OLD DOMINION EMERGENCY MEDICAL SERVICES ALLIANCE

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# Medical Direction Committee

May 14, 2026
8:00 am – 10:00 am
**Chair**: Dr. Allen Yee, Regional Operational Medical Director

**Members and Guests Present:** N/A
**Virtual Attendees:** Michael Cieslinski, MD; Monty Dixon; Jeff Ferguson, MD; Joanne Lapetina, MD; Bleck Ngwafang, MD; Joseph Ornato, MD; John Perry, MD; Debra Perina, MD; Robert Powell, MD; Carlton Stadler, MD; Alan Thurman, MD; Allen Yee, MD
**ODEMSA Staff:** Ryan Scarbrough, Chris Vernovai
**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** | • Meeting was called to order by the Chair, Dr. Allen Yee, at 8:00 AM.<br>• Introductions were conducted.<br>• A quorum was confirmed to be present.<br>• Meeting minutes from the previous meeting (February 12, 2026) and meeting agenda were approved as provided. | Motion to approve the 02/12/2026 Meeting Minutes and agenda made by **John Perry**; Seconded by **Michael Cieslinski**. Motion passed. |
| **State Medical Control – Allen Yee** | | |
| **State Medical Control** | • Reported that the Governor's Advisory Board has reorganized its committee structure, reducing committees from approximately 15–18 down to 6–7; former committees now operate as time-limited, task-specific work groups that dissolve upon completion of their assigned task.<br>• Reported on modifications to the required ambulance equipment list, which has been generalized to address ALS and BLS transport and non-transport units, with additional recommendations for safety officers, ALS intercepts, battalion chiefs, and MIH vehicles. The proposal is pending final vote at the next State Medical Control meeting. | None |

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| | • Noted specific language changes, including replacement of “hard cervical collars” with “materials or devices to provide spinal motion restriction.”<br>• Reported that EMSC is pushing for all transport units to carry newborn sling-type restraint devices (~$200 each); debate is ongoing between a per-unit requirement versus agency-level availability. The revised equipment list includes provisions allowing exemptions based on patient populations served.<br>• Reported that the Scope of Practice was updated to include provisions for canine medications administered to humans; however, noted that the Scope of Practice may have been informally treated as a living document, which may not be legally sound. The last legally effective Scope of Practice may date to 2011. The Office of EMS is working with the Office of the Attorney General to identify a legal solution.<br>• Reported that State Medical Control committee membership will be reduced from 11 to 7 regional medical directors, for a total of 10 seats including the Chair, with 2 at-large member positions. All regional councils are required to be fully functional by the end of June 2026.<br>• Noted that white papers are in development on trauma resuscitation, with emphasis on prioritizing circulation over airway (CAB over ABC model). | |
| **Hospital Reports** | | |
| Bon Secours – MRMC | **Carlton Stadler, MD**<br>• No report. | None |
| **EMS Agency Reports** | | |
| Henrico County Division of Fire | **Monty Dixon**<br>• No report. | None |
| **OMD Agency Reports** | | |
| **Michael Cieslinski, MD** | • Nothing new to report.<br>• Noted that Brunswick EMS has new leadership in place; looking forward to the resulting organizational changes. | None |
| **Jeff Ferguson, MD** | • No report. | None |
| **Bleck Ngwafang, MD** | • No report. | None |
| **Joseph Ornato, MD** | • No report. | None |

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| **John Perry, MD** | • No report. | None |
| **Debra Perina, MD** | • Reported that the agency is implementing guidelines from the consensus document on resuscitation of trauma patients in the field, as previously discussed by Dr. Yee.<br>• Reported that the agency is in the process of training and planning for deployment of blood products, with a target go-live date of July 1, 2026.<br>• Reported that following a quality improvement review, the agency has deployed updated protocols that prioritize defibrillation before application of the mechanical CPR device, addressing findings that device placement was sometimes delaying defibrillation. | None |
| **Joanne Lapetina, MD** | • No report. | None |
| **Alan Thurman, MD** | • No report. | None |
| **Allen Yee, MD** | • No report. | None |
| **ODEMSA / OEMS Report – Ryan Scarbrough** | | |
| **ODEMSA / OEMS Report** | **ODEMSA:**<br>• Chris Vernovai joined ODEMSA as Training Director effective the beginning of April 2026; this meeting marks his first with the committee.<br>• Heather Nelson was hired as Field Coordinator in late February 2026.<br>• ODEMSA continues to work on populating all committees with full representation.<br>• A regional whole blood program is anticipated within the next 12 months.<br>• EMS Week is the following week (May 18–24, 2026).<br>• An email regarding the SS4A grant and the regional whole blood program was distributed to agencies on April 28, 2026; ODEMSA has been following up with agencies throughout the week.<br><br>**OEMS:**<br>• A new ticket system has been implemented for all ACE (Accreditation, Certification, and Education) division inquiries and issues.<br>• Cam Crittenden is currently on medical leave; Ron Passmore is serving in an interim capacity.<br>• Debbie Aker's position has been posted for a second time. | None |

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| | • The Virginia Office of EMS position previously held by Chris Vernovai has also been posted. | |
| **Old Business** | | |
| **Protocol Review and Suggestions** | • No additional items brought forward beyond those covered under New Business. | None |
| **Legislative Update** | • Dr. Yee reported that the DEA final regulations have been published and that Virginia was already operating in full compliance.<br>• Clarified that a DEA-222 form was never required for transfer of Schedule II medications by EMS at the time of patient transfer, as an exemption for EMS has always existed under federal law.<br>• The Virginia Board of Pharmacy has created EMS-specific regulations, including an EMS Controlled Substances (CS) registration pathway.<br>• EMS agencies are now eligible to obtain their own DEA license, removing the need for a physician's DEA number to be tied to the agency. Dr. Yee encouraged agencies to apply; licensure is free for governmental agencies.<br>• Agencies that routinely operate across state lines and receive or exchange controlled substances in another state will need a separate DEA registration in each state. | None |
| **New Business** | | |
| **PI Data Presentation** | • Ryan Scarbrough presented Q1 2026 (January–March) regional EMS performance data from ESO (state data repository), representing 74 reporting agencies.<br>**Call Volume & Disposition:**<br>• Transport by this EMS unit: ~68%; no transport: ~12%; patient refusal: ~12%; transport by another unit: ~8%.<br>• Elevos submission errors were reduced from over 2,000 failed records to 265 through targeted agency outreach.<br>• Top 10 provider-documented impressions, medications administered, and procedures were reviewed with the committee.<br>**Cardiac Events:**<br>• 142 incidents documented with a primary impression consistent with myocardial infarction (STEMI and equivalent presentations). | None |

- 585 incidents with cardiac arrest as primary impression; 52 as secondary impression.
- 753 documented cardiac arrests occurred prior to EMS arrival; 105 occurred after EMS arrival.
- AED use prior to EMS arrival: 9% with defibrillation; 23% AED applied without defibrillation.

**Pediatric Calls:**

- 2,238 pediatric calls, including 26 pediatric cardiac arrests.
- Average scene-to-transport time for pediatric arrests: 10 minutes. Average time to first epinephrine: 9.5 minutes.

**Stroke:**

- 894 stroke-related transports; 46 to comprehensive stroke centers; 42 to primary stroke centers. Higher-level transports predominantly originate from Planning Districts 15 and 19.
- Blood glucose documentation to rule out altered mental status with possible stroke patients: performing well regionally.
- Pre-arrival stroke alert documented in 70.8% of qualifying transports; approximately 30% of providers not documenting whether a stroke alert was or was not activated.
- Last known well documented in a structured EPCR field in 78% of incidents.
  - Dr. Yee noted that the state is moving toward prioritizing last known well over symptom onset for documentation.
- Stroke scale documented in ~84% of incidents. Cincinnati pre-hospital stroke scale positive: 56%; FAST positive: 67%. Current regional protocols call for Cincinnati/FAST as the initial screen, followed by VAN assessment if positive, to guide transport destination decisions.

