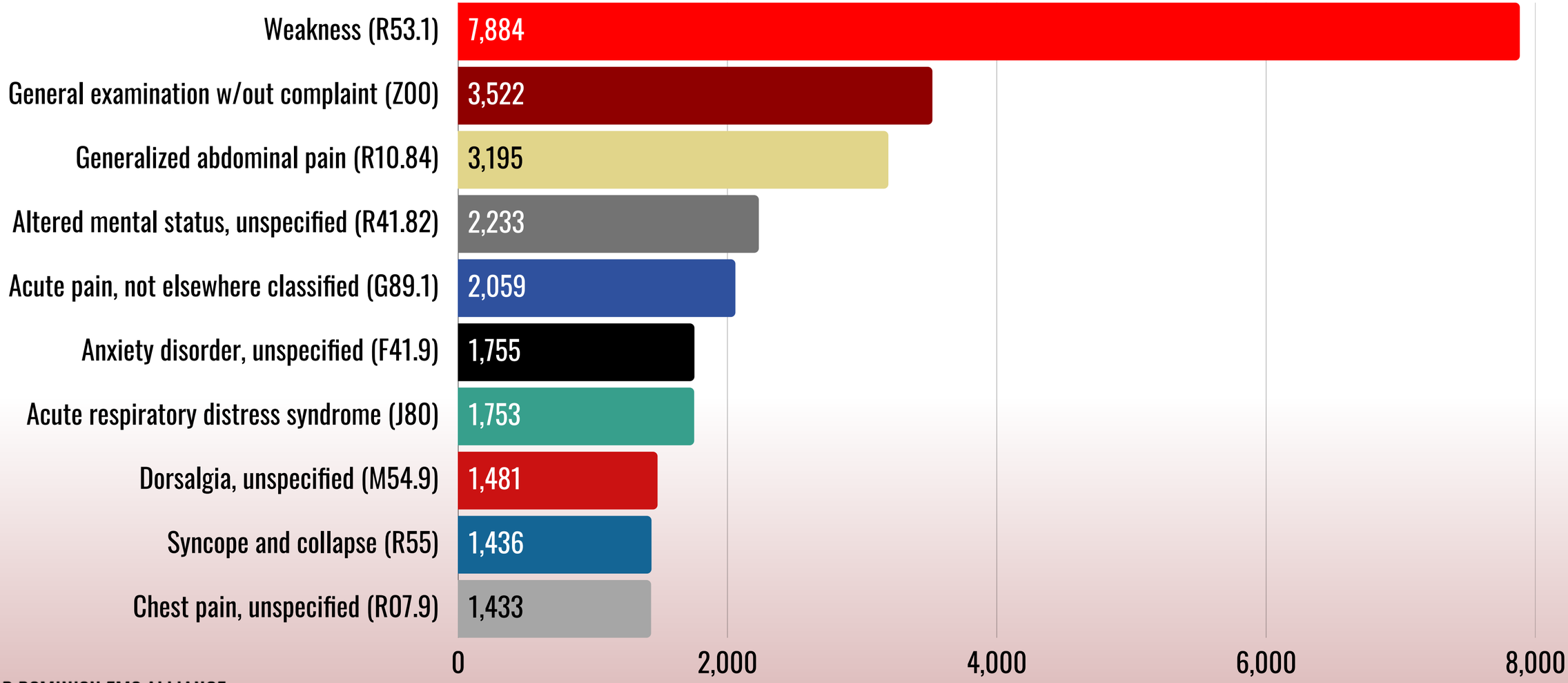
Total Submissions by Vendor



Data from ESO, NEMSIS 3.5

Top 10 Primary Impressions

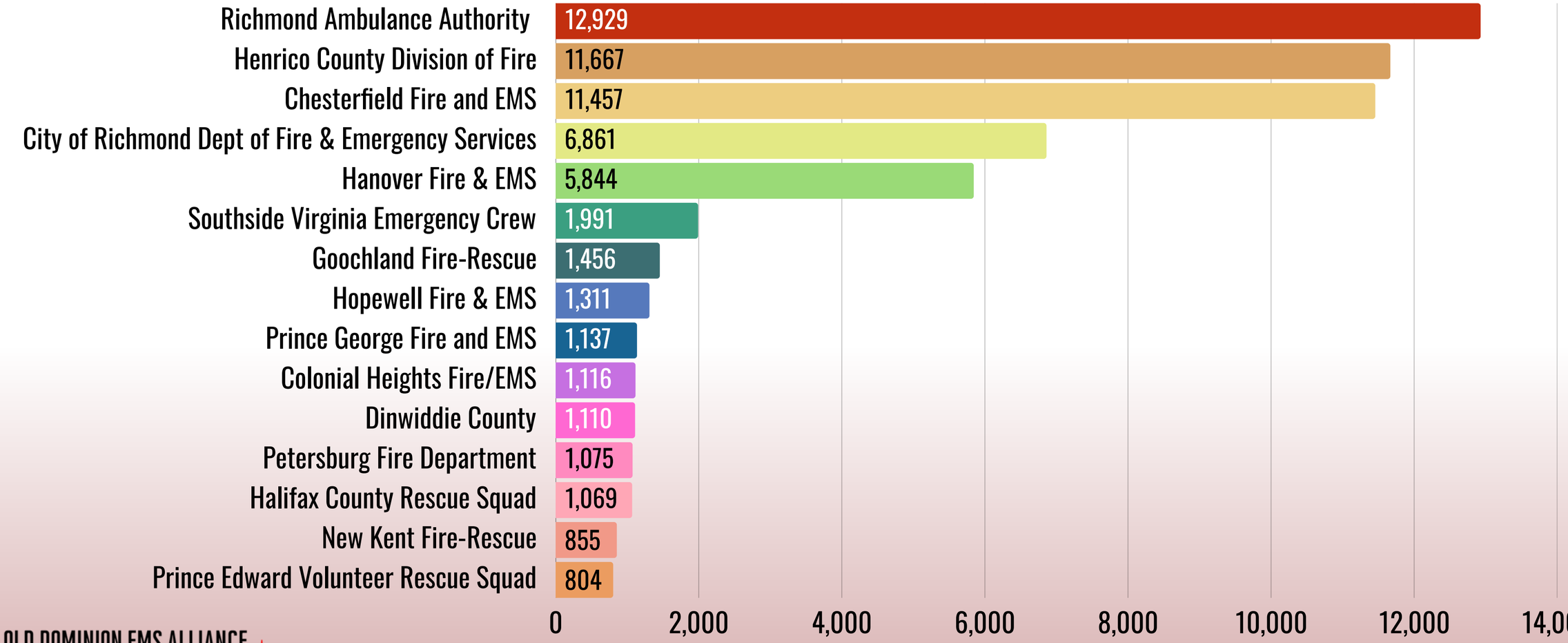
This slide shows the Top 10 Primary Impressions across our region based on aggregated patient care data pulled by the Provider Primary Impression (eSituation.11). These represent the most common conditions encountered by EMS providers.



Data from ESO, NEMSIS 3.5

Call Volume by Agency (Top 15)

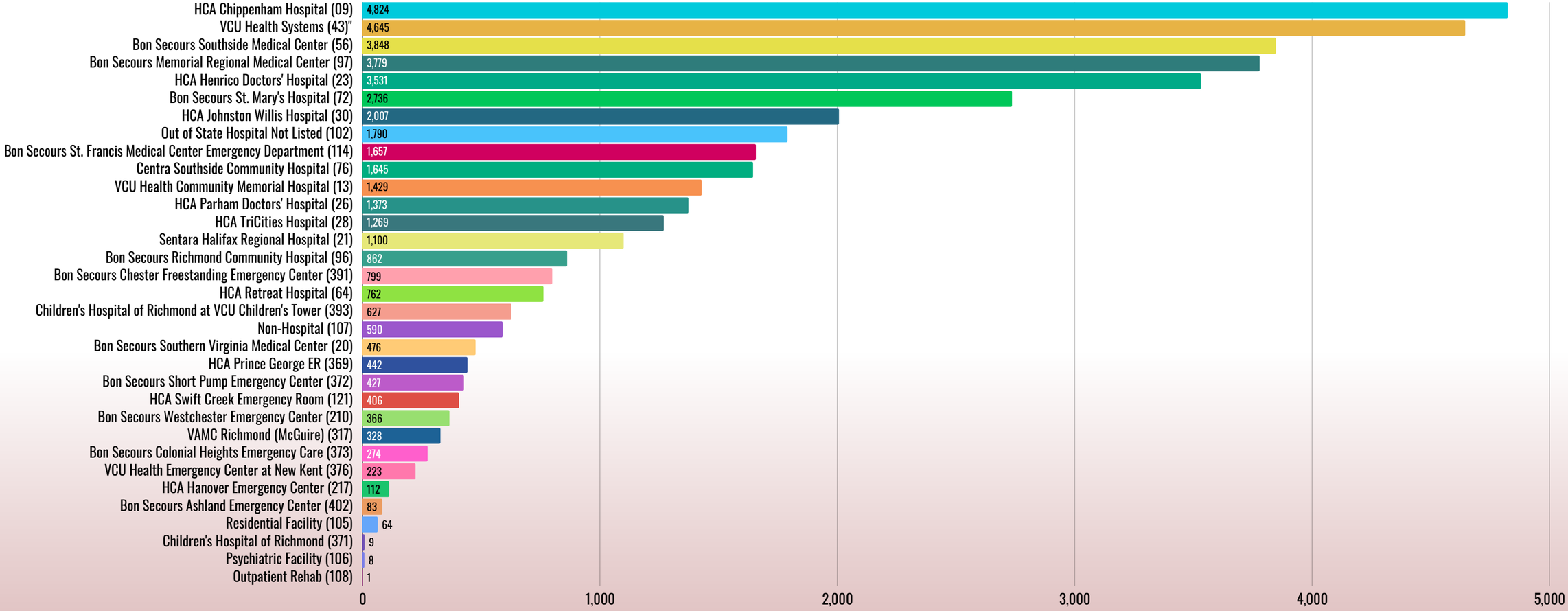
This chart displays the Top 15 agencies in the region by call volume. It provides an overview of the total number of calls run by agencies over the past quarter.



Data from ESO, NEMSIS 3.5

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 NEMSIS 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.

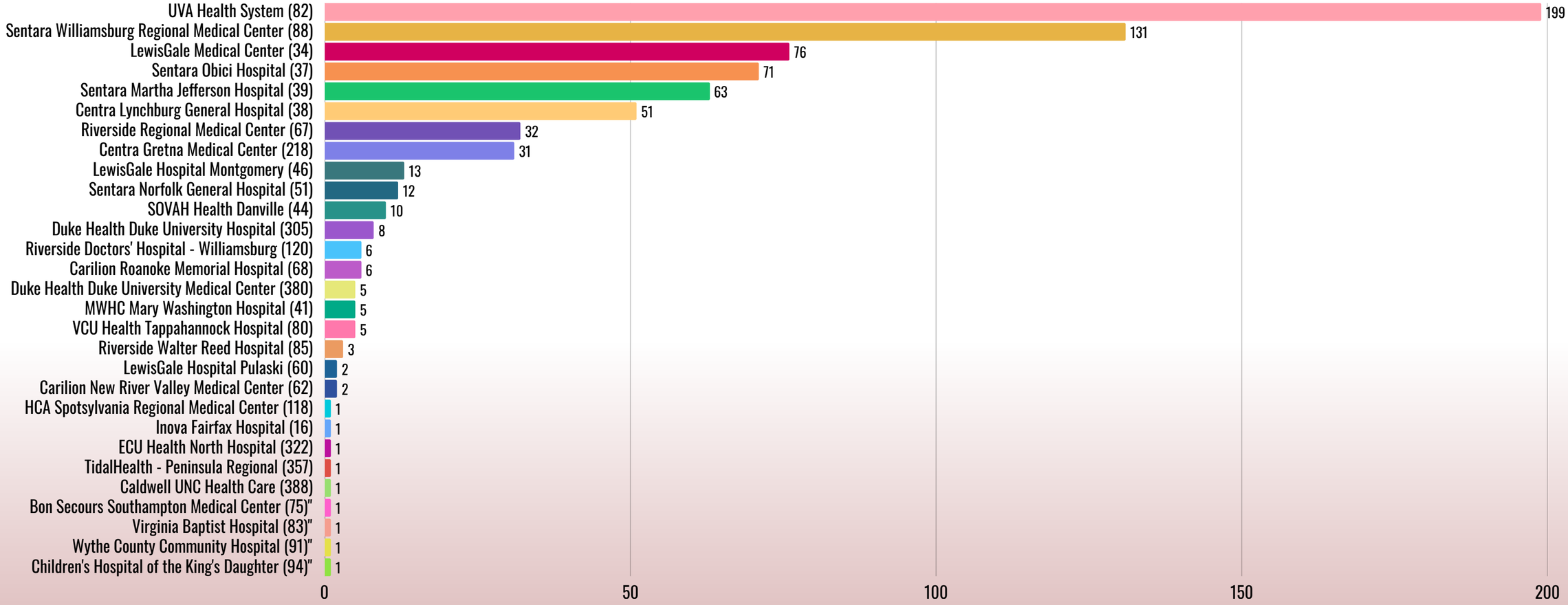


https://nemsis.org/media/nemsis_states/repository.html?repository=virginia&file=Resources/VA_StateDataSet.xml&at=refs%2Fheads%2Frelease-3.5.0#Facilities

Data from ESO, NEMSIS 3.5

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.

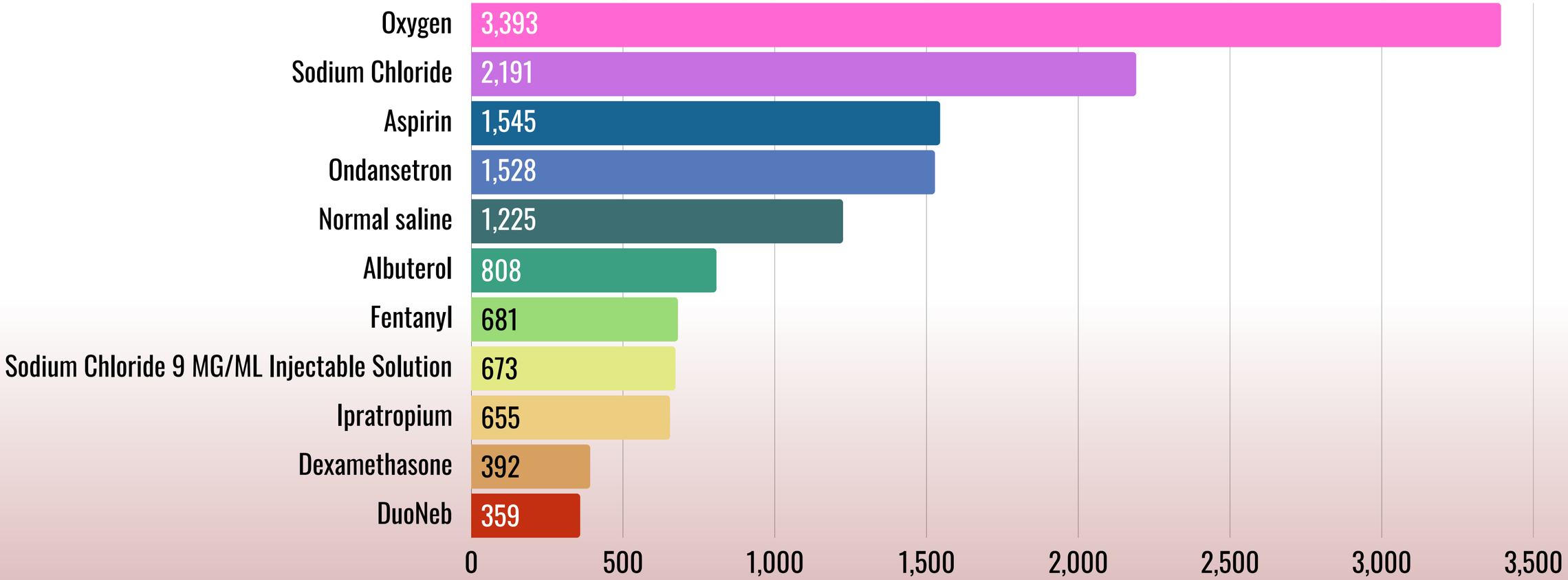


https://nemsis.org/media/nemsis_states/repository.html?repository=virginia&file=Resources/VA_StateDataSet.xml&at=refs%2Fheads%2Frelease-3.5.0#Facilities

Data from ESO, NEMSIS 3.5

Top 10 Medications Administered

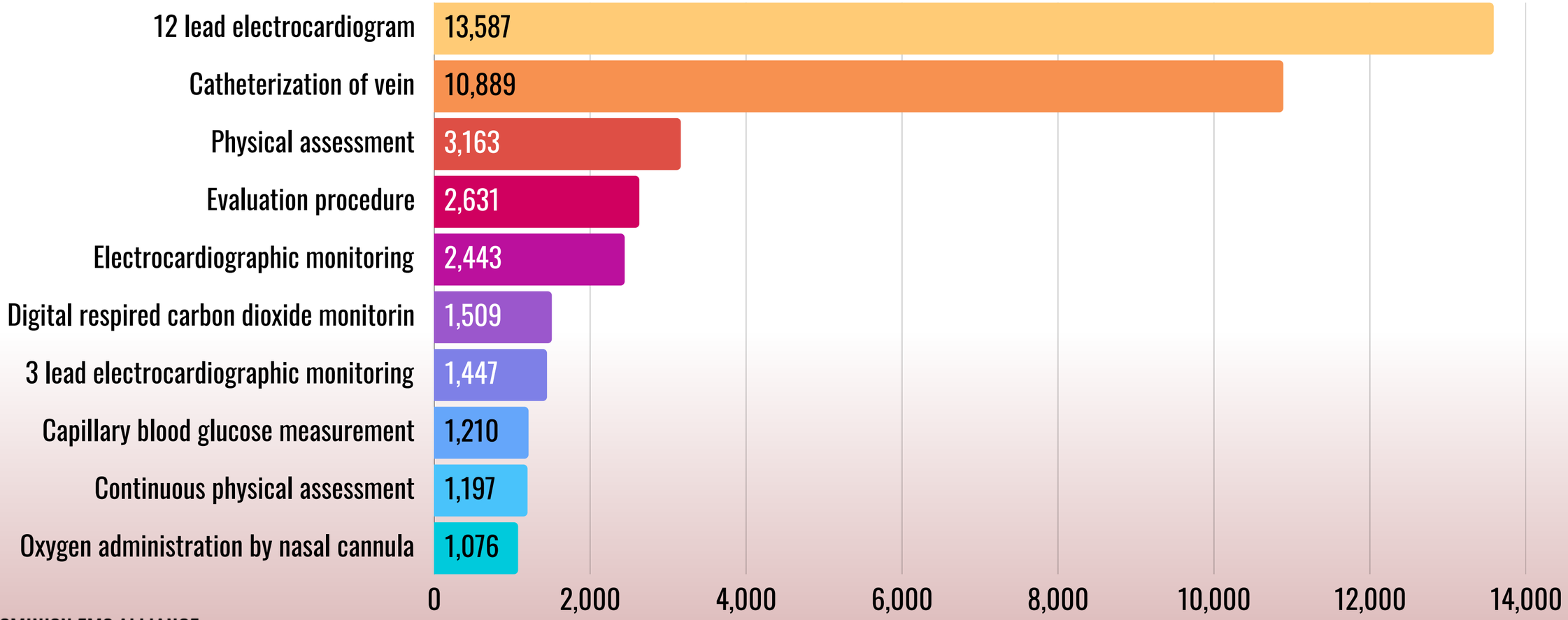
DuoNeb administration counts may be overreported, as some providers may select the trade name rather than documenting the individual components (albuterol and ipratropium) when both medications are administered together. Additionally, it is possible that Sodium Chloride 9 mg/mL Injectable Solution (only 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.