**Pain & Seizures:**

- Pain scale documented in 79% of adult incidents and 61% of pediatric incidents (patients age ≤2 excluded). Lower pediatric rate may reflect clinical challenges and documentation habits.
- Pain management effectiveness: improvement and unchanged each documented in ~14% of incidents; ~72% documented as NA, likely entered in the narrative rather than structured fields.
- Seizure / Status Epilepticus (NEMSQA measure): Of 95 eligible incidents, 46 received benzodiazepines (48.4%); national ESO benchmark is >90%. Noted that post-ictal presentations may be a significant driver of the lower rate; no

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| | current structured EPCR field exists at this time to distinguish active seizure from post-ictal status at EMS arrival. | |
| **CARES Initiative** | • Dr. Yee reported that he has approached both the Office of EMS and the regional council directors regarding participation in the CARES (Cardiac Arrest Registry to Enhance Survival) program.<br>• The Office of EMS supports participation but has no available funding.<br>• Two regional councils currently participate (~$6,000 each); total statewide participation is estimated at $15,000–$20,000.<br>• Regional council directors expressed lukewarm support due to concerns about staff bandwidth required for data completion.<br>• Dr. Yee proposed inviting Dr. McNally from CARES to present directly to the regional council directors to address concerns. | None |
| **Protocol Updates – AHA Standards** | • Chris Vernovai met with Megan Middleton (previous ODEMSA Training Director) within the prior two weeks to review the status of regional protocol updates.<br>• Identified area requiring near-term update: all AHA-referenced charts within the regional protocols must be revised to reflect the October 2025 AHA standards.<br>• Dr. Yee recommended priority review of the tachycardia with pulse protocol, noting that metoprolol is not adequately addressed in the current flowchart despite being commonly available in EMS drug boxes.<br>• Committee members were invited to identify any additional protocols requiring immediate or short-term AHA updates. | Chris Vernovai to work on updating AHA charts and the tachycardia with pulse protocol. Committee members to flag additional protocols requiring updates. |
| **Protocol Updates – Symptomatic Bradycardia** | • Dr. Yee presented information from SEMSO on an approach used in the Phoenix/Scottsdale, Arizona area: proceeding directly to chest compressions for symptomatic bradycardia, rather than atropine or pacing, based on findings that a significant proportion of these patients are in pulseless electrical activity (PEA).<br>• Dr. Ornato expressed interest in reviewing the data; noted a potential concern that forceful chest compressions in a patient with bradycardia who is not in true cardiac arrest could precipitate an arrest. Requested additional information prior to forming a recommendation and noted Arizona's strong track record in organized, team-based resuscitation approaches. | Dr. Yee to forward the SEMSO presentation to Dr. Ornato for review. |
| **Protocol Updates – Tourniquet Downgrade Protocol** | • Dr. Yee discussed the need for a regional protocol for reassessment and downgrading of hastily applied tourniquets (high, tight, over-clothing applications) once patients are in a cold zone or evacuation environment. | Dr. Ferguson and Dr. Yee to share existing tourniquet downgrade protocols with Chris Vernovai. Chris Vernovai to develop a |

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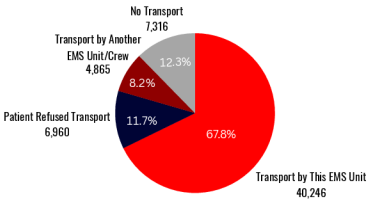
| | • Dr. Ferguson shared that Henrico County has a tourniquet downgrade protocol developed by a former EMS fellow and offered to share it; noted that he has received ED patients with prolonged tourniquet use due to providers lacking a reassessment or removal protocol.<br>• Monty Dixon requested Chris Vernovai's email address via the meeting chat.<br>• Dr. Yee noted that Chesterfield also has an existing protocol and will share it with Chris Vernovai.<br>• Dr. Yee also shared notes from the SOMA/CTEC meeting on proper CAT tourniquet application technique: the strap must be drawn tight enough that only 2 windlass turns are needed; inadequate strap tension is a leading cause of tourniquet failure. | regional draft protocol for committee review. |
| **Regional Blood Protocols** | **Allen Yee**<br>• Agencies with existing ground blood transport programs: Chesterfield, Buckingham, Hanover, and Goochland.<br>• A regional blood program is being developed; the Office of EMS will provide 50% match funding, with a project start date of July 2026. The goal is to establish a ring of blood-capable agencies around Metro Richmond, extending into the southern portions of the ODEMSA region and Buckingham County given its geographic distance from higher-level resources. | Chris Vernovai to work with Dr. Yee on drafting a regional Whole Blood protocol. |
| **SS4A (Safe Streets and Roads for All) Grant** | **Allen Yee**<br>• ODEMSA (OEMS Region 6) is positioned to submit a grant application in collaboration with Regions 1 and 2. Regions 3, 4, and 7 are not anticipated to participate. Regions 1, 2, and 6 together represent approximately 51% of the Commonwealth's land mass and 32% of its population.<br>• Grant focus: post-crash care, including automatic crash notification, appropriate resource deployment, clinical care, and pre-hospital blood programs.<br>• Proposed grant components: EMS education, rural trauma training, critical access hospital education, rural trauma program, and ATLS for physicians.<br>• This is a 20% match grant; in-kind contributions are accepted. Training costs may qualify as in-kind dollars. Preliminary estimates suggest a 30–40% effective match is achievable using existing training expenditures. No cash match is anticipated from EMS agencies.<br>• Outreach is ongoing to localities, metropolitan planning organizations, and public safety partners. Agency staff may hear from their county administrators, boards of supervisors, or mayors regarding letters of support. | None |

| Business from the Floor | | |
|---|---|---|
| **Measles Outbreak Update** | • Joanne Lapetina reported that the State Health Commissioner has issued a notification regarding a measles outbreak in Buckingham County, with 14 confirmed cases as of the meeting date (up from 11 cases reported the prior day).<br>• Dr. Perina confirmed the updated case count of 14 as of that morning.<br>• Dr. Yee reported that the outbreak is believed to be isolated to a specific community. EMS has been asked to administer immunoglobulin; the Centra MIH program is sending assets to assist with immunoglobulin administration.<br><br>**EMS Guidance (per Dr. Lapetina):**<br>• N95 masks are required for any suspected measles patient contact.<br>◦ Standard surface cleaning does not kill measles; decontamination requires a minimum of 2 hours of time decontamination (vehicle doors open, unit out of service).<br>◦ Dr. Lapetina noted she had previously distributed a measles tip sheet at the South Central meeting and indicated she would refer the official state notification to Heidi Hooker for regional dissemination.<br>• Dr. Yee noted unconfirmed reports of possible cases outside of Buckingham County, including monitoring of one person in North Carolina and an unconfirmed report from Northern Virginia. Providers are encouraged to remain alert. | Joanne Lapetina to forward the official state notification to Chris Vernovai for regional dissemination.<br><br>Following the meeting, a provider education page for measles was published. https://odemsa.net/measles-and-ems-what-providers-need-to-know/ |
| **Adjournment** | | |
| **Adjourn** | • Dr. Yee announced the next meeting date.<br>• Meeting was adjourned at 8:51 AM. | **Next Meeting:** August 13, 2026, at 8:00 AM |

# EMS Call Summary

EMS agencies in the region responded to over 70,788 EMS calls for service during the quarter. A total of 74 agencies submitted records to the state repository. Of these records, 69,893 had a Type of Service Requested (eResponse.05) documented as Emergency Response (Primary Response Area), Emergency Response (Intercept), or Emergency Response (Mutual Aid).

## Transport Dispositions




This pie chart breaks down transport dispositions for 59,387 EMS calls in Q3 FY2026 across Region 6. Records with N/A or non-patient transport dispositions are excluded. 'Transport by This EMS Unit' was the most common at 67.8% (40,246 cases), combining 'this crew only' and 'with a member of another crew.'

| Response Type | Intercept | Mutual Aid | Prim Resp Area | Public Assist | Standby | Support Srvs | Total |
|---|---|---|---|---|---|---|---|
| No Transport | 2 | 13 | 7,000 | 175 | 96 | 30 | **7,316** |
| Non-Patient Transport (Not Otherwise Listed) | 1 | 0 | 11 | 0 | 1 | 1 | **14** |
| Patient Refused Transport | 9 | 7 | 6,913 | 20 | 6 | 5 | **6,960** |
| Transport by Another EMS Unit | 1 | 2 | 4,499 | 16 | 8 | 10 | **4,536** |
| Transport by Another EMS Unit, with a Member of This Crew | 2 | 1 | 325 | 0 | 0 | 1 | **329** |
| Transport by This EMS Unit (This Crew Only) | 23 | 72 | 39,142 | 18 | 4 | 1 | **39,260** |
| Transport by This EMS Unit, with a Member of Another Crew | 0 | 2 | 975 | 1 | 0 | 8 | **986** |
| N/A | 8 | 52 | 10,833 | 226 | 164 | 104 | **11,387** |
| **Total** | 46 | 149 | 69,698 | 456 | 279 | 160 | **70,788** |

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

*Data from ESO, NEMSIS 3.5*

This chart shows the overall call volumes for the quarter. Across 74 agencies, there were 70,788 total calls, with 69,893 documented as emergency responses under eResponse.05.