Data from ESO, NEMSIS 3.5

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.

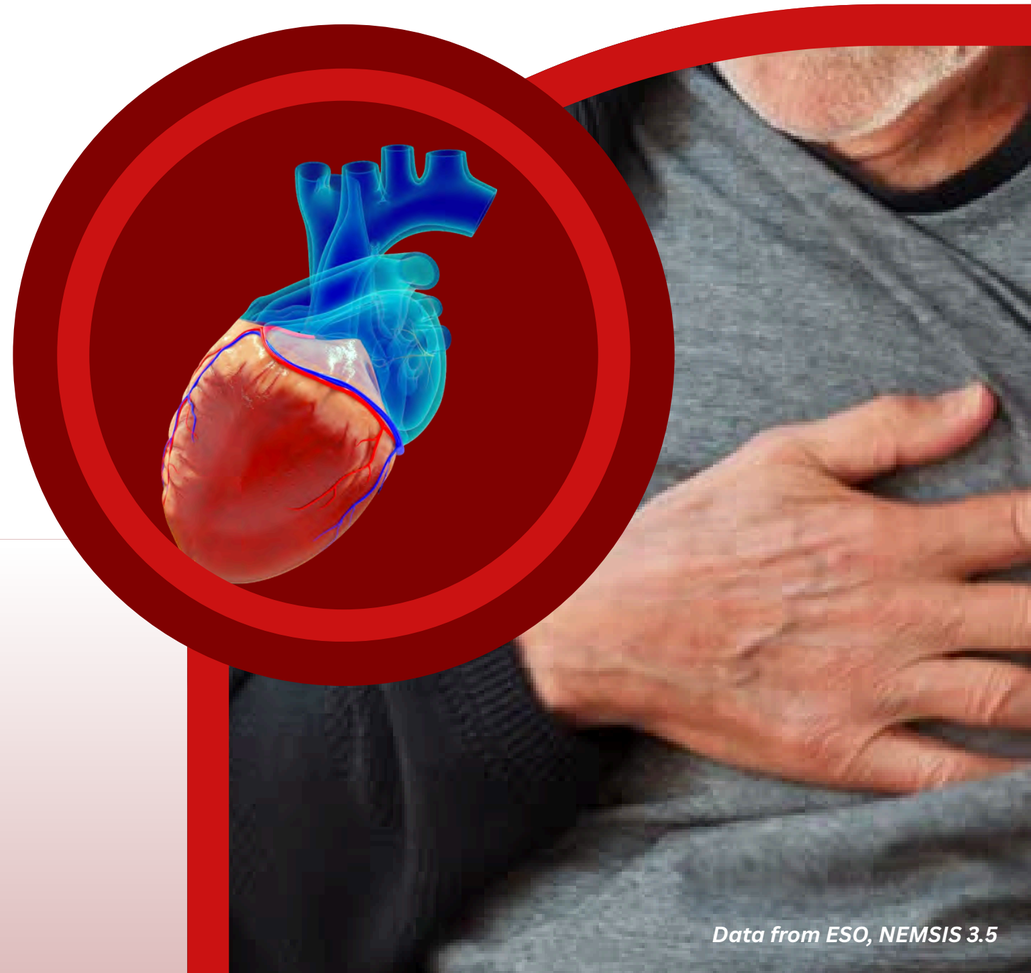


Data from ESO, NEMSIS 3.5

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**



OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

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)

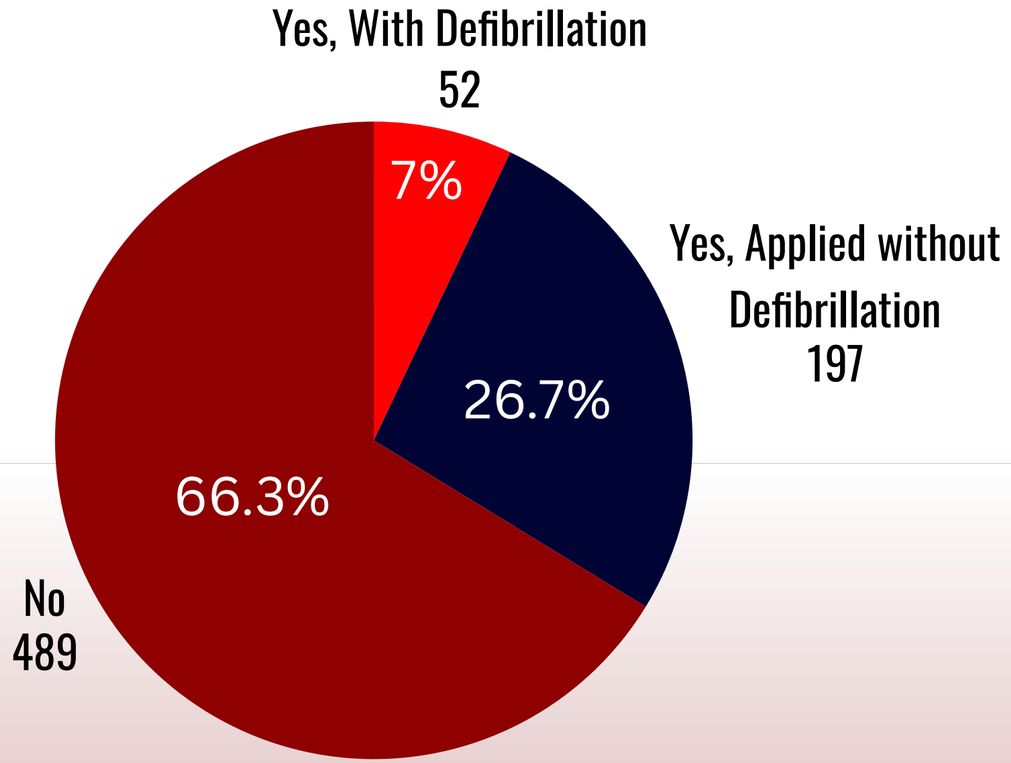
44 Respiratory Arrest (R09.2)

Data from ESO, NEMSIS 3.5

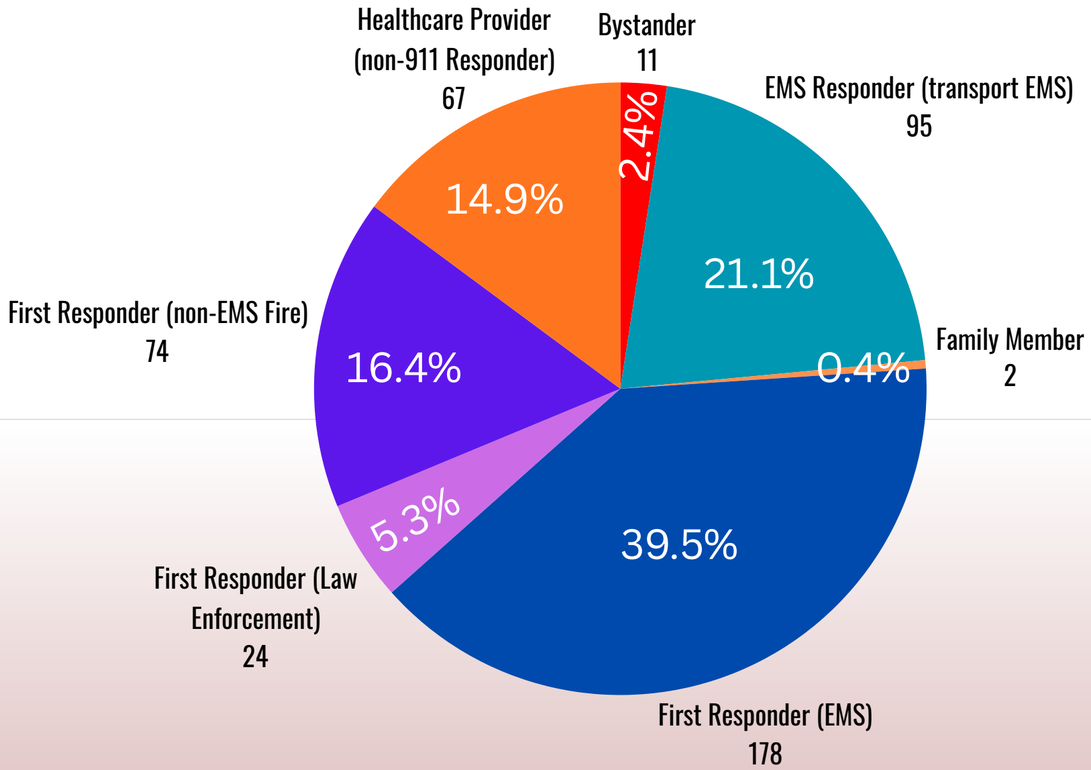
OEMS REGION 6 CARDIAC MEASURES

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?



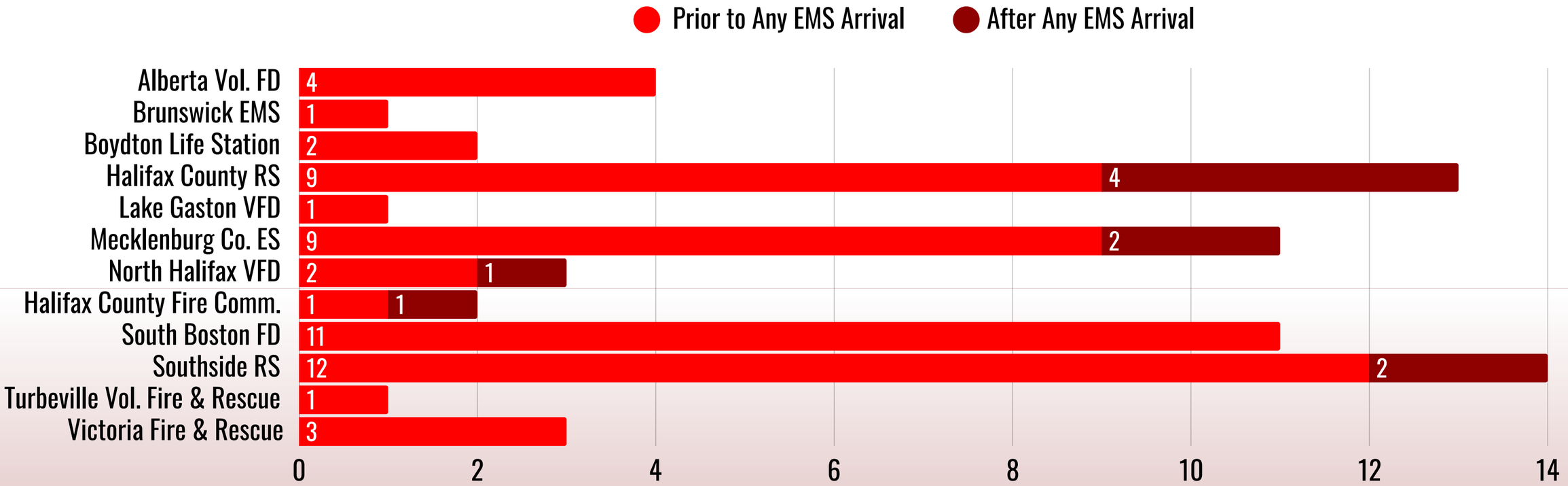
405 selected N/A

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).

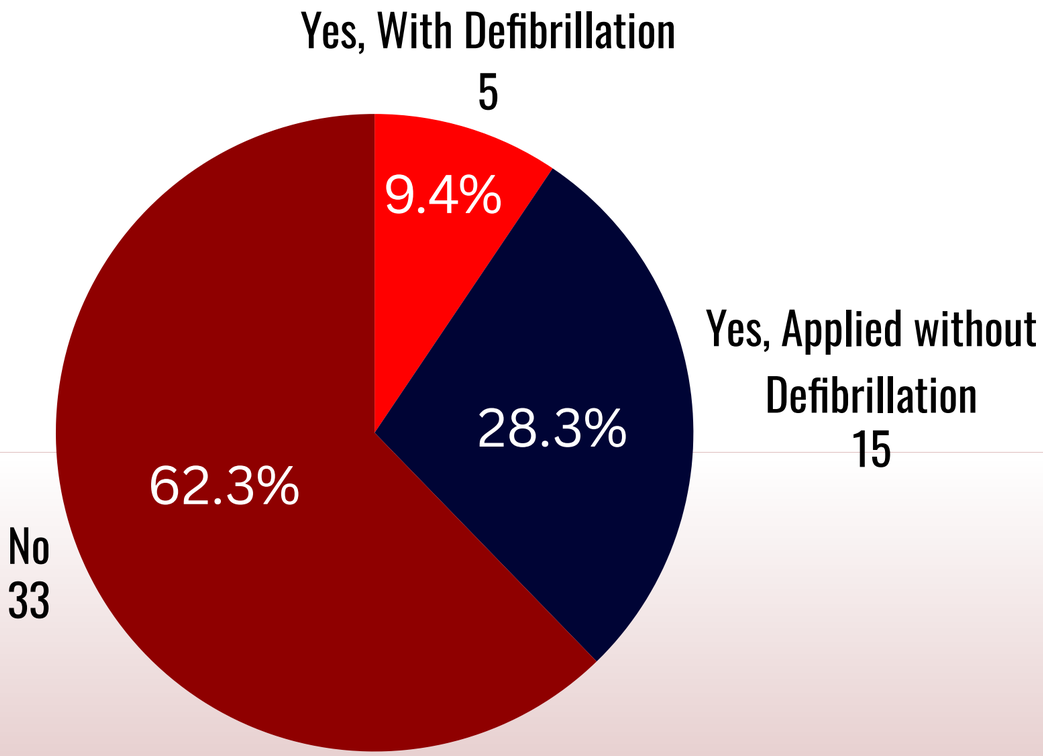


Data from ESO, NEMSIS 3.5

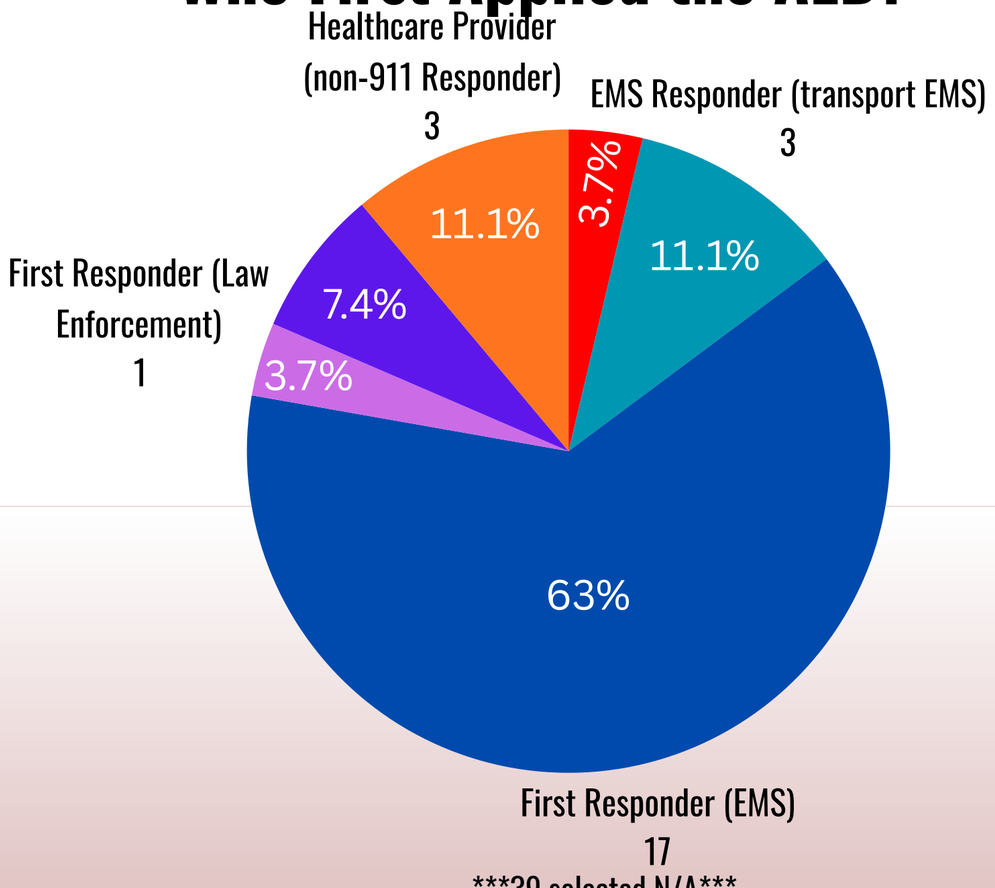
OEMS REGION 6 CARDIAC MEASURES

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?



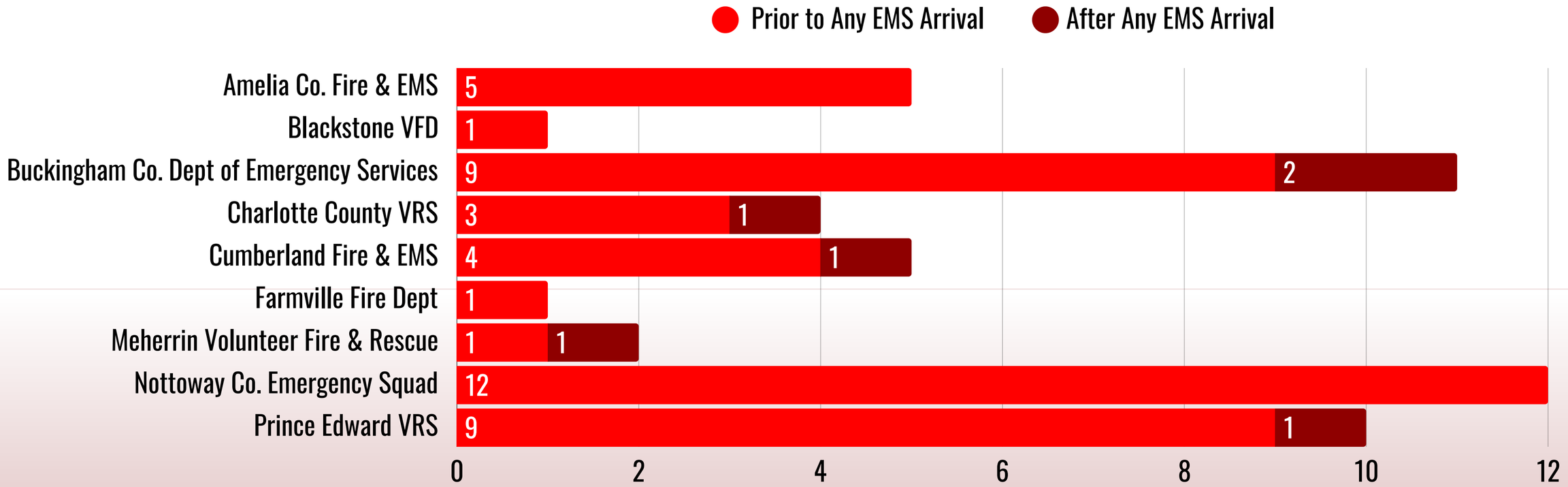
OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

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).

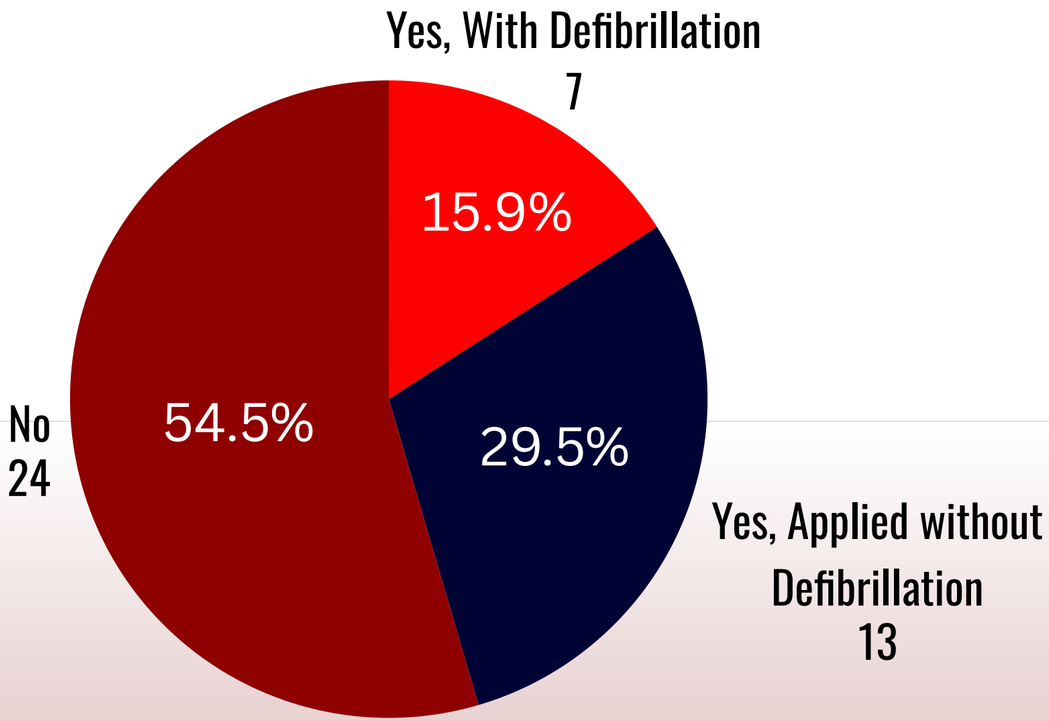


Data from ESO, NEMSIS 3.5

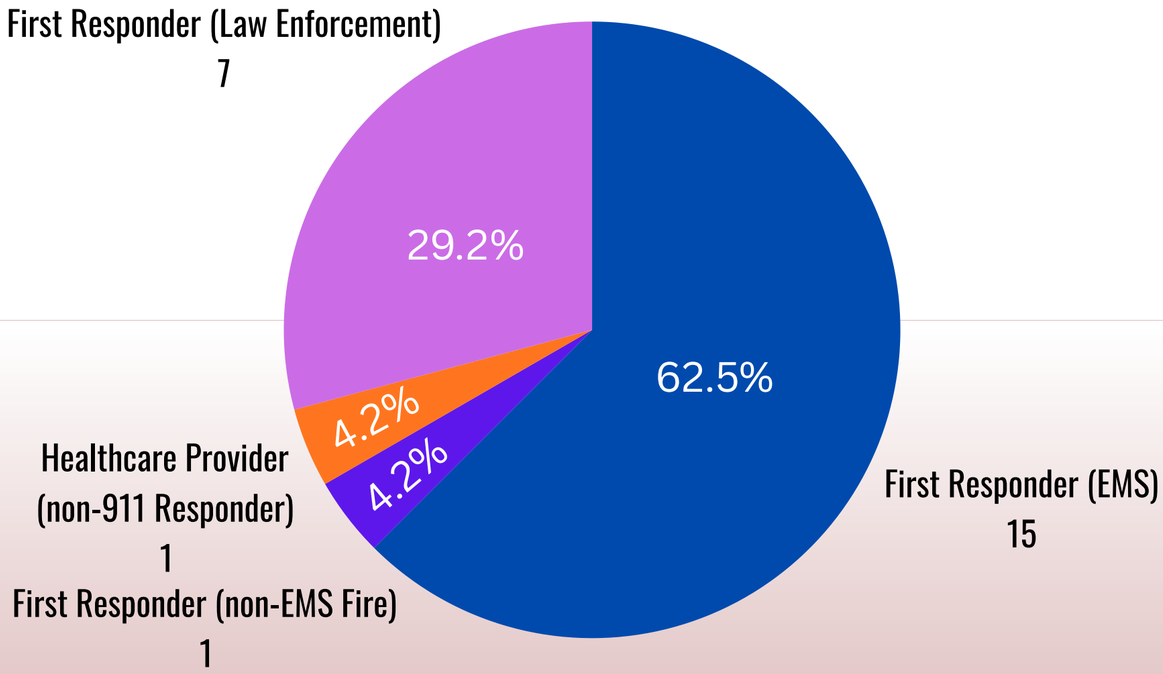
OEMS REGION 6 CARDIAC MEASURES

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?



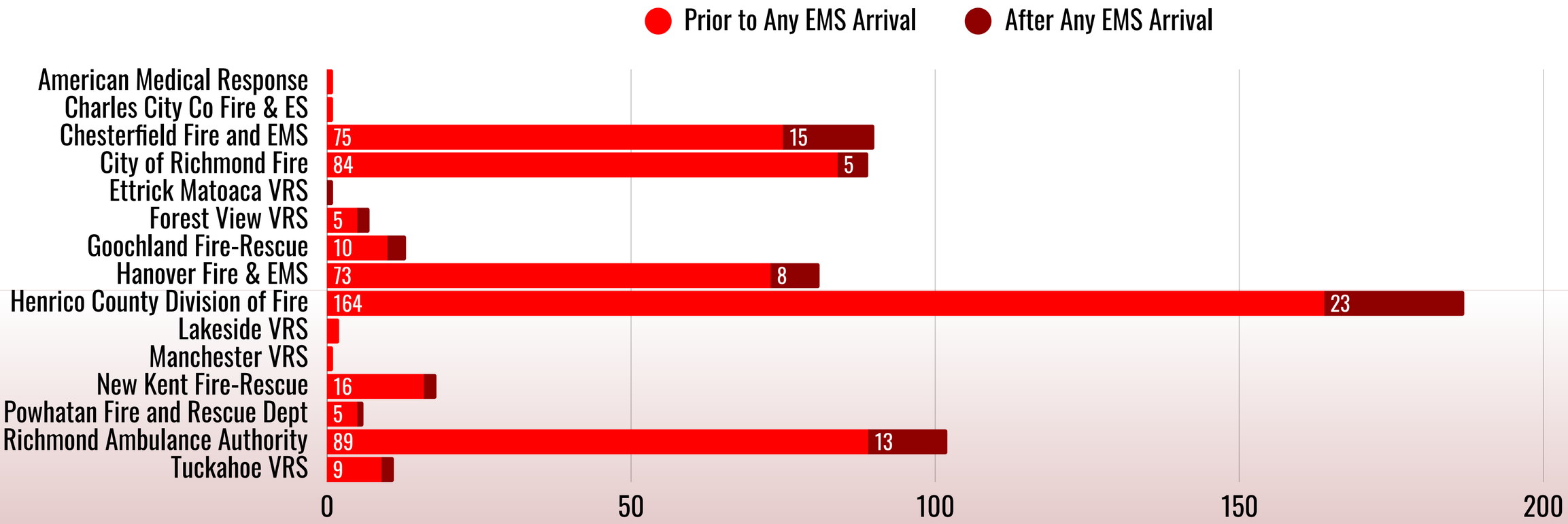
27 selected N/A

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).

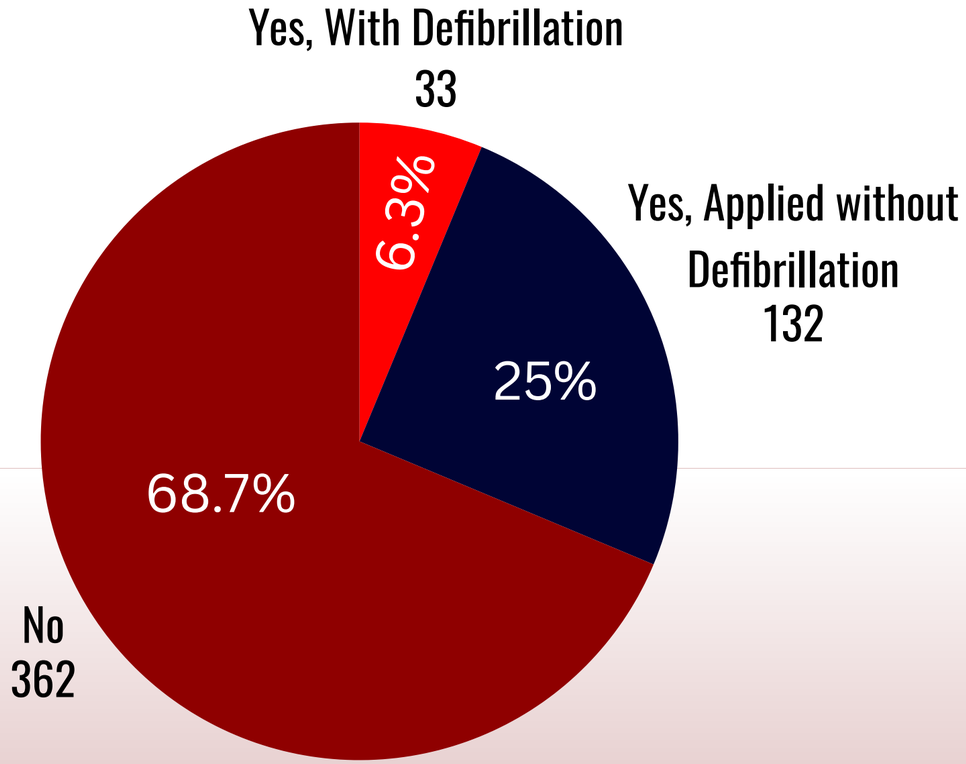


Data from ESO, NEMSIS 3.5

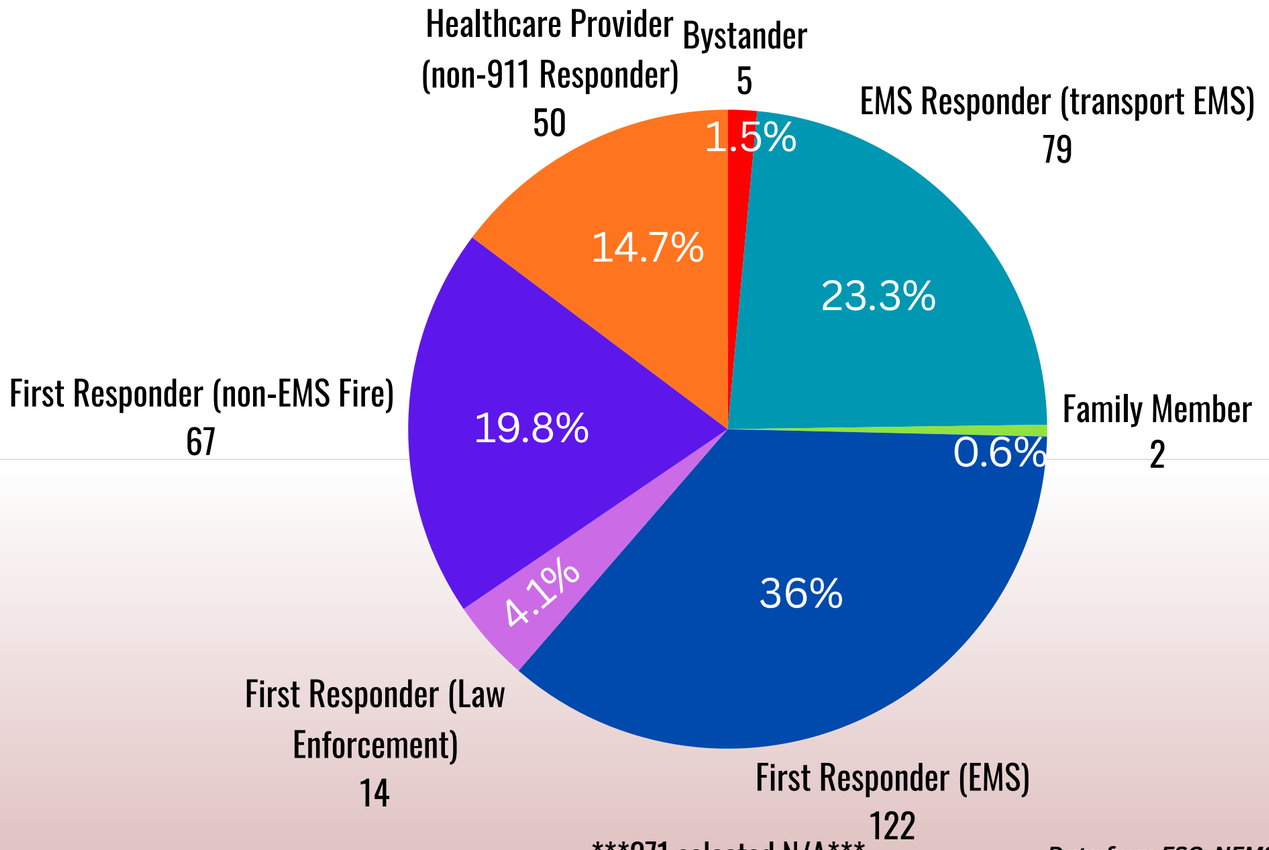
OEMS REGION 6 CARDIAC MEASURES

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?