Looking at the pie chart, transport by this EMS unit makes up the largest share at about 68%. That includes calls where the primary crew completed the transport, along with a smaller number where another crew member rode along.

After that, no transport and patient refusal were fairly similar, both at about 12%.

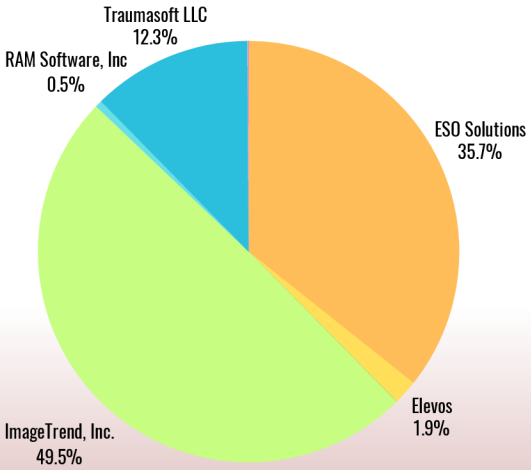
The remaining 8% reflects transports completed by another EMS unit or crew, which is still an area where we see some of the disposition documentation inconsistencies we've talked about in previous quarters.

# Submissions by Vendor

**Record Submissions by Vendor**

| Software Vendor | # of Records | | | |
|---|---|---|---|---|
| | Fail | Pass | Pending | Total |
| AngelTrack LLC | 0 | 32 | 0 | **32** |
| ESO Solutions | 413 | 36,198 | 0 | **36,611** |
| Elevos | 265 | 1687 | 1 | **1,953** |
| First Due Size Up | 0 | 12 | 0 | **12** |
| ImageTrend, Inc. | 6 | 50,793 | 2 | **50,801** |
| RAM Software, Inc | 0 | 546 | 0 | **546** |
| Traumasoft LLC | 1 | 12,582 | 0 | **12,583** |
| ZOLL | 0 | 91 | 0 | **91** |
| Total | **685** | **101,941** | **3** | **102,629** |

**Total Submissions by Vendor**

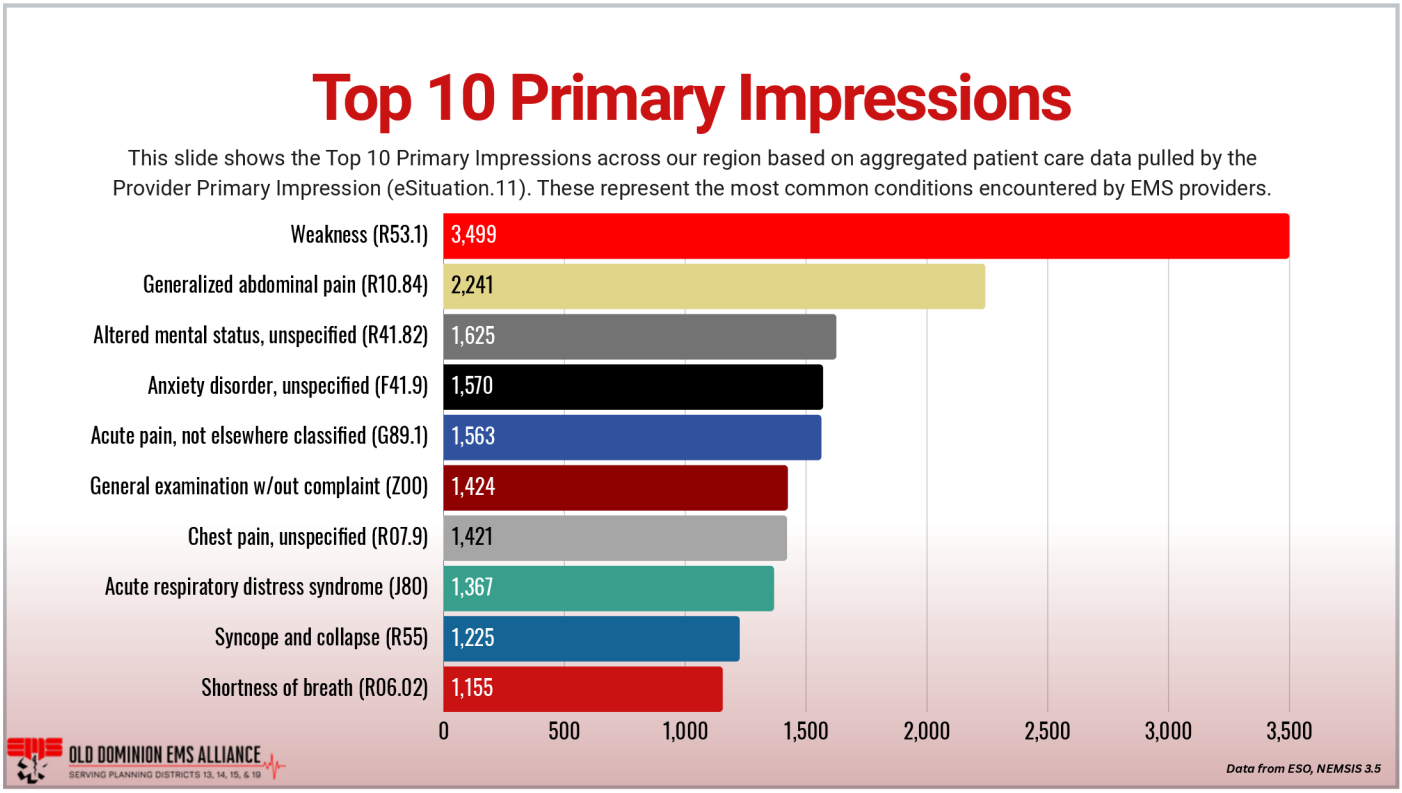



OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

*Data from ESO, NEMSIS 3.5*

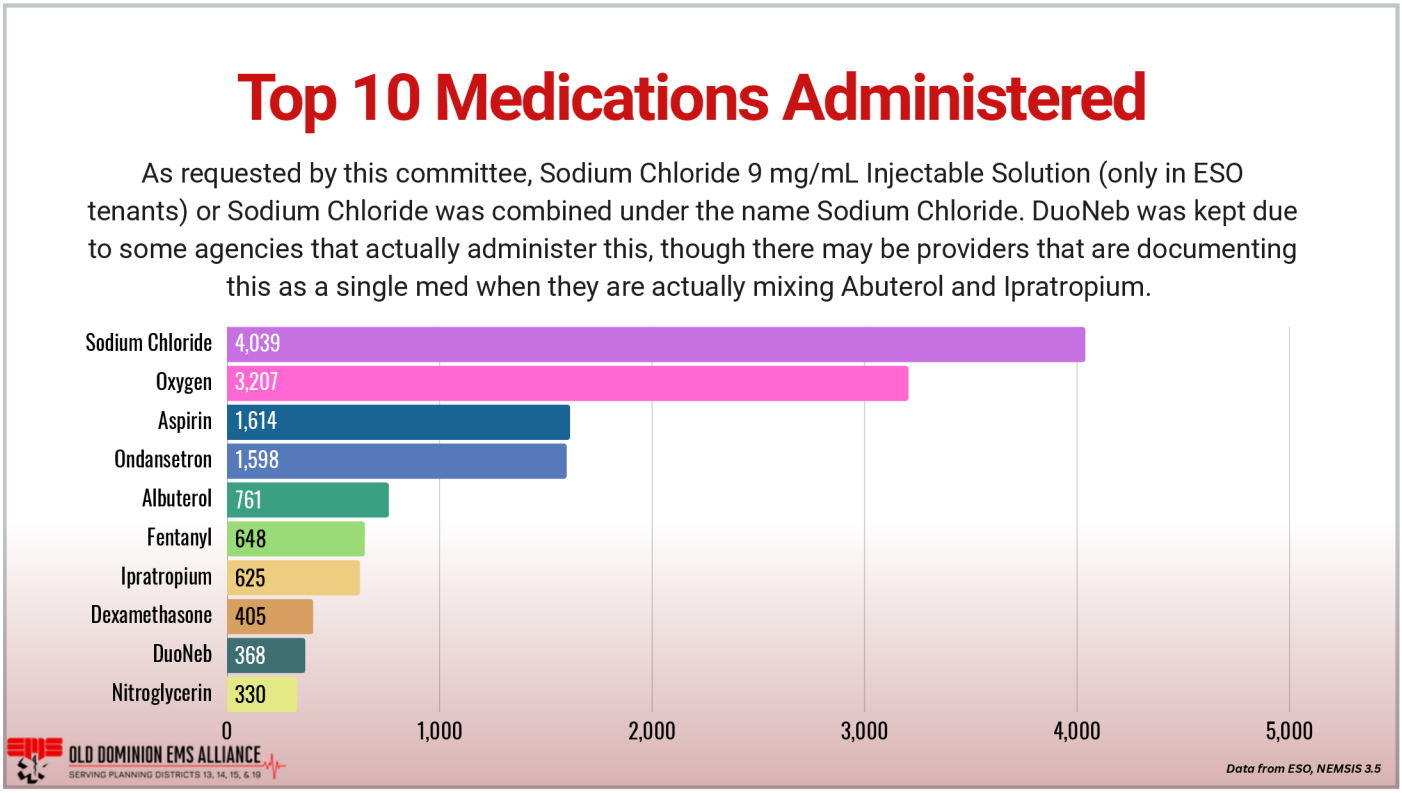
This chart shows record submissions by ePCR vendor. ImageTrend and ESO continue to account for most of the regional volume, and most records submitted passed validation.