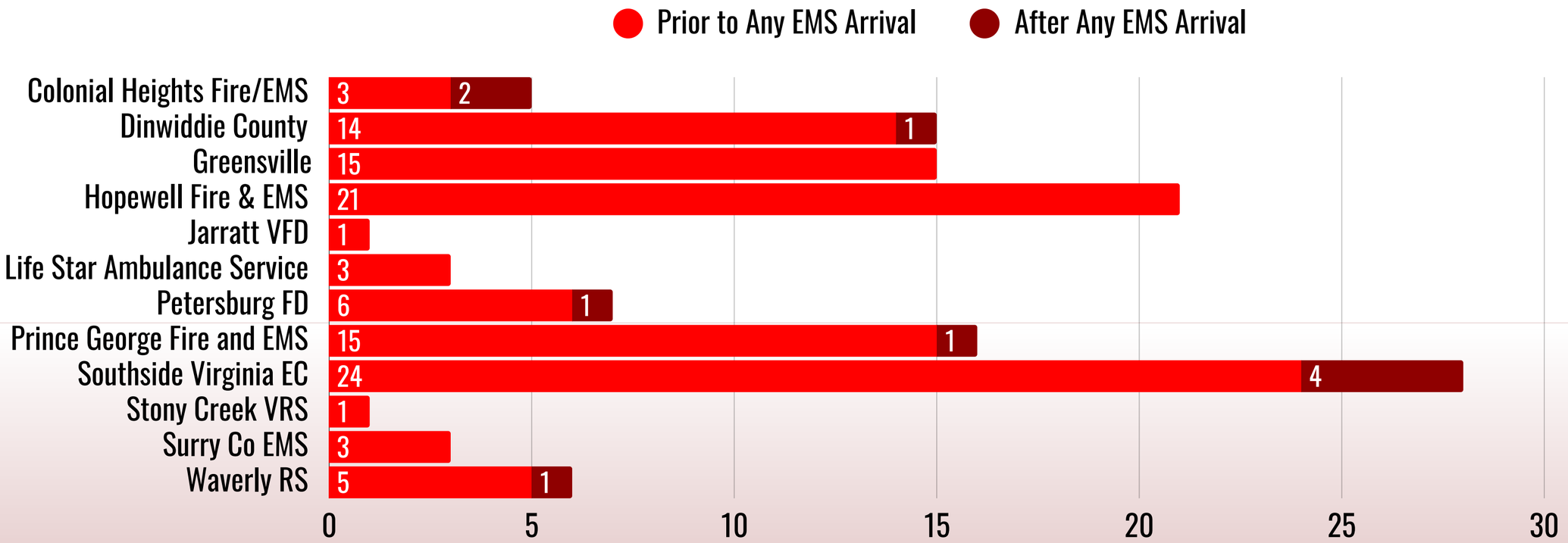


Data from ESO, NEMSIS 3.5

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).

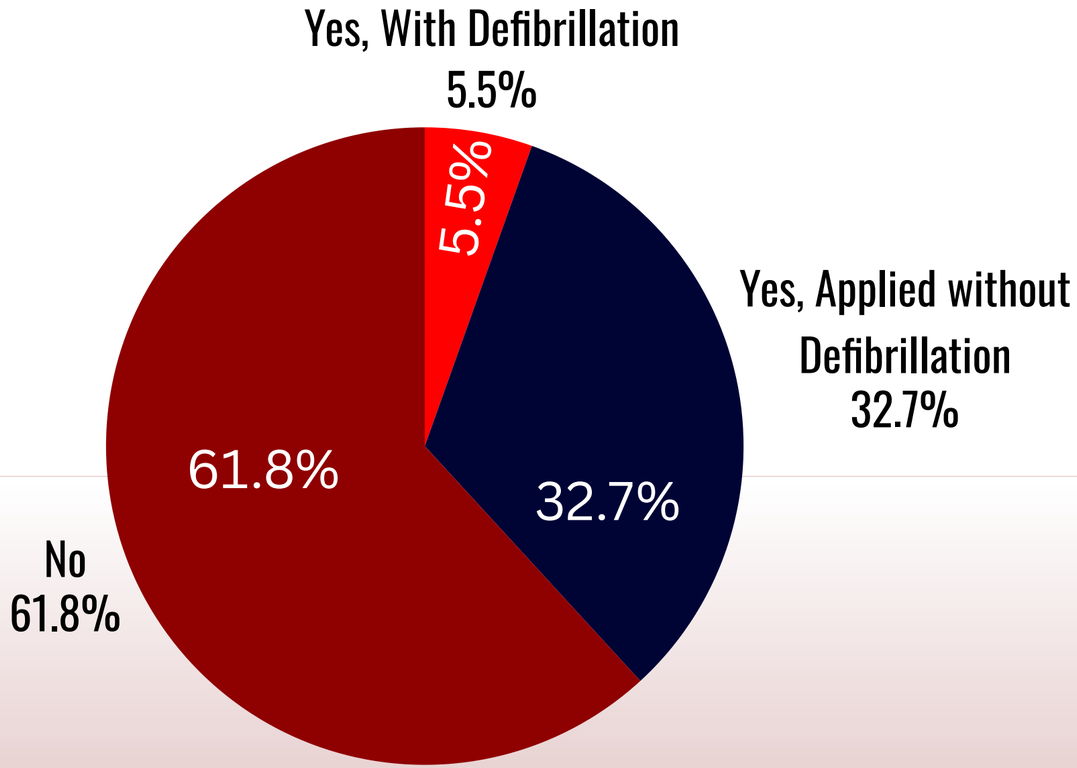


Data from ESO, NEMSIS 3.5

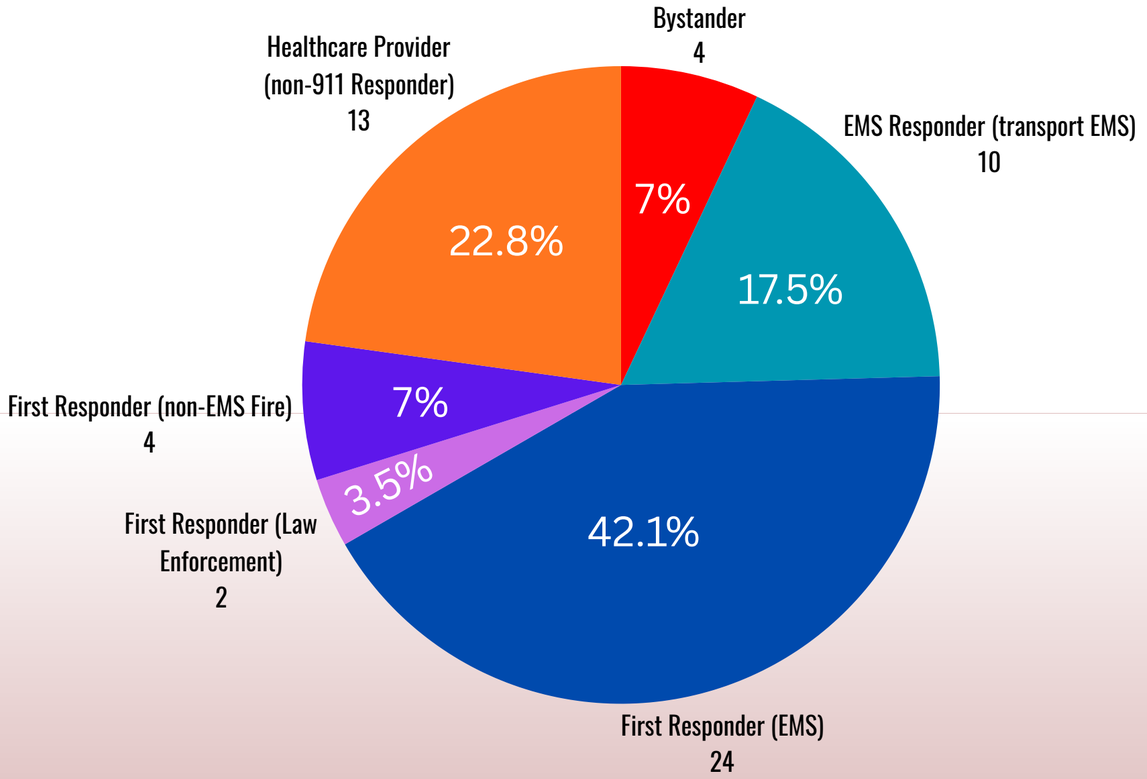
OEMS REGION 6 CARDIAC MEASURES

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



Who First Applied the AED?



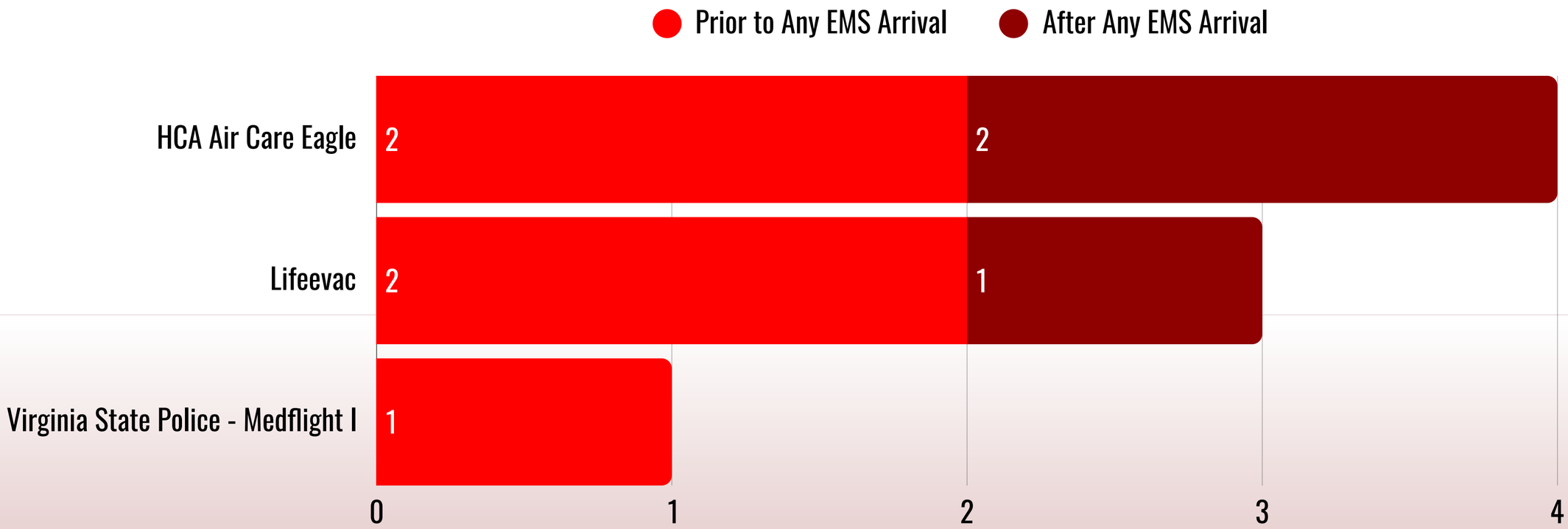
64 selected N/A

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)

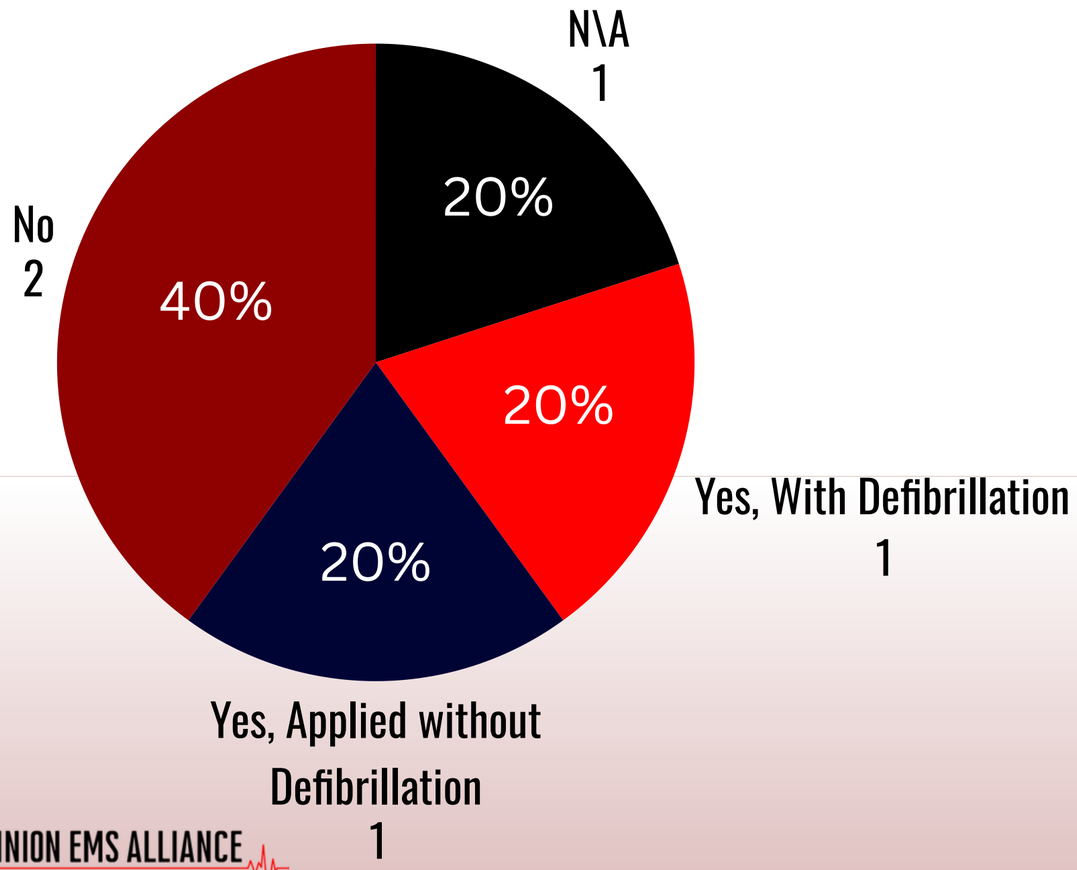


Data from ESO, NEMSIS 3.5

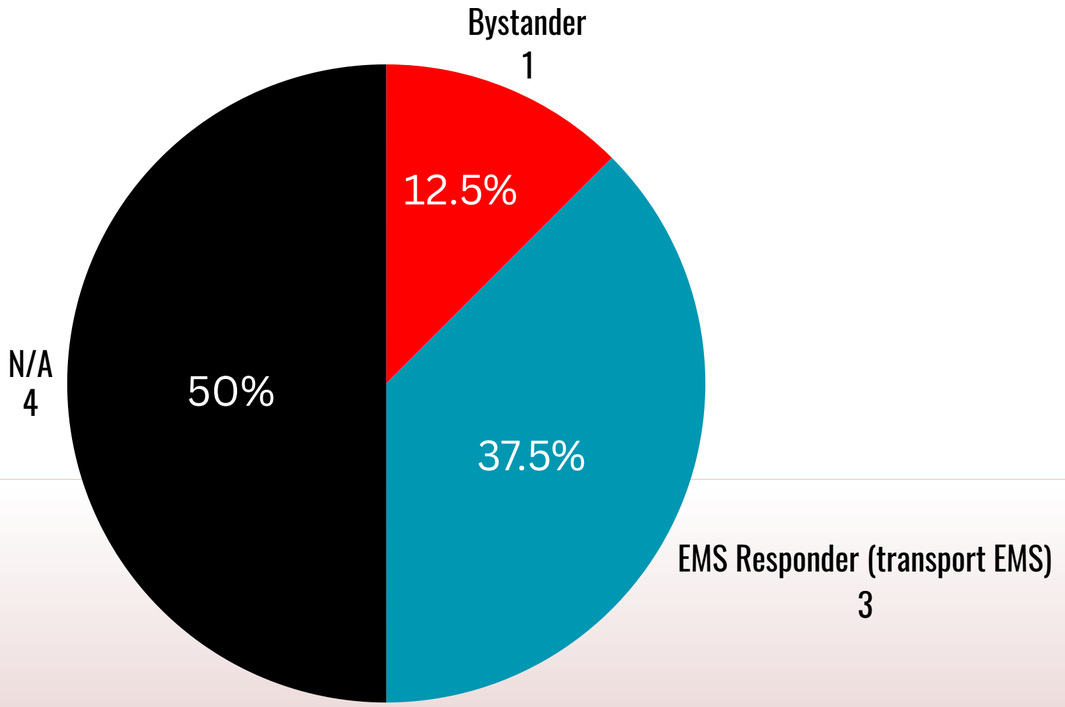
OEMS REGION 6 CARDIAC MEASURES

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

OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

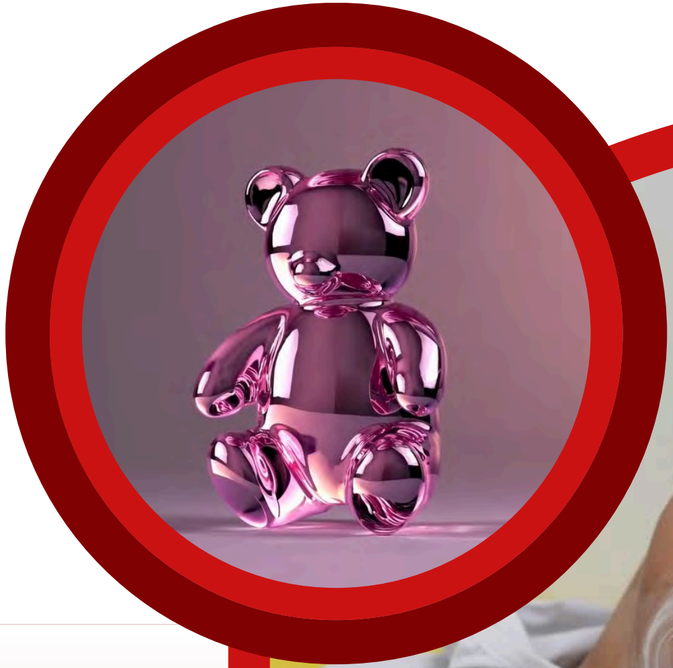
OEMS REGION 6 PEDIATRIC MEASURES

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



OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

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

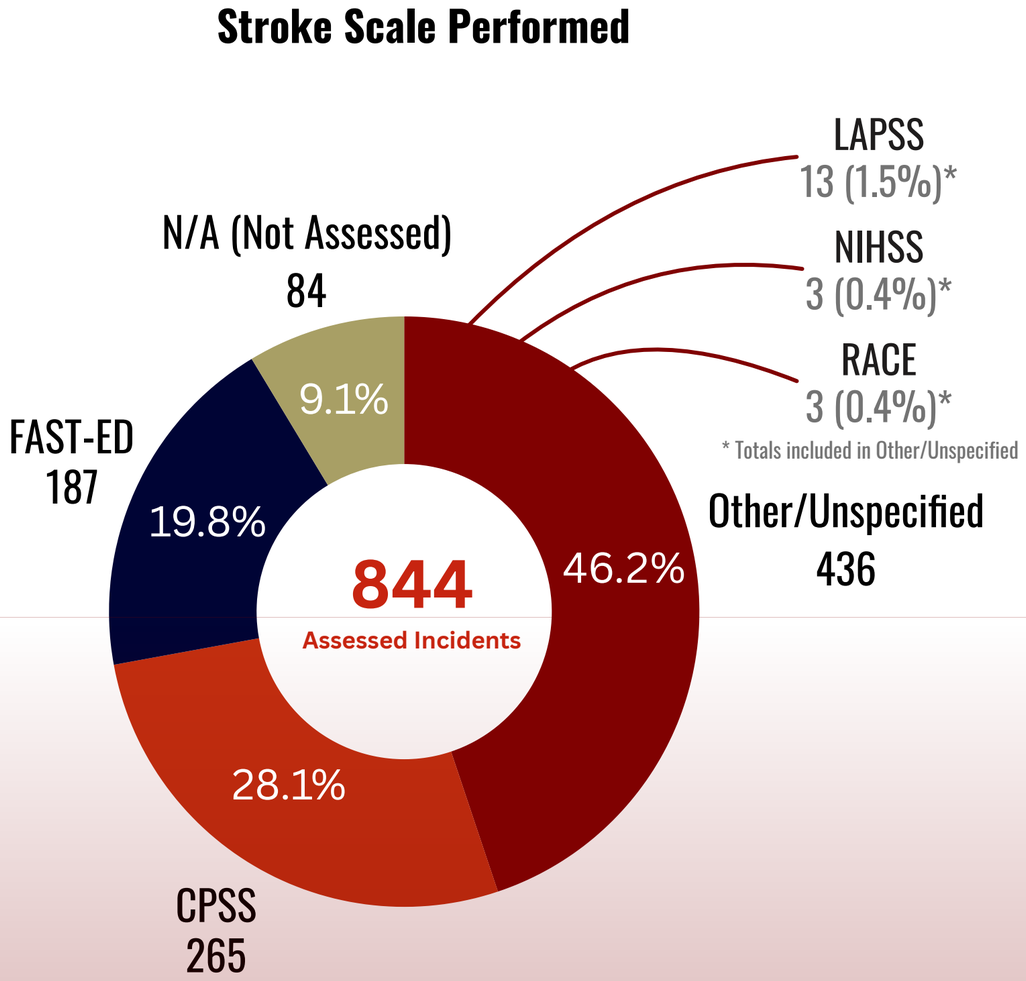
Data from ESO, NEMSIS 3.5

OEMS REGION 6

STROKE MEASURES

Overview of Stroke Scale Performance (Stroke-01)

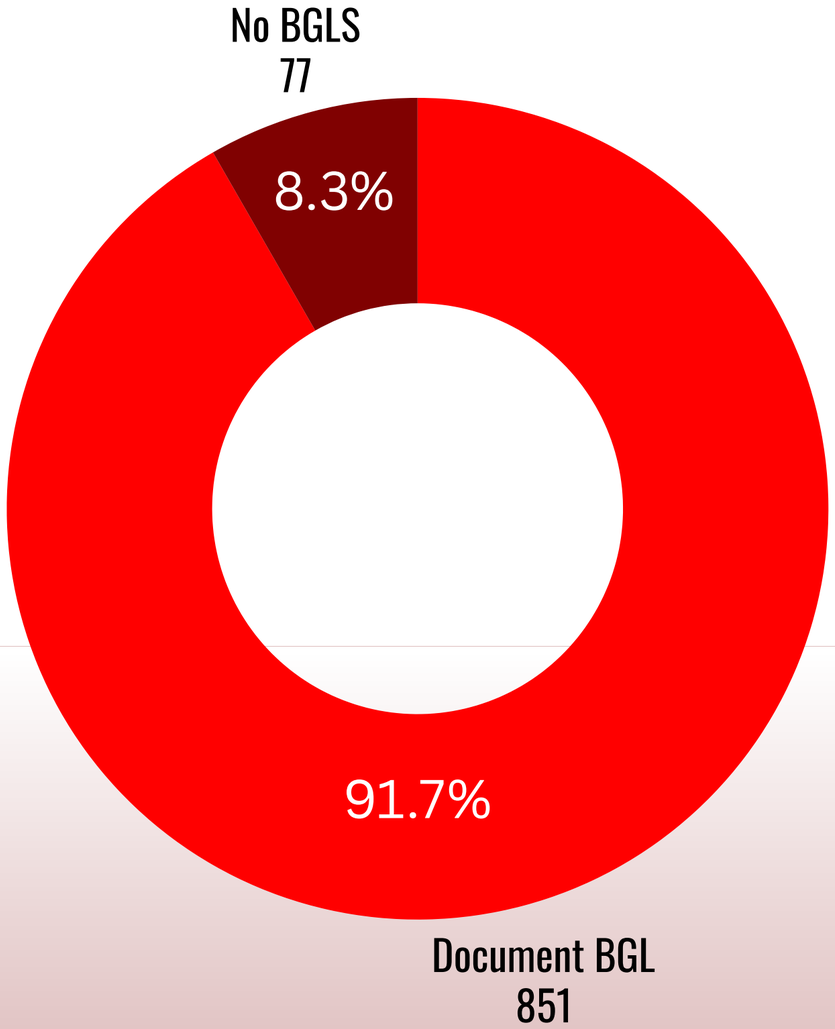
This chart summarizes the types of stroke scales used by EMS agencies in Planning Districts 13, 14, 15, and 19 for suspected stroke patients in Q4 2025 (928 total incidents). Other/Unspecified scales dominate at 46.2% (436 cases, including sub-types like LAPSS 13/1.5%, NIHSS 3/0.4%, RACE 3/0.4%), followed 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.



Data from ESO, NEMSIS 3.5

OEMS REGION 6 STROKE MEASURES

Documented Blood Glucose Level (Stroke-04)



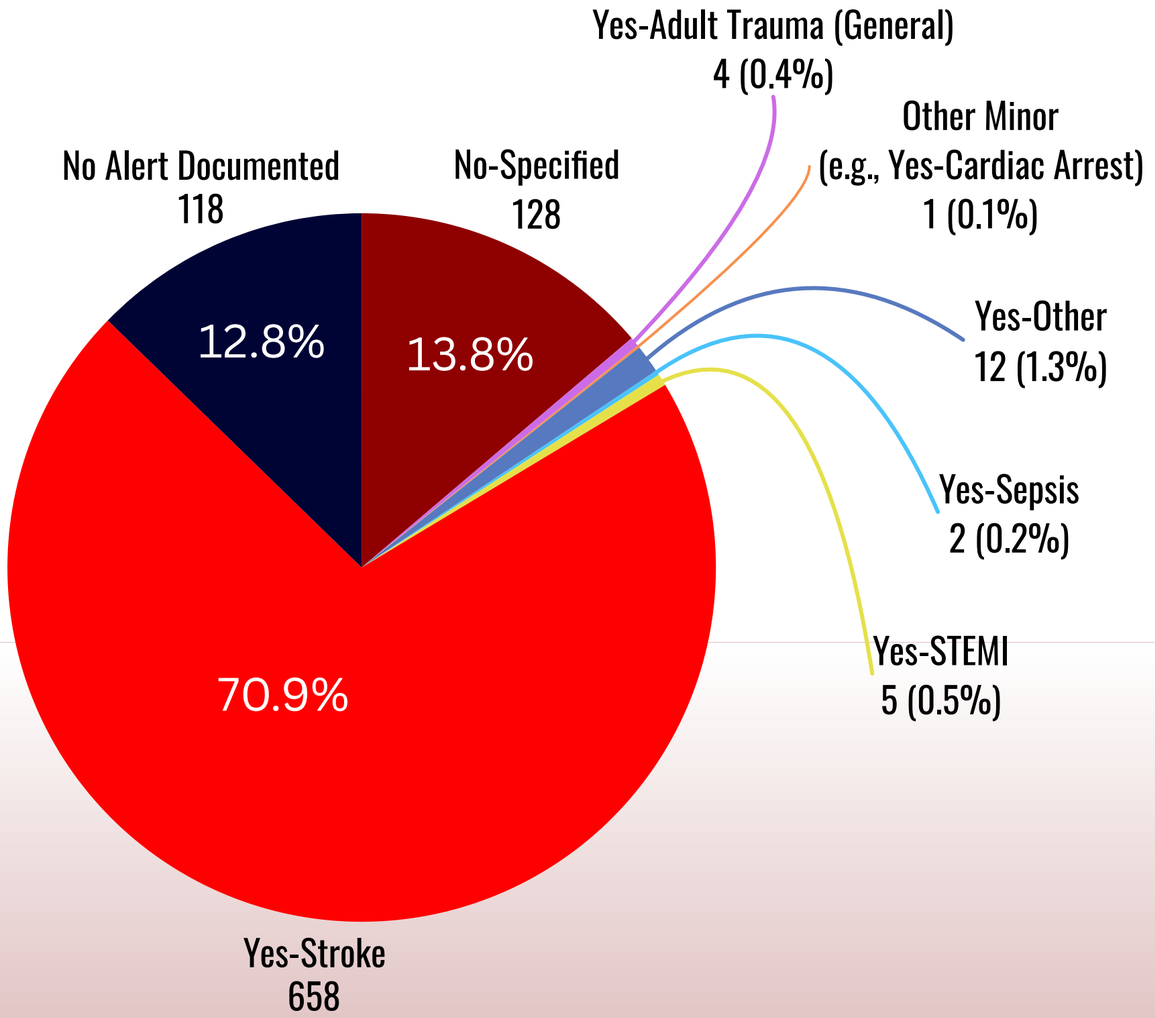
This chart shows documented blood glucose levels for suspected stroke patients in the previous quarter. In 91.7% of cases (851 incidents), a blood glucose level was recorded, while 8.3% (77 incidents) had no documented value. Overall, documentation compliance remains high, aligning with NEMSQA Stroke-04 (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.

Data from ESO, NEMSIS 3.5

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.

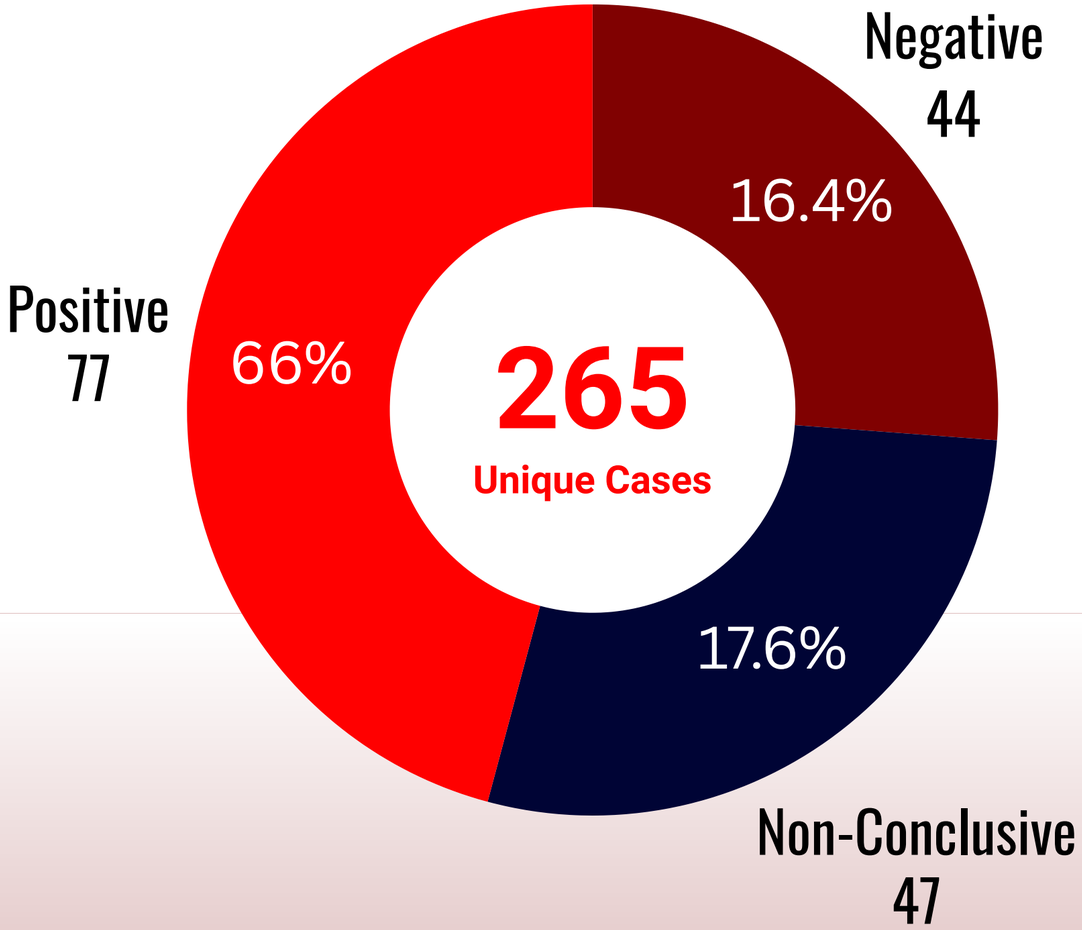


Total Incidents: 928 (percentages are of this total; alerts documented in 812 cases, but use full denominator for compliance) *Data from ESO, NEMSIS 3.5*

OEMS REGION 6 STROKE MEASURES

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

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.

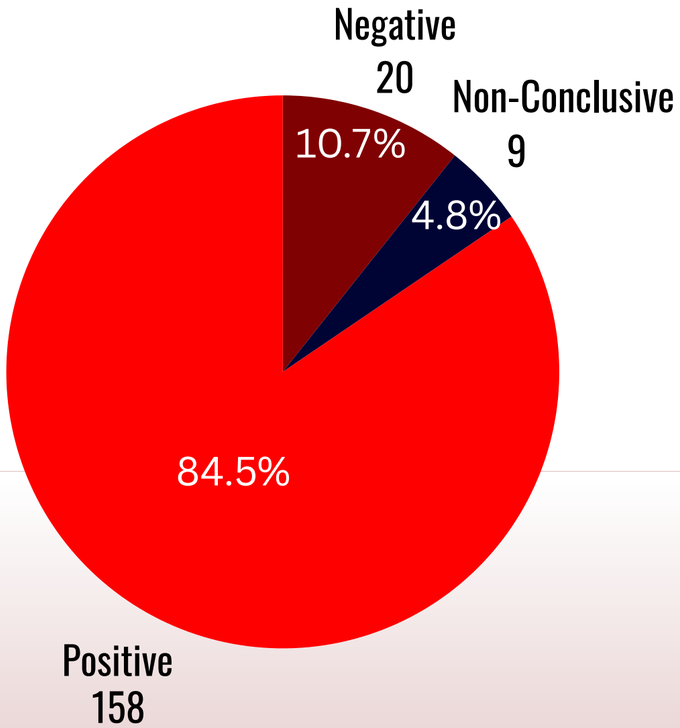


Total CPSS Cases: 268 assessments (265 unique incidents; percentages are of 268 for outcomes).

Data from ESO, NEMSIS 3.5

OEMS REGION 6 STROKE MEASURES

FAST-ED Outcomes

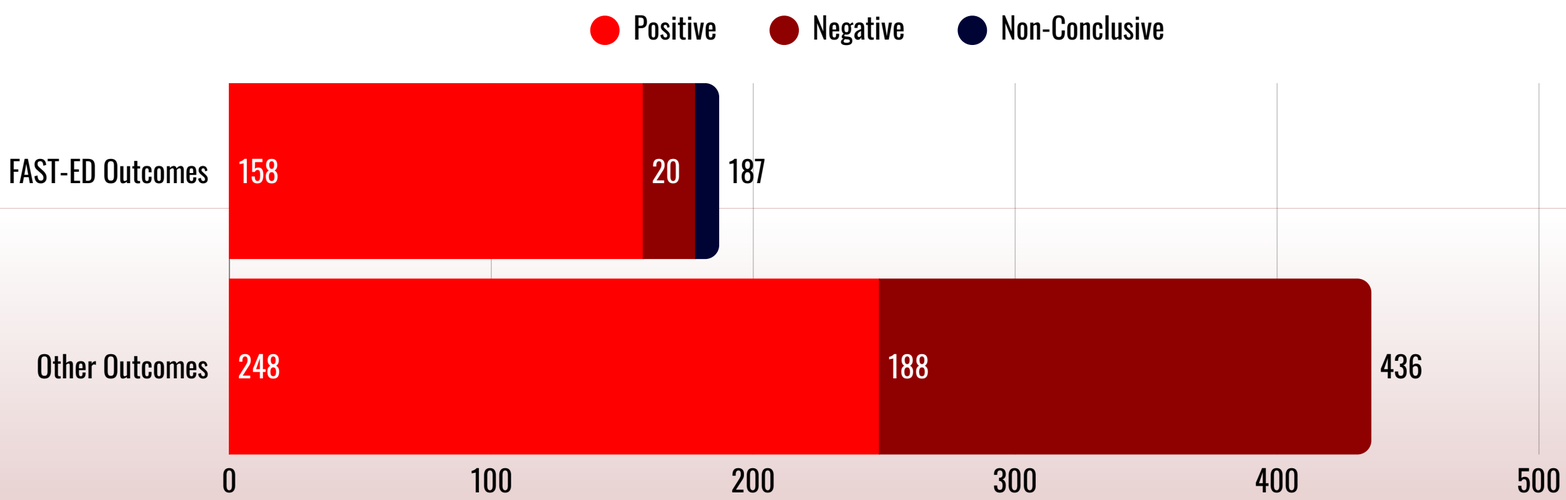


Total FAST-ED Cases: 187 (percentages are of this total).