One positive update this quarter is with Elevos. Last quarter, the agency using that platform had 2,084 failed records and only 6 that passed validation. After we reached out and worked with the agency to connect them with their vendor, that improved significantly this quarter to 265 failed records and 1,687 passing records. That's a substantial improvement and something we'll continue to monitor and address.




This chart shows the top ten primary impressions for the quarter. Weakness continues to lead the list, which is consistent with what we're still seeing at the state level.

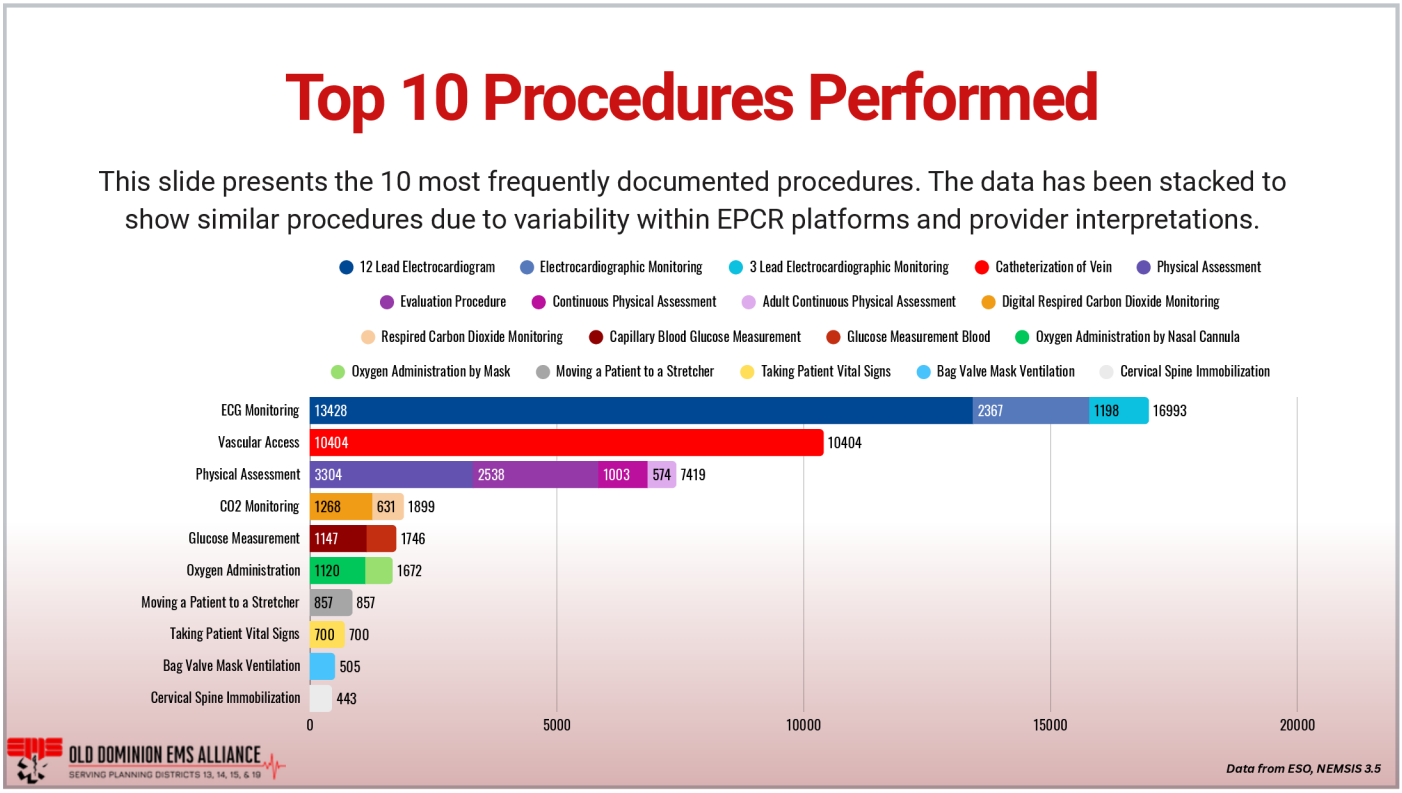
General examination without complaint also remains near the top. We believe both are used as broader catch-all impressions when providers either can't find a more specific option in the dropdown or default to a broader selection.




This chart shows the top ten medications administered this quarter. Per the committee's request, normal saline and sodium chloride 9 mg/mL were combined into a single category so they were not being counted twice under different naming conventions.

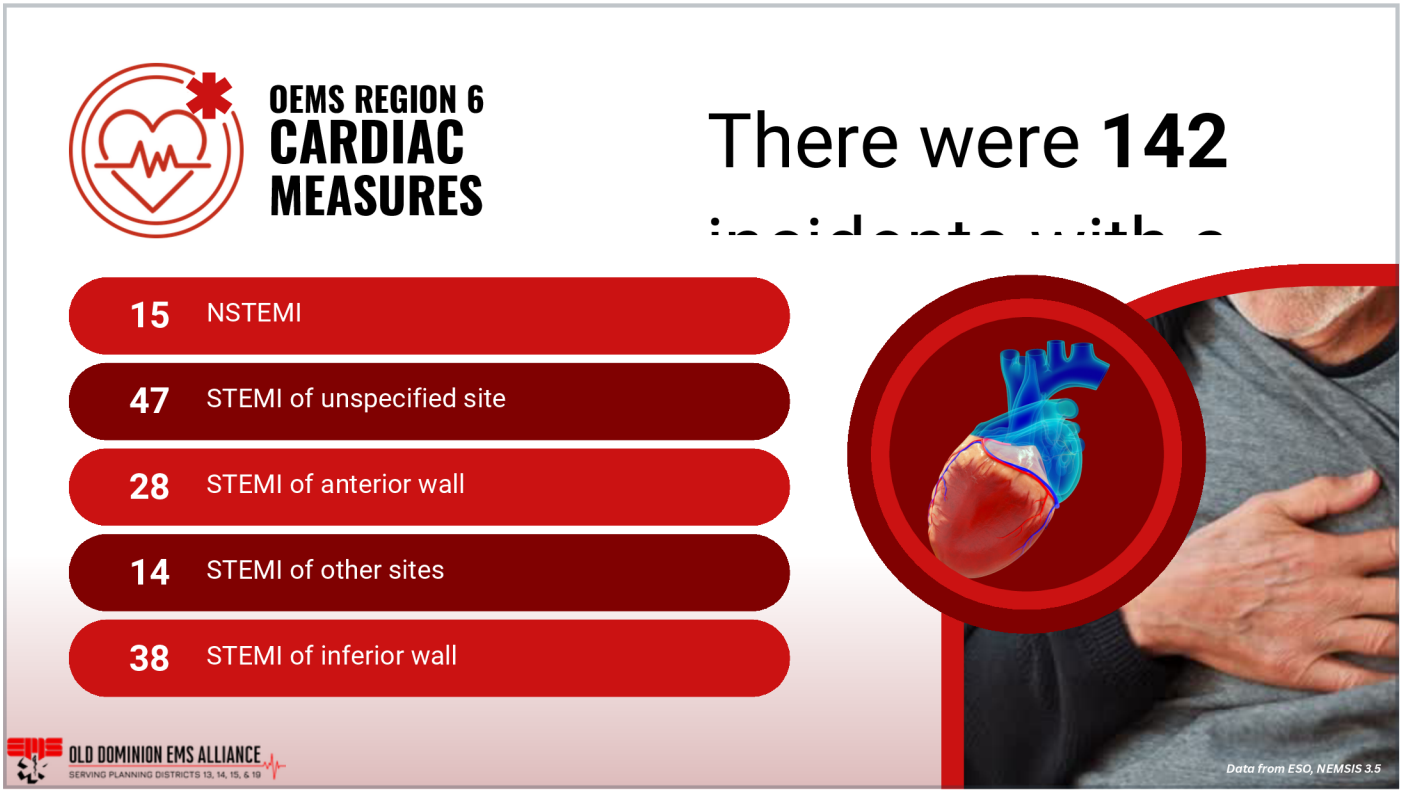
DuoNeb stayed separate because some agencies do carry and administer it as a brand-name combination medication. That said, it's also possible some providers are selecting DuoNeb when they administer albuterol and ipratropium separately, either because it's faster or they don't see a need to document both medications individually.