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.

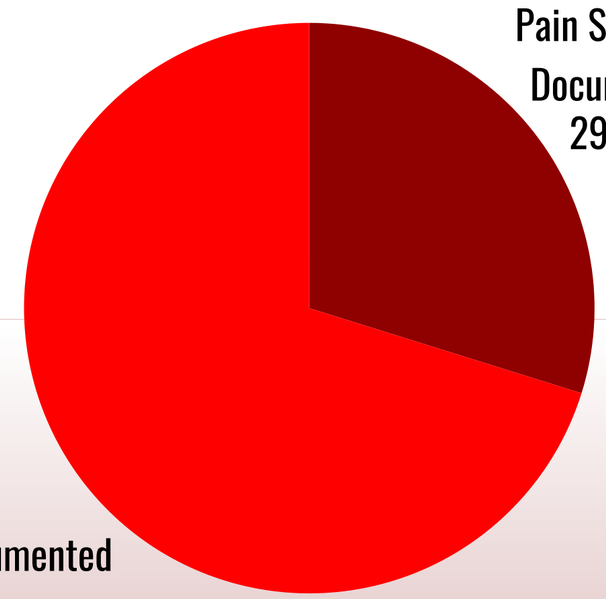
FAST-ED Outcomes



Data from ESO, NEMSIS 3.5

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 SCORE OBTAINTED BASED ON PROVIDER IMPRESSION

5, 573 With a Pain Scale Obtained

2,368 With Out a Pain Scale Obtained

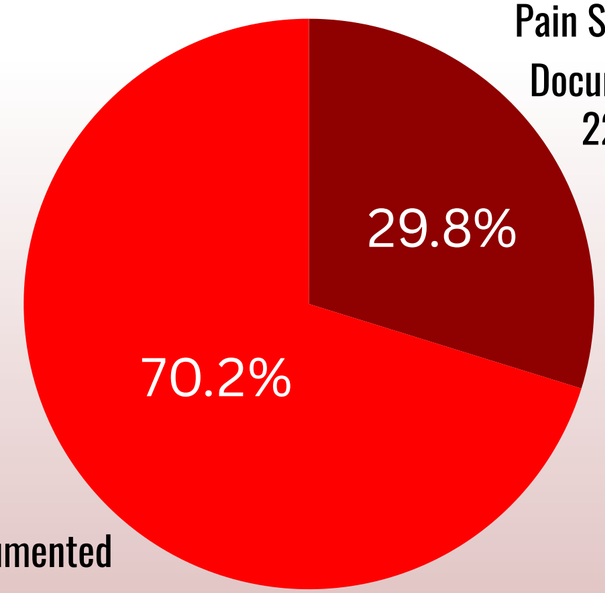
Total impressions: 7,941; evaluable for change (≥2 assessments, initial >0): 2,972

Data from ESO, NEMSIS 3.5

OEMS REGION 6
TRAUMA
MEASURES

OEMS Region 6
All Planning Districts

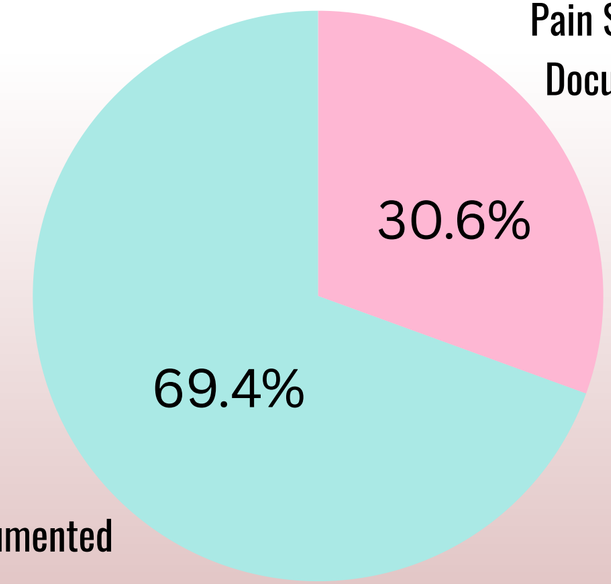
Adult Pain Scales



Pain Scale Not Documented
2269

Pain Scale Documented
5348

Peds Pain Scales



Pain Scale Not Documented
99

Pain Scale Documented
225

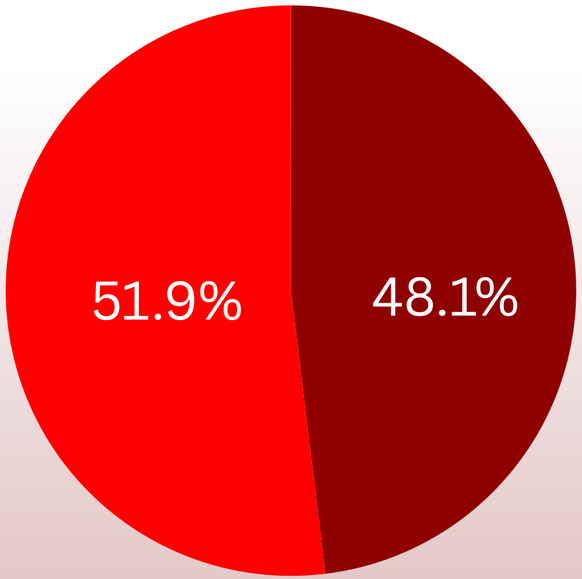
OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

OEMS REGION 6
TRAUMA MEASURES

Planning District 13 Southside

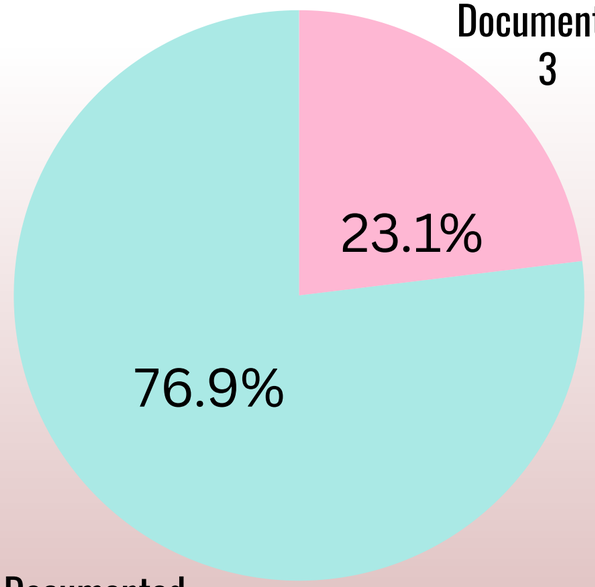
Adult Pain Scales



Pain Scale Documented
390

Pain Scale Not Documented
361

Peds Pain Scales



Pain Scale Not Documented
3

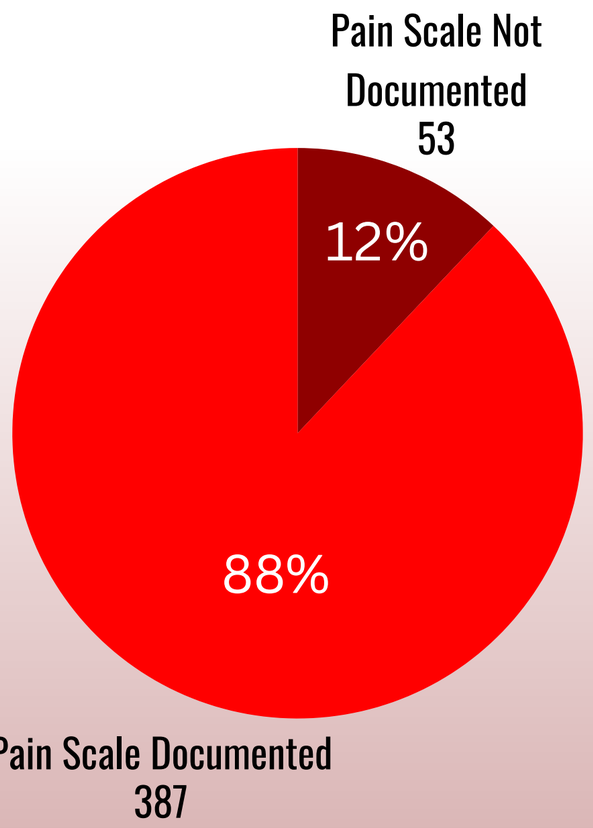
Pain Scale Documented
10

Data from ESO, NEMSIS 3.5

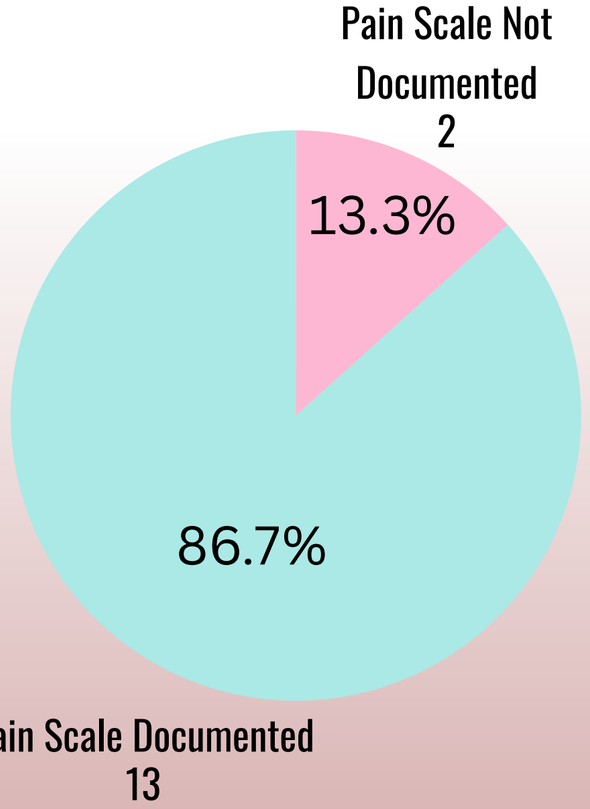
OEMS REGION 6 TRAUMA MEASURES

Planning District 14 South Central

Adult Pain Scales



Peds Pain Scales



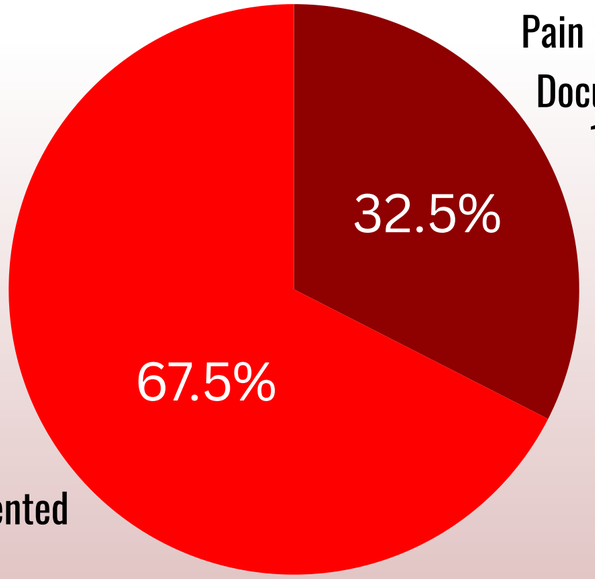
OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

OEMS REGION 6
TRAUMA MEASURES

Planning District 15 Metro Richmond

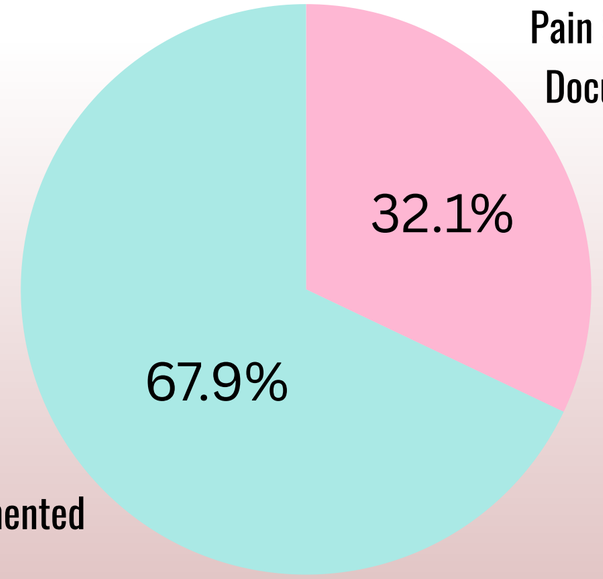
Adult Pain Scales



Pain Scale Not Documented
1885

Pain Scale Documented
3914

Peds Pain Scales



Pain Scale Not Documented
84

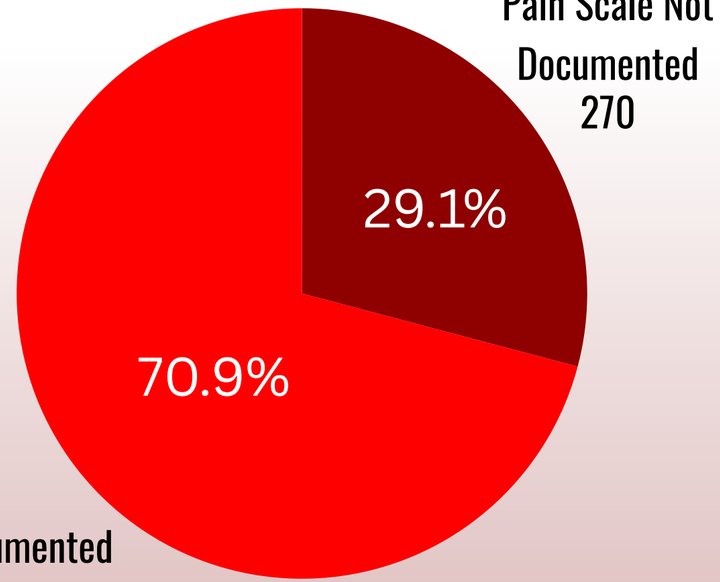
Pain Scale Documented
178

Data from ESO, NEMSIS 3.5

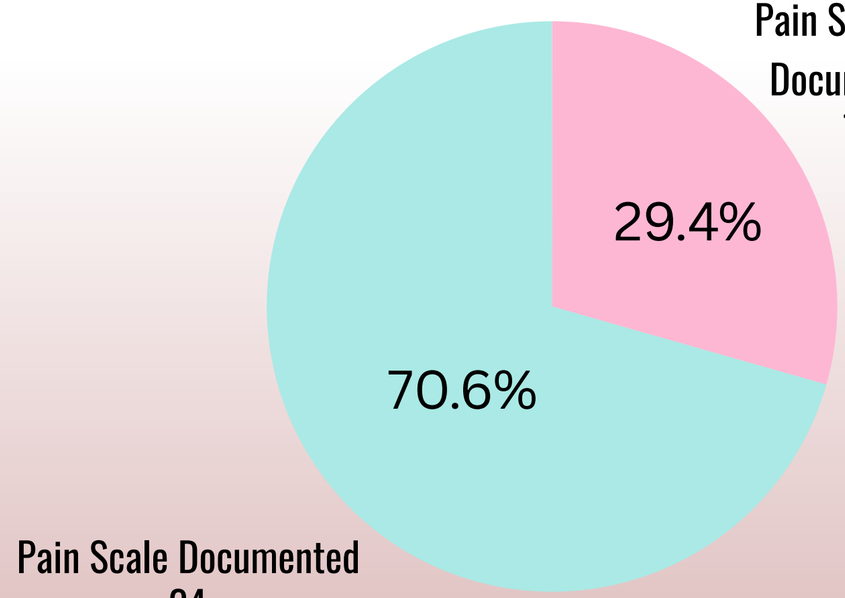
OEMS REGION 6
TRAUMA MEASURES

Planning District 19 Crater

Adult Pain Scales



Peds Pain Scales

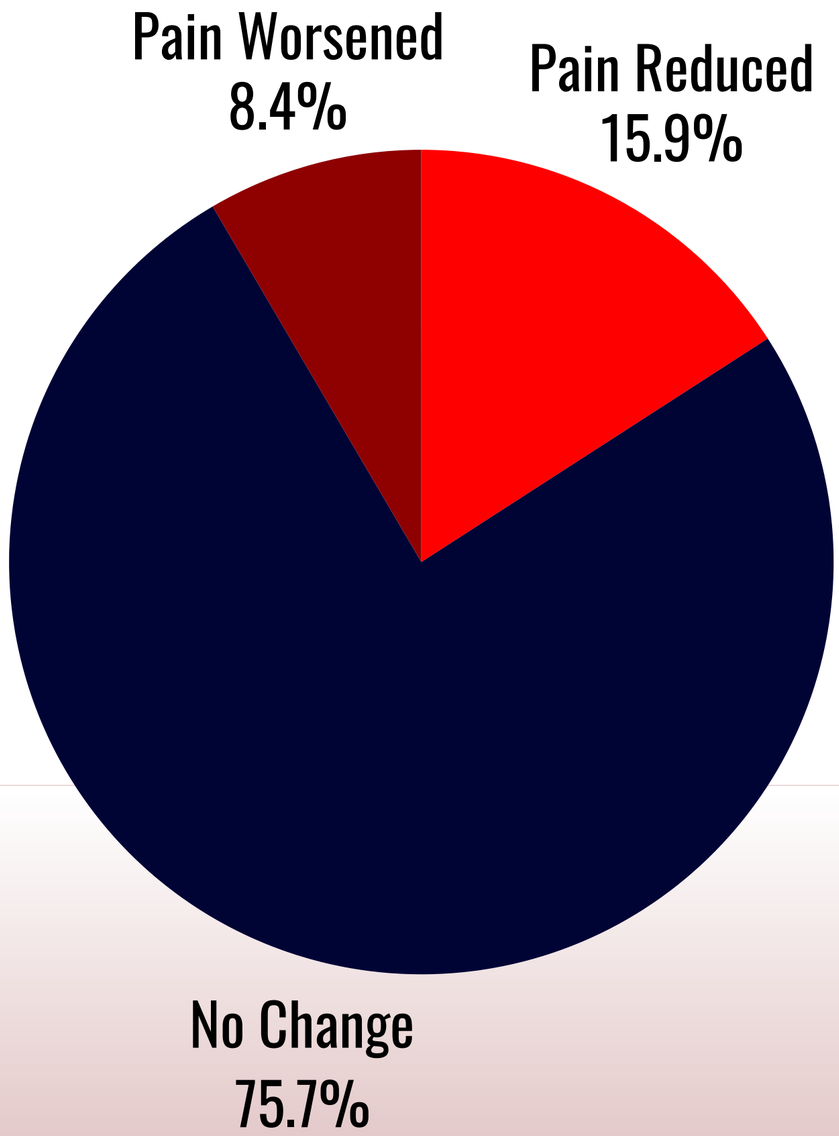


Data from ESO, NEMSIS 3.5

OEMS REGION 6 TRAUMA MEASURES

Overview of Pain Management Effectiveness

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).