Outside of that, the overall medication rankings are pretty consistent with prior quarters.




This chart shows the top ten procedures this quarter, with similar procedures grouped together to reduce some of the variation we've been seeing across ePCR platforms and documentation habits.

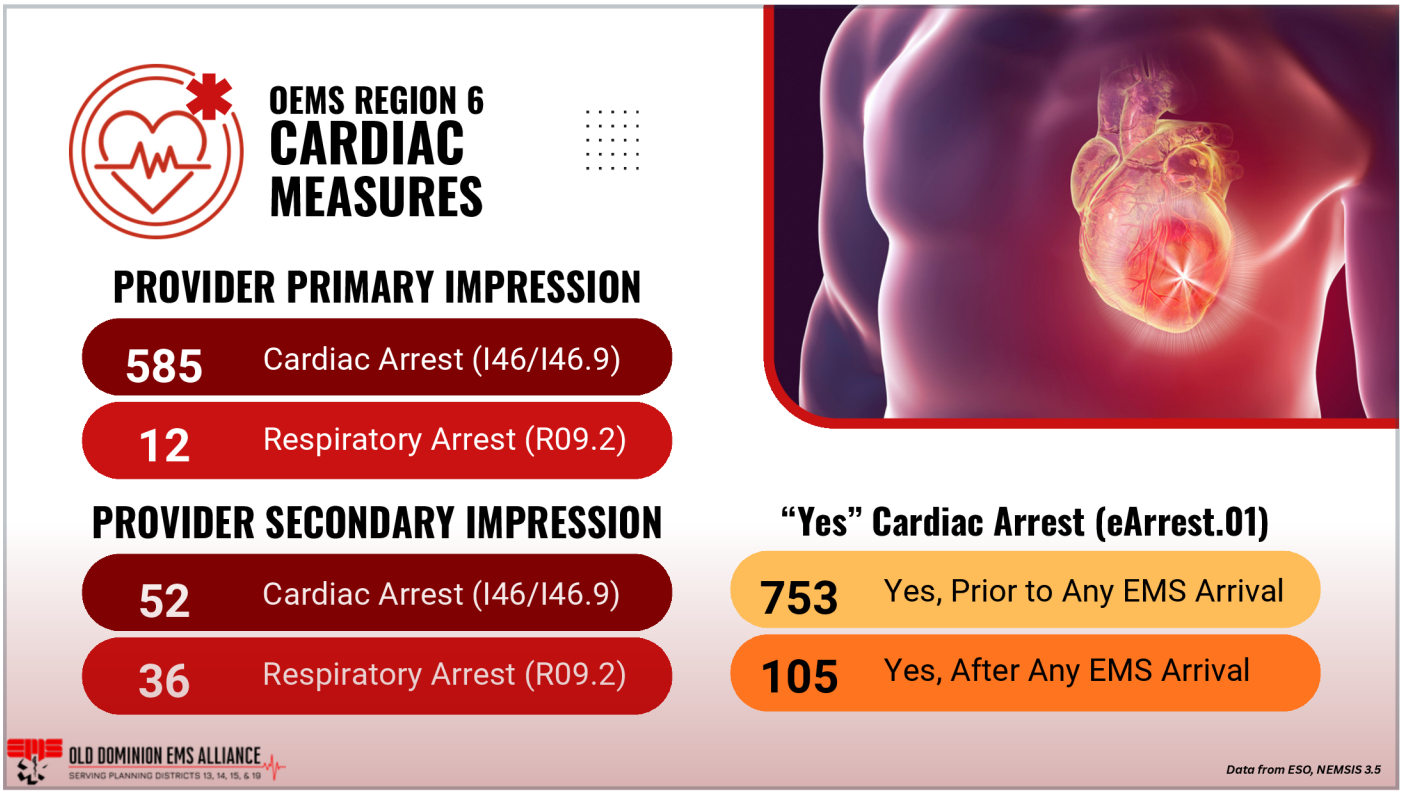
ECG monitoring, vascular access, and physical assessment continue to be the highest-volume categories. Grouping these similar procedures also gave us a broader picture of what providers are actually documenting as procedures performed.




We had 142 cardiac incidents this quarter where providers selected a primary impression consistent with myocardial infarction, including both STEMI and NSTEMI presentations.

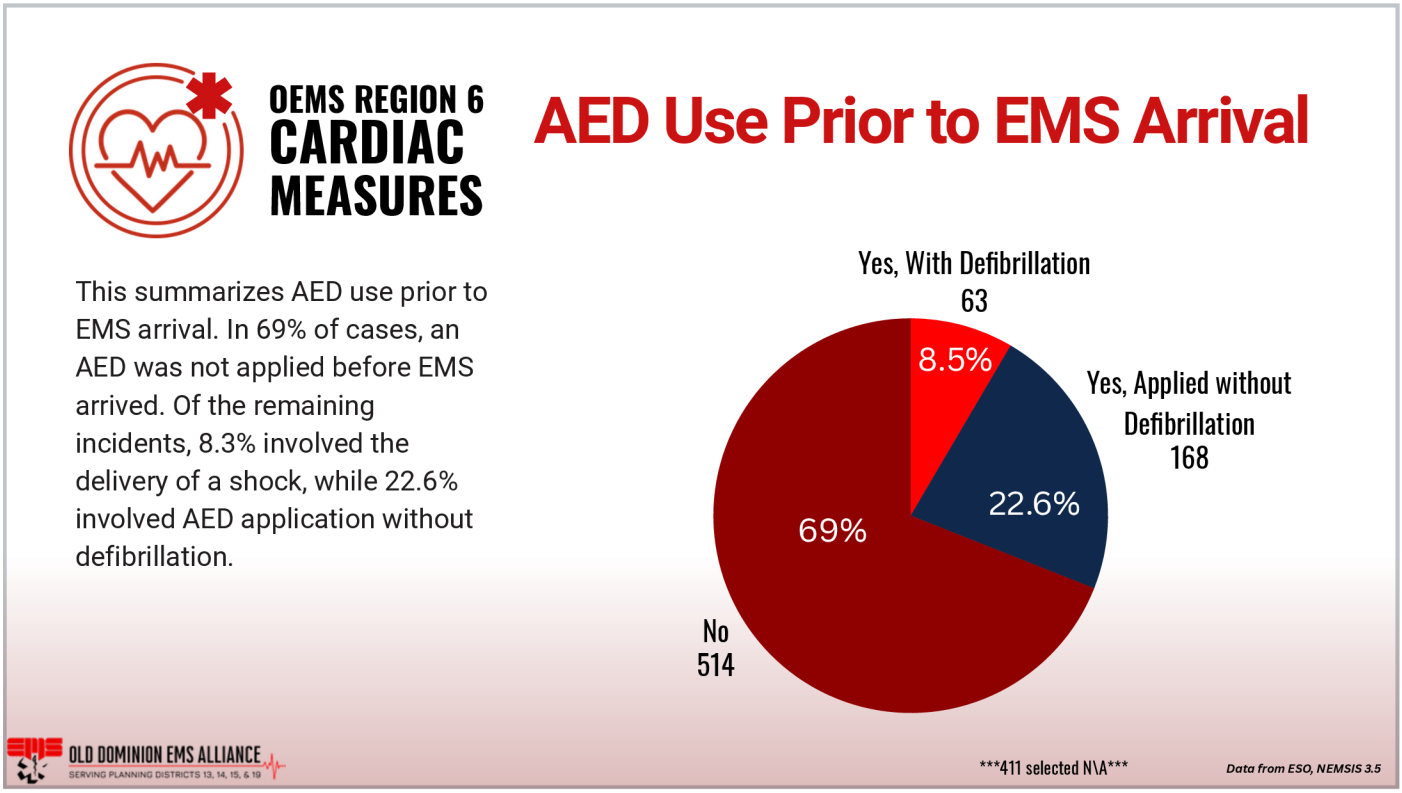
STEMI of unspecified site was the most commonly selected impression at 47 incidents, followed by STEMI of inferior wall at 38, and STEMI of anterior wall at 28.

Just as a reminder, this reflects what providers selected in the impression dropdown and not the hospital's final diagnosis.



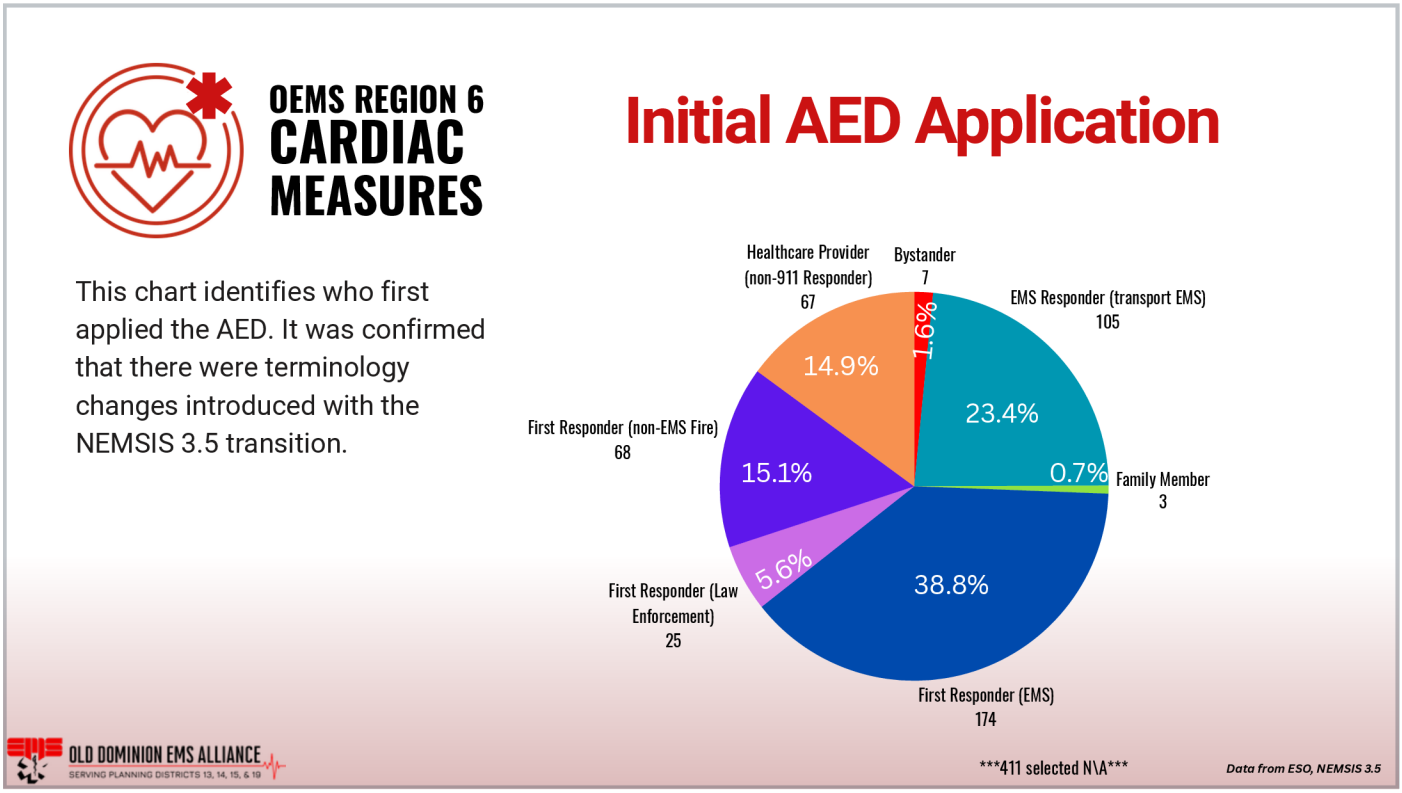

We had 585 incidents this quarter where providers selected cardiac arrest as the primary impression, along with another 52 incidents where it was documented as a secondary impression.

Looking at the eArrest.01 cardiac arrest field, 753 arrests were documented as occurring prior to EMS arrival, while 105 occurred after EMS arrival.




This looks at AED use prior to EMS arrival across the region. In 69% of cases, an AED was not applied before EMS arrived. In about 8% of cases, a shock was delivered, and in another 23%, the pads were applied but no shock was advised.

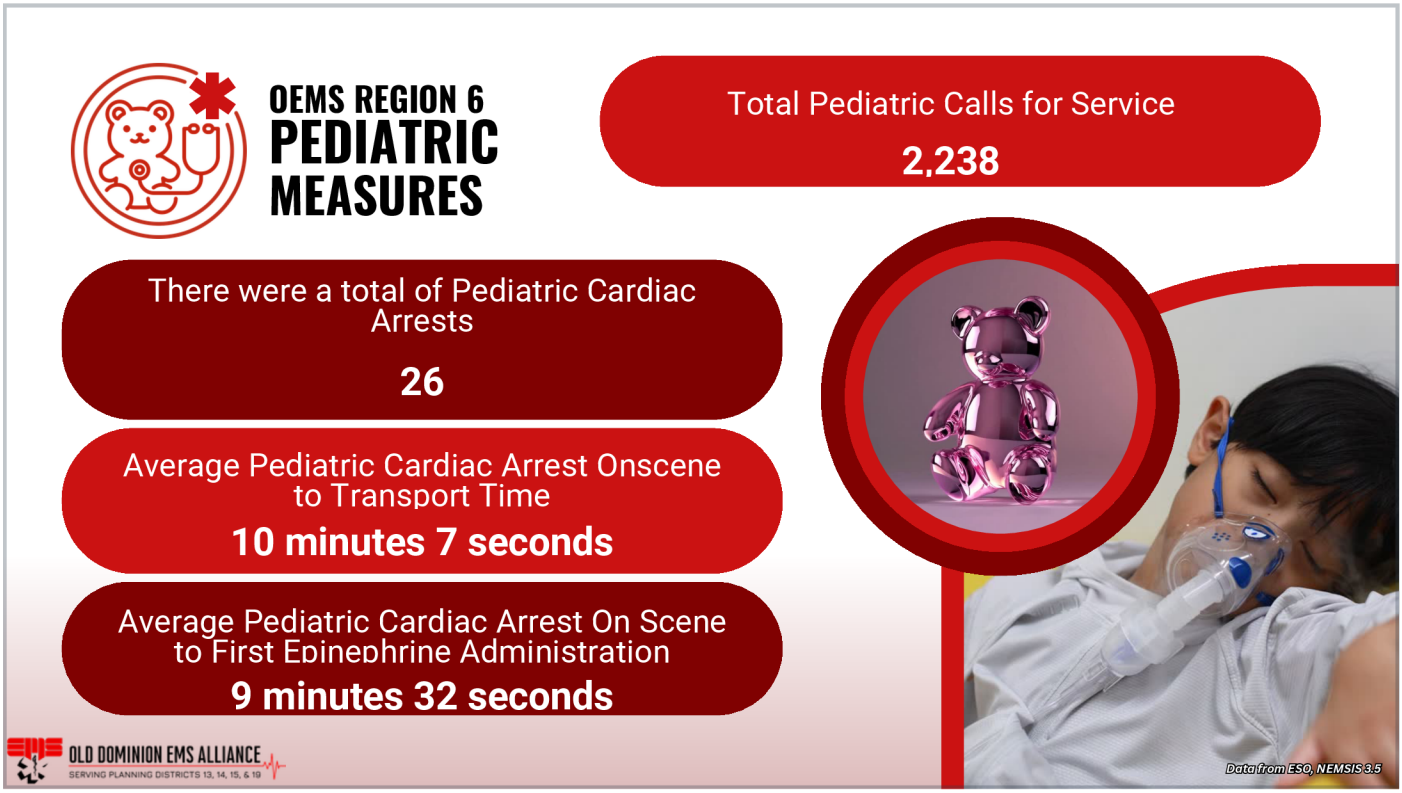
This came up quite a bit during the last meeting, and I think it's important to keep regional differences in mind. In some of our more rural areas, access to public AEDs is limited, and most people do not have AEDs in their homes, which likely plays a role in what we're seeing here. The bigger question is whether there are other solutions outside of placing AEDs on police response units that could get AEDs to patients in those rural areas faster than EMS can arrive.