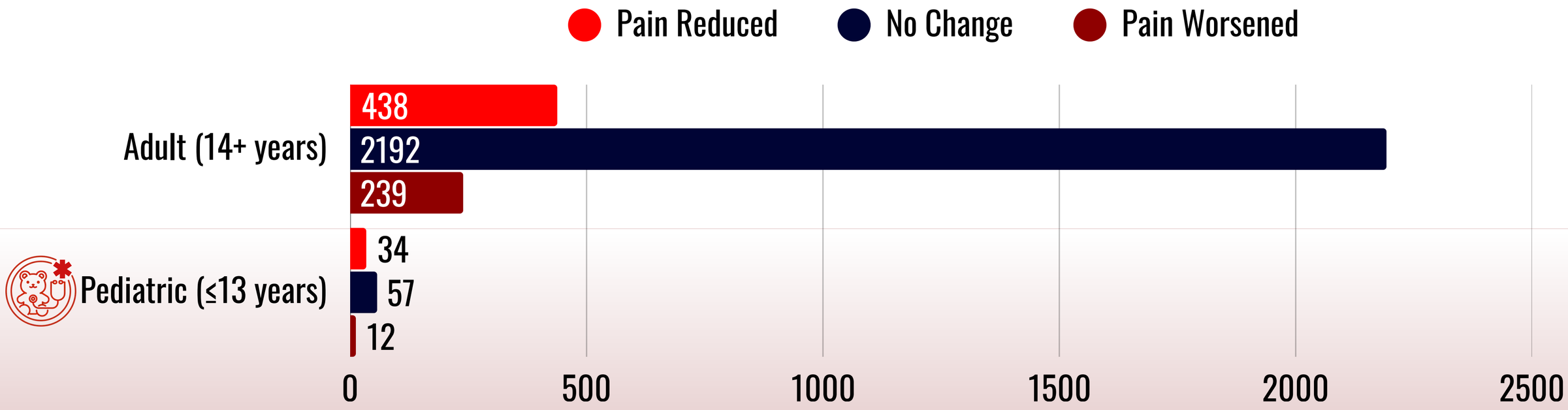
Data from ESO, NEMSIS 3.5

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.

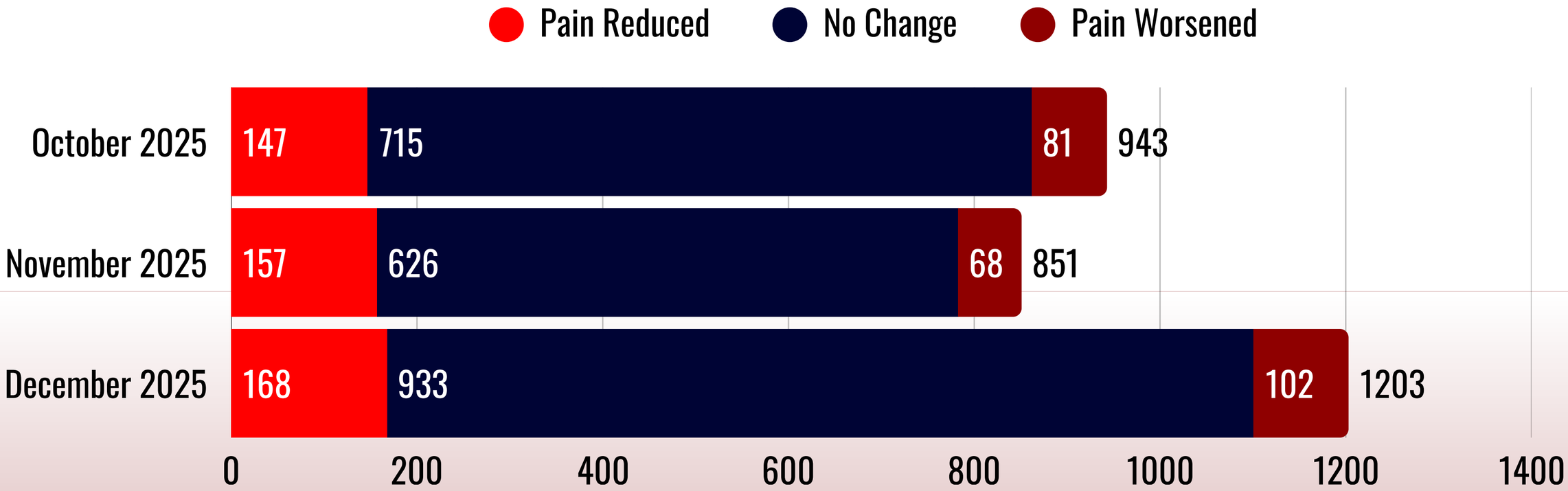


Data from ESO, NEMSIS 3.5

Monthly Trends in Pain Management Effectiveness

OEMS REGION 6
TRAUMA
MEASURES

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).



OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

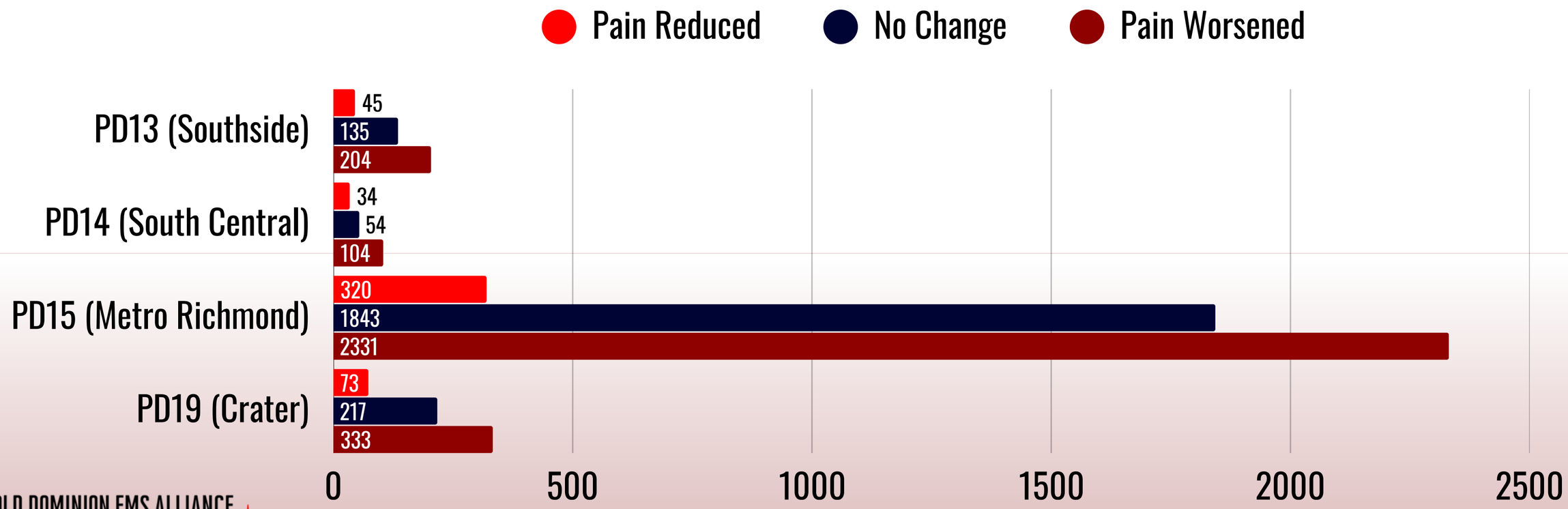
Data from ESO, NEMSIS 3.5

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.

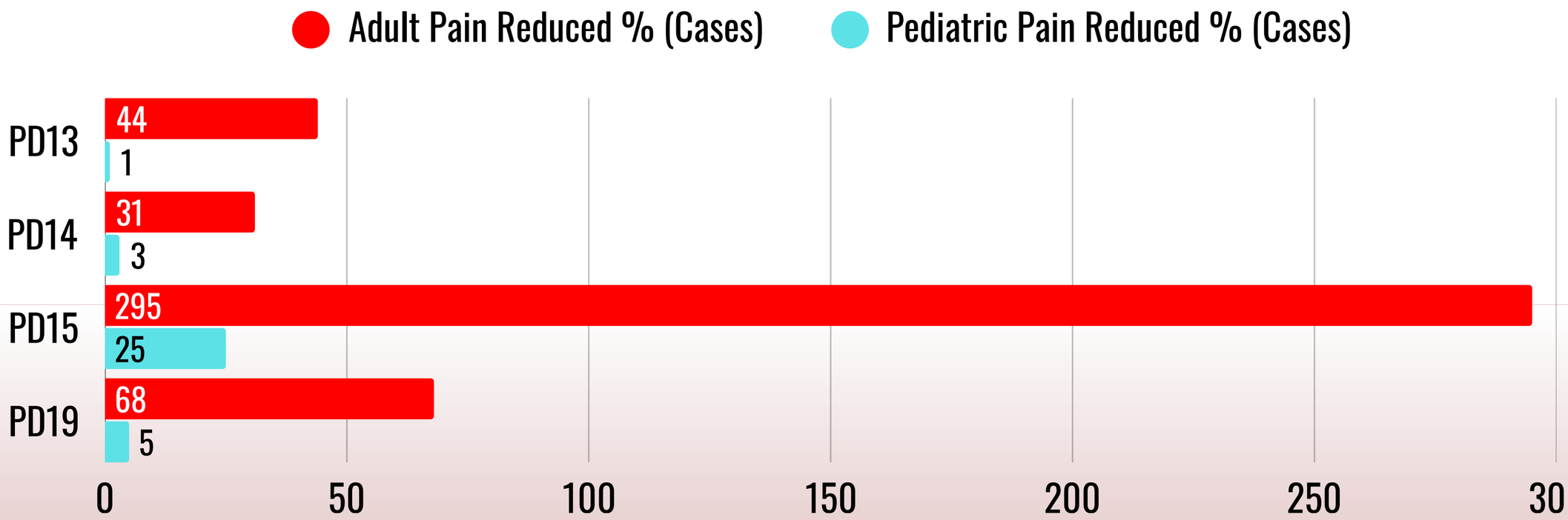


Data from ESO, NEMSIS 3.5

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.



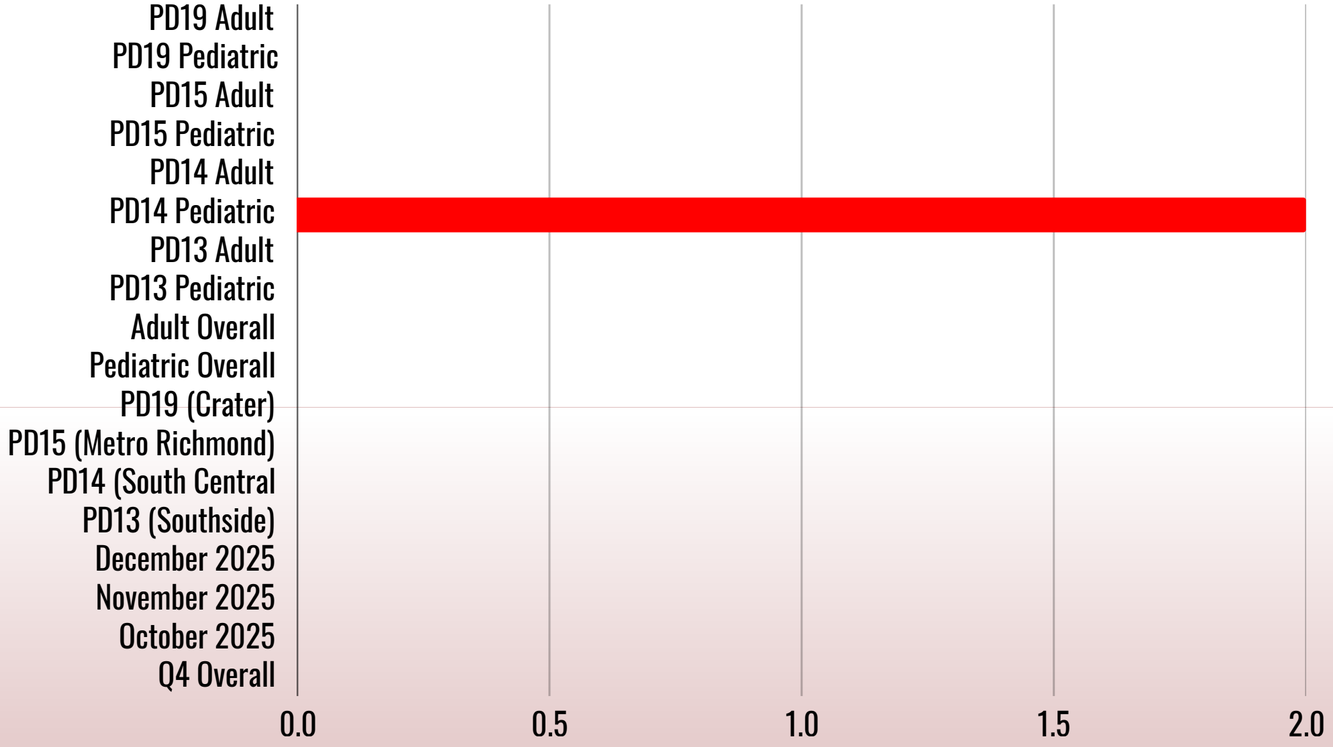
OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

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).

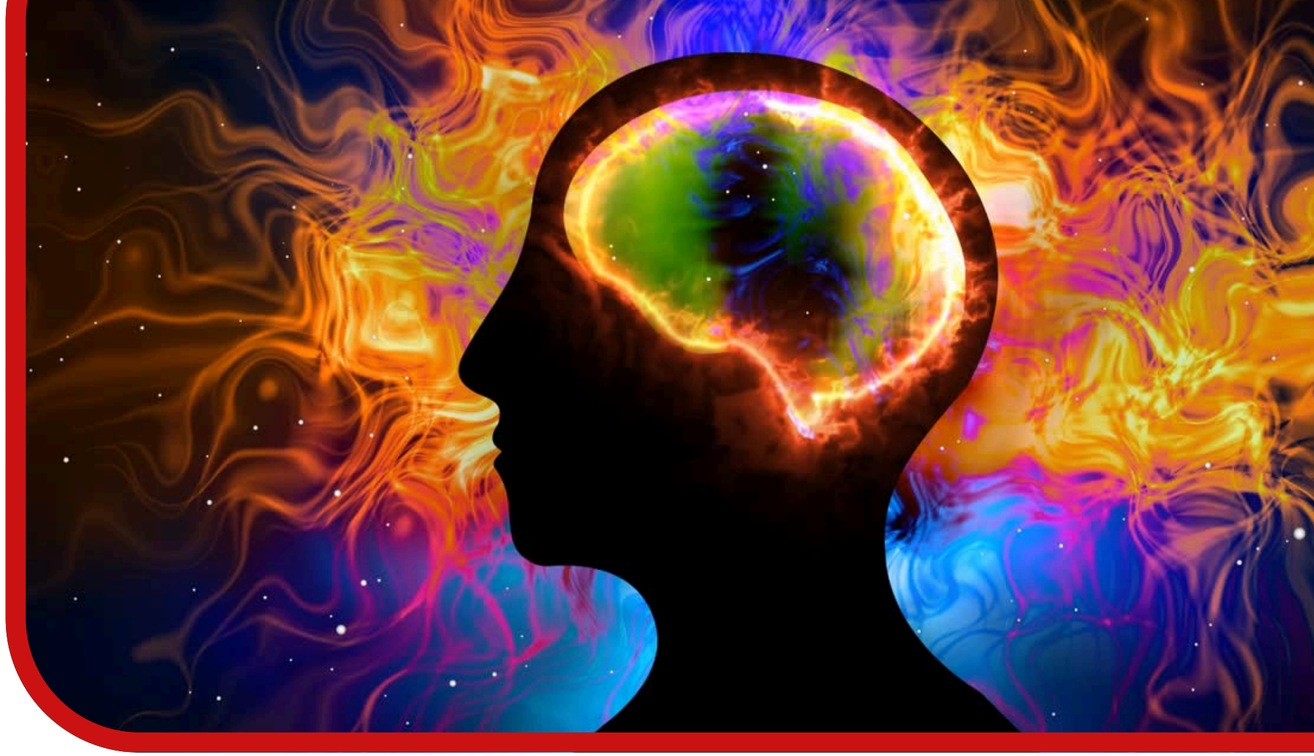
Why Mostly 0?: In Q4 2025 data, most groups had high "no change" rates (66-80%), keeping the median at 0 (half or more patients saw no improvement).