This breakdown shows who first applied the AED. First Responder EMS makes up the largest category, followed by EMS transport responders and non-EMS fire.

Part of what you're seeing here is continued variation in how providers are classifying themselves under these categories. Based on the discussion from the last meeting, this appears to be more of a documentation and interpretation issue than an operational one, which is why it's been added to the list of future documentation education topics.

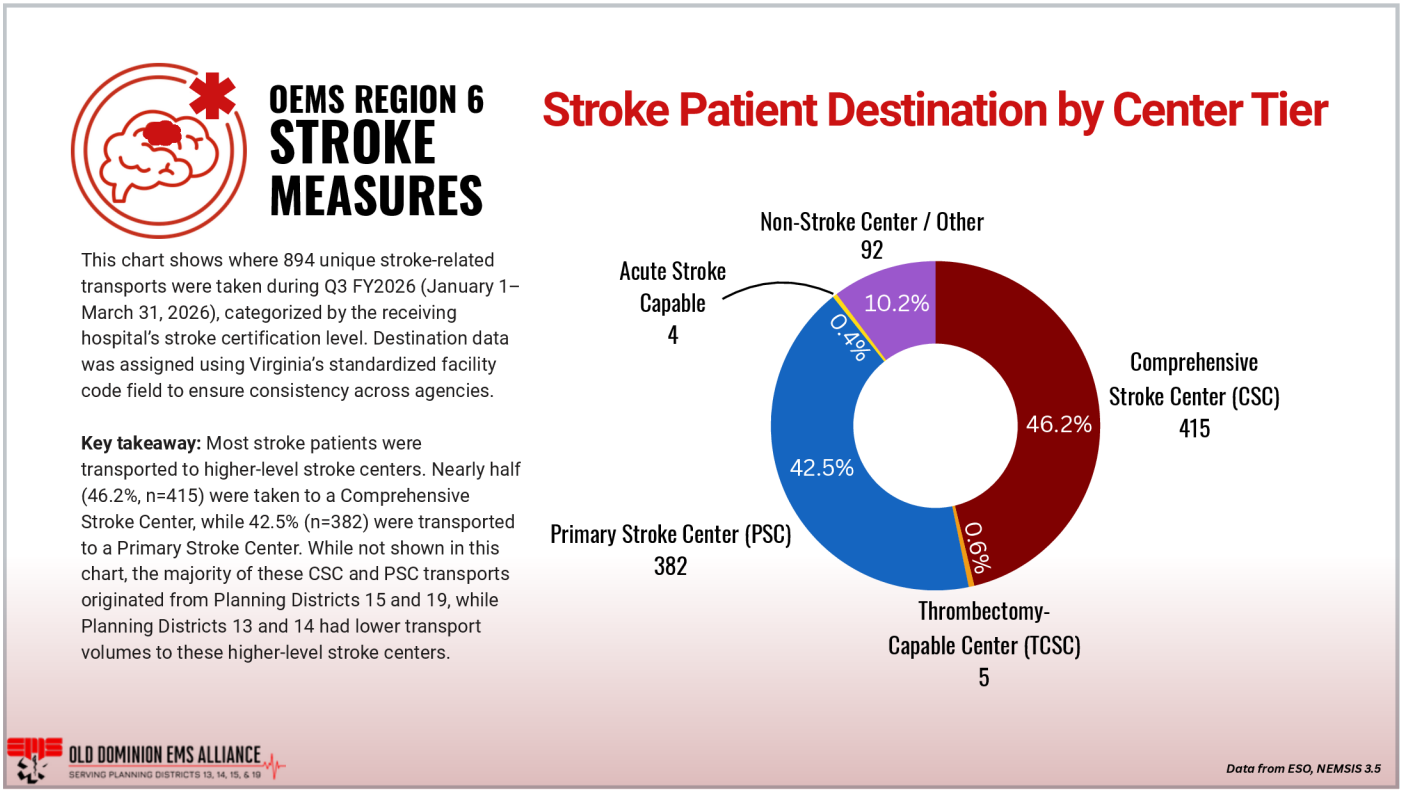
I do have the planning district breakdowns available if the committee wants to continue reviewing them, but if the group feels we've gotten what we need from that level of detail, I'm also fine moving past those slides going forward.




This slide looks at pediatric activity for the quarter. We had 2,238 pediatric calls, including 26 pediatric cardiac arrests.

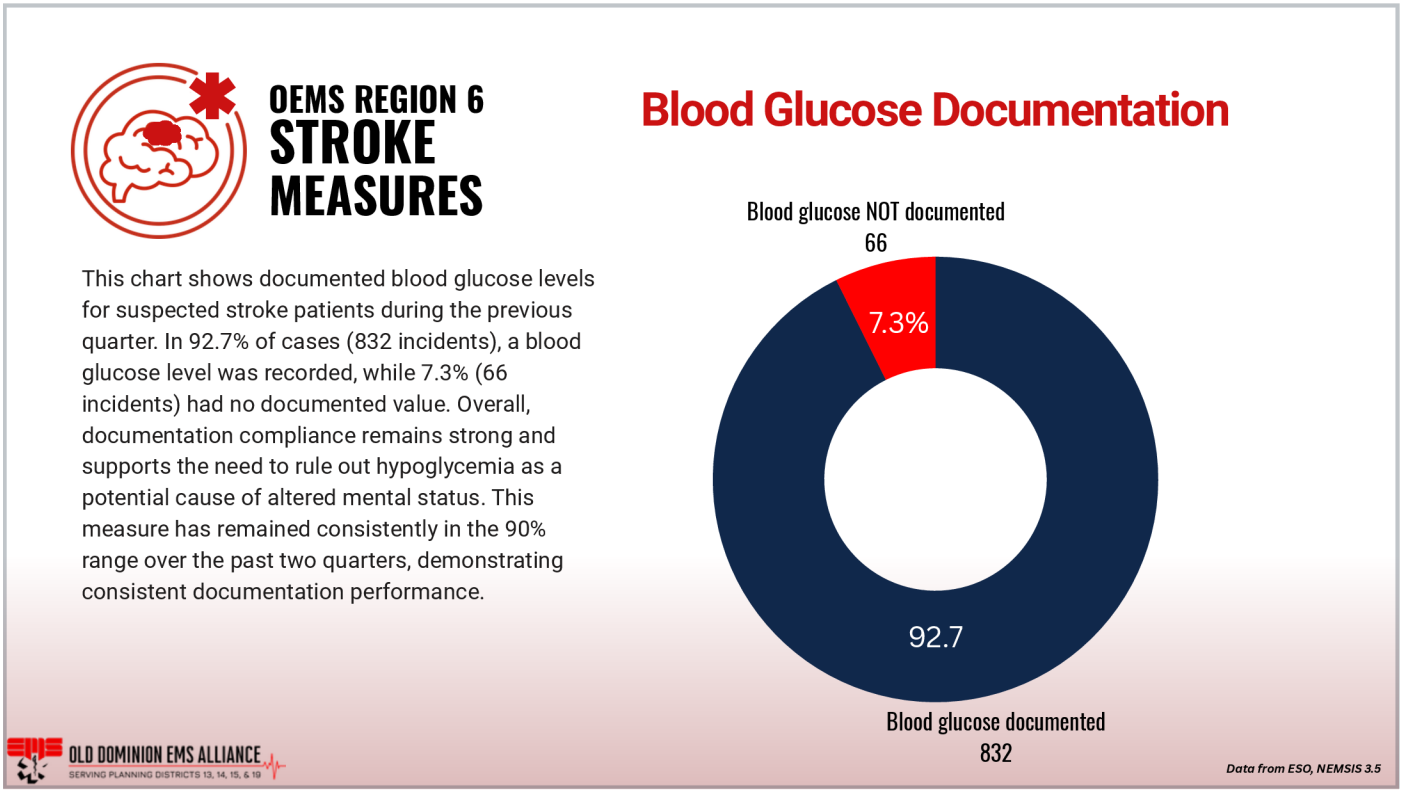
Average on-scene to transport time for pediatric cardiac arrest was about 10 minutes, and average on-scene to first epinephrine administration was about 9 and a half minutes.