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).

Data from ESO, NEMSIS 3.5

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

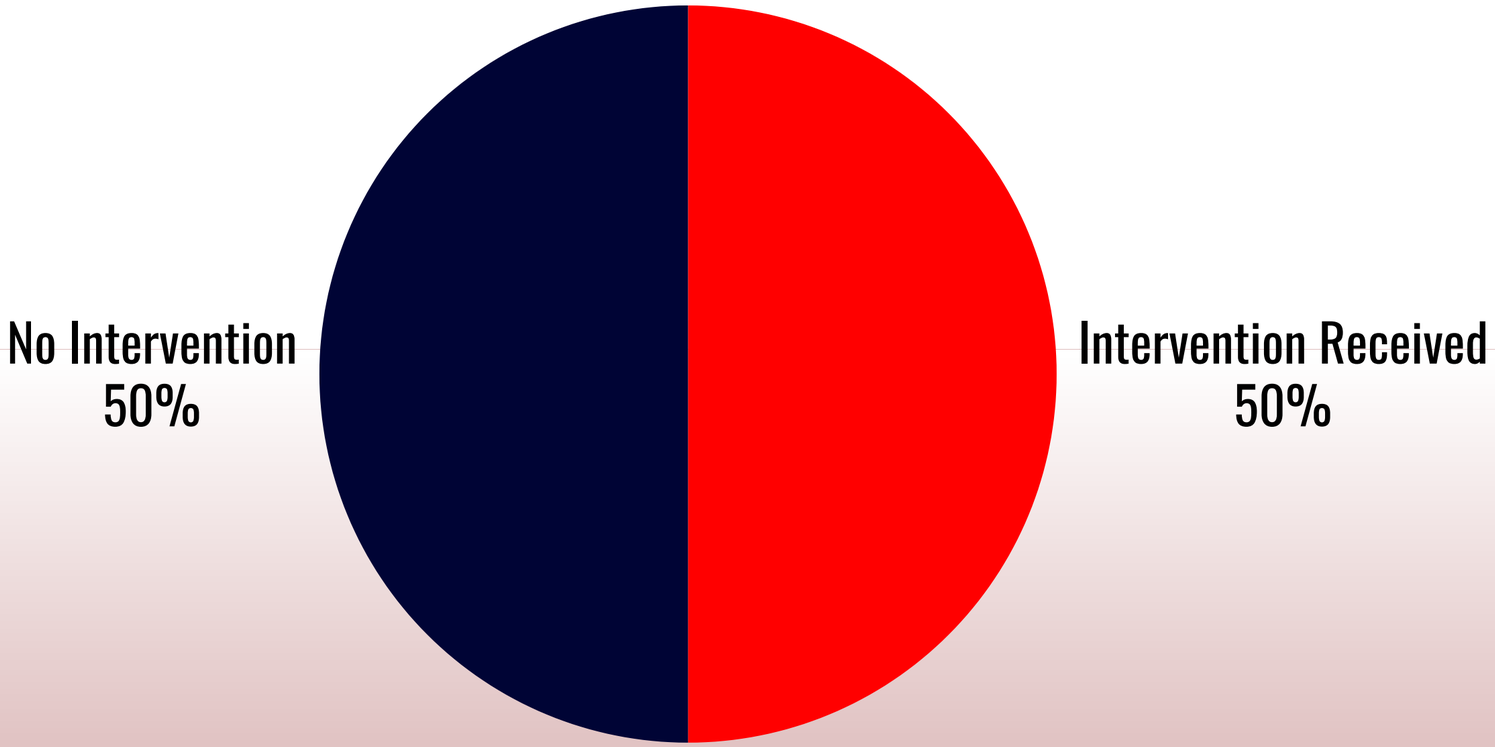
60	Other Seizures
33	Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus
16	Weakness

Data from ESO, NEMSIS 3.5

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).

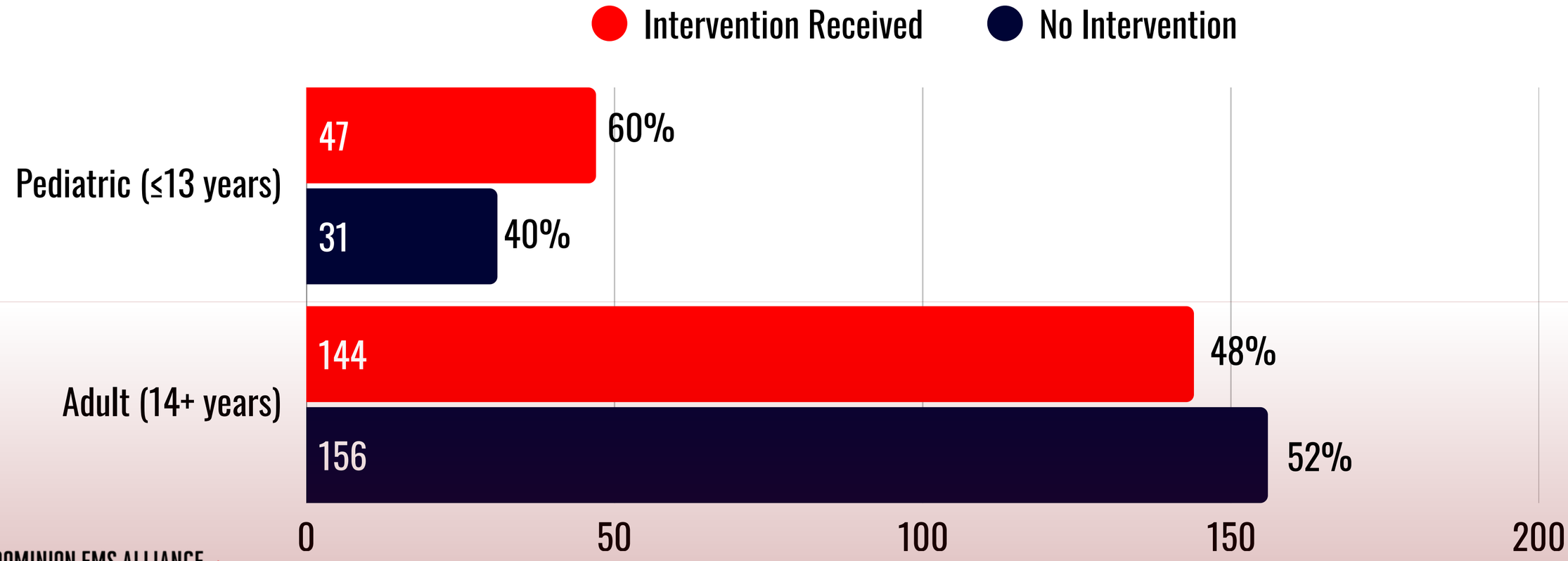


Data from ESO, NEMSIS 3.5

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.

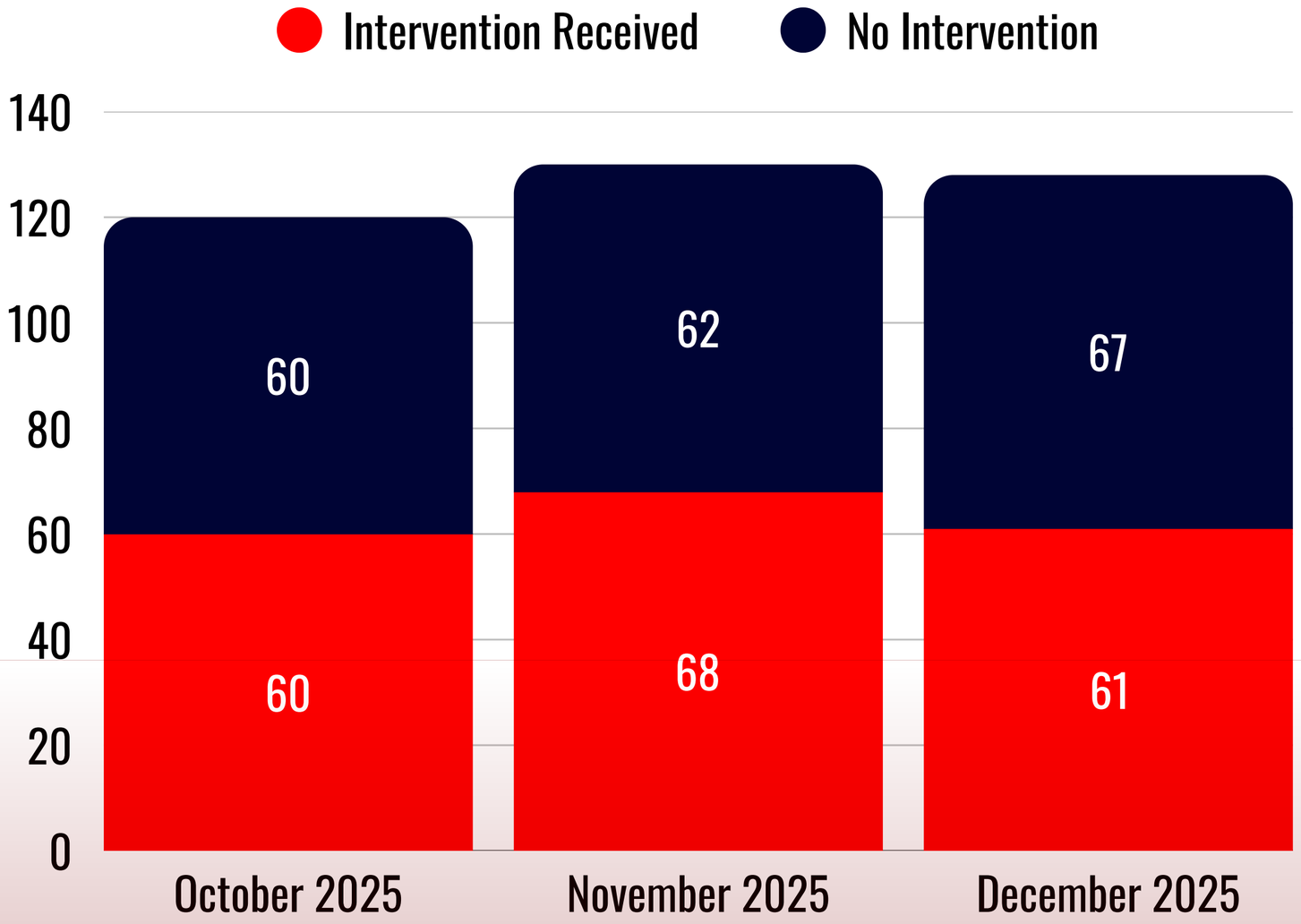


Data from ESO, NEMSIS 3.5

OEMS REGION 6 SEIZURE MEASURES

Monthly Trends in Seizure Intervention Effectiveness

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.



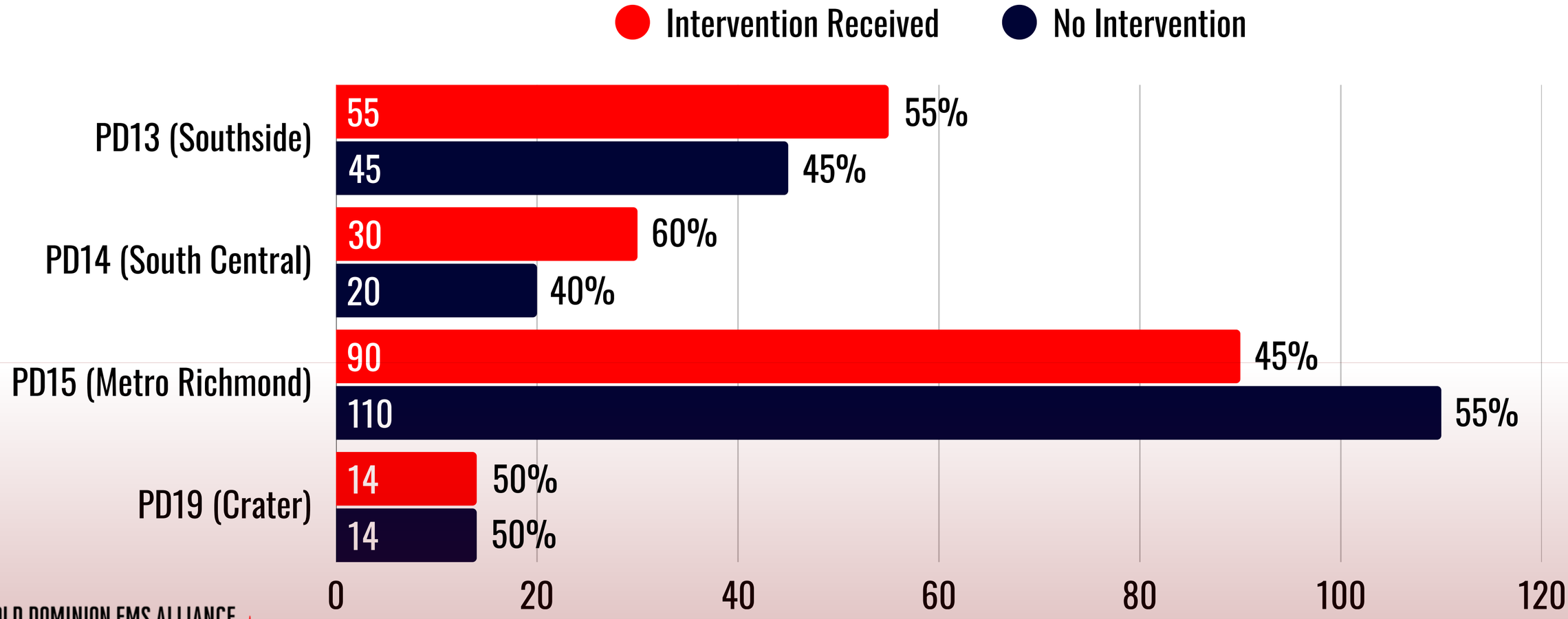
National ESO benchmark: >90%; opportunity for protocol review.

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.



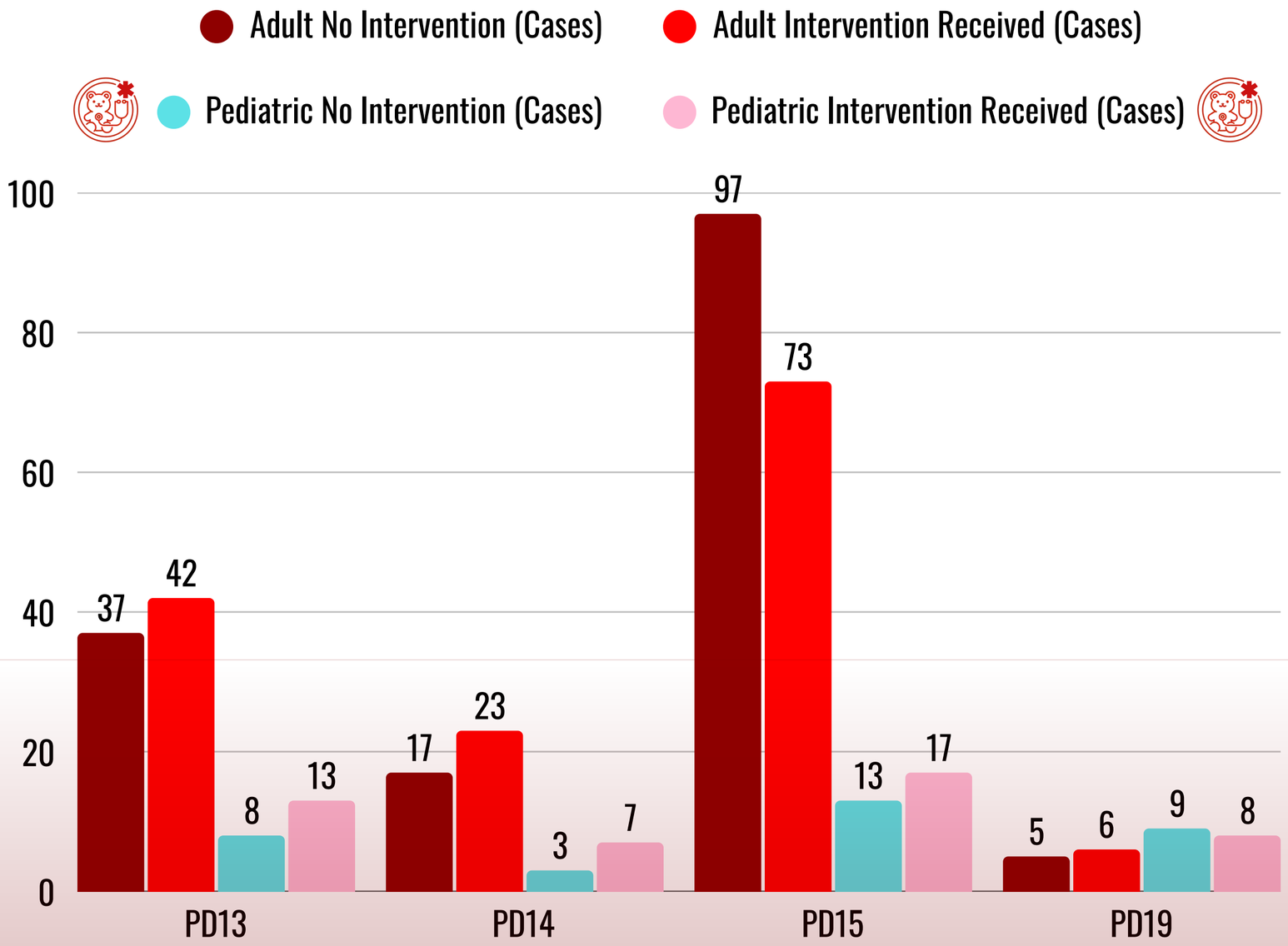
OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

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



OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

www.odemsa.net
804.560.3300
ODEMSA@vaems.org

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 Your For Your Attention