Given the smaller call volume in pediatric arrests, this is really more of a trend we'll continue watching over time as we build more quarter-over-quarter data, unless there are other pediatric-specific metrics the committee would like us to focus on. You'll also see pediatric data incorporated into other sections of the report where it makes sense.



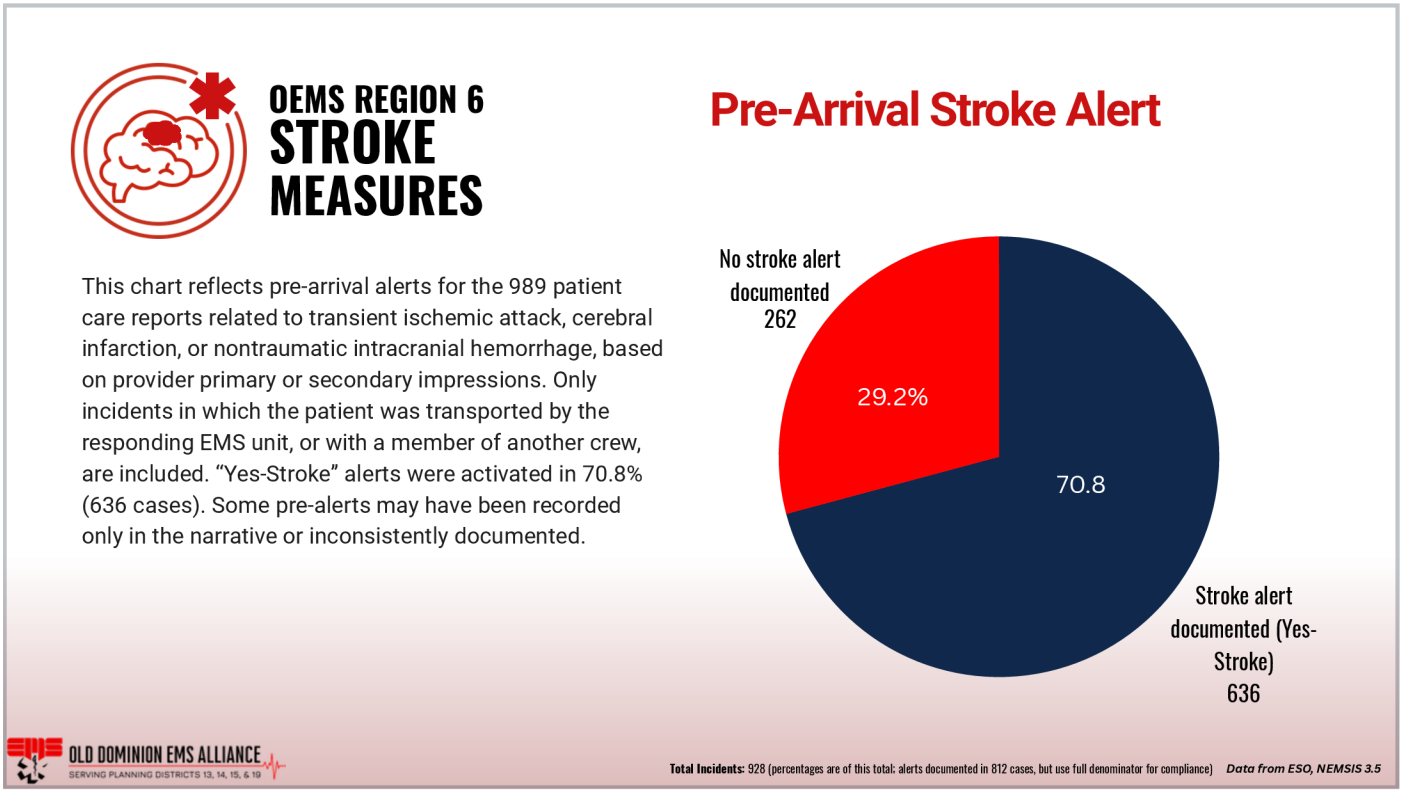

This slide looks at where 894 stroke-related transports went this quarter based on the receiving hospital's stroke certification level. About 46% were transported to a Comprehensive Stroke Center, and another 42% went to a Primary Stroke Center.

While it's not broken out on this slide, most of those higher-level transports came from PD 15 and PD 19. PD 13 and PD 14 had lower volumes to those facilities, which likely reflects transport decisions to the closest most appropriate facility based on geography, transport times, and available resources.



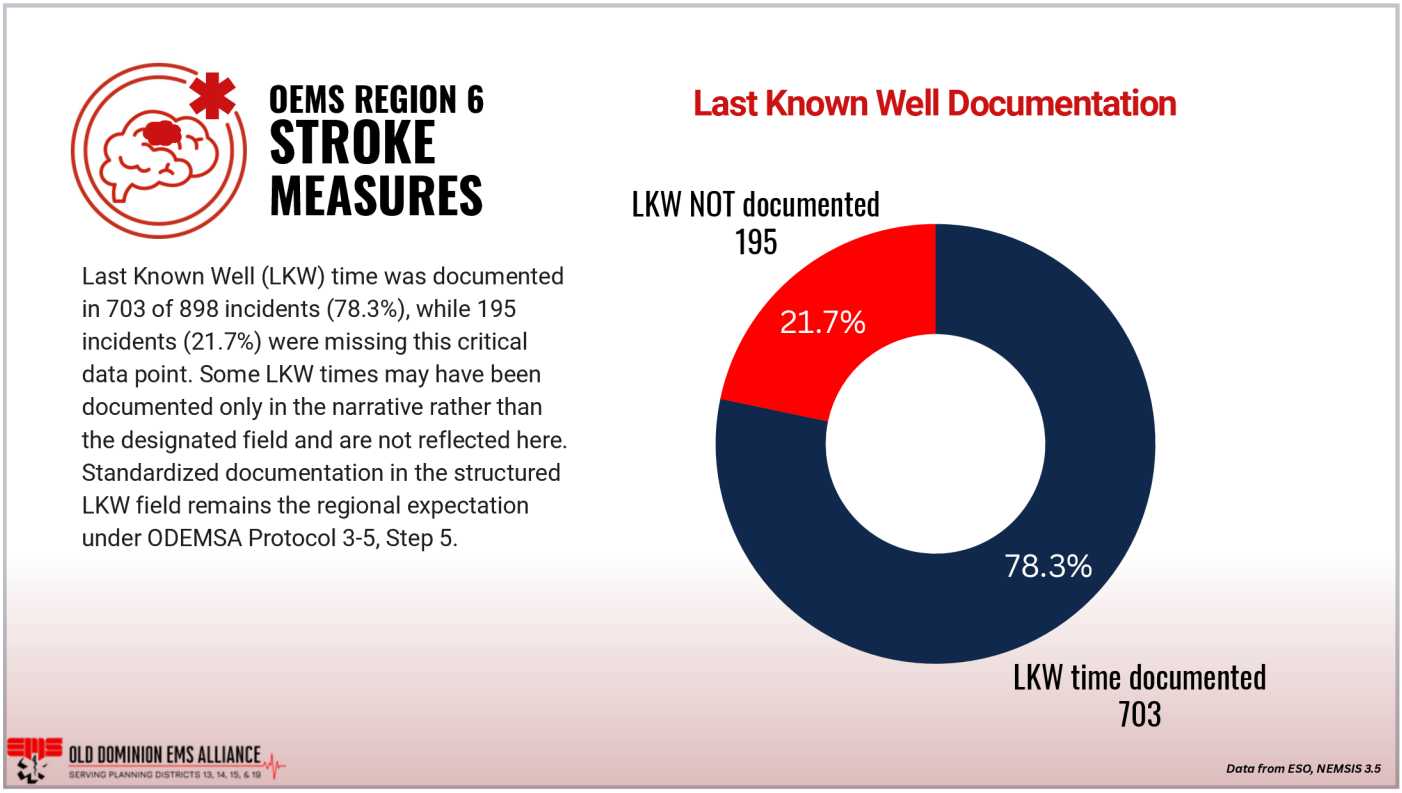

This chart looks at blood glucose documentation for suspected stroke patients. Compliance was 92.7% this quarter, which keeps us pretty consistent with the last two quarters.

This continues to support ruling out hypoglycemia as a potential cause of altered mental status and remains a strong area overall. The bigger question for the committee is whether we want to continue monitoring this at this level or if we feel performance here has remained stable enough to shift focus to other measures.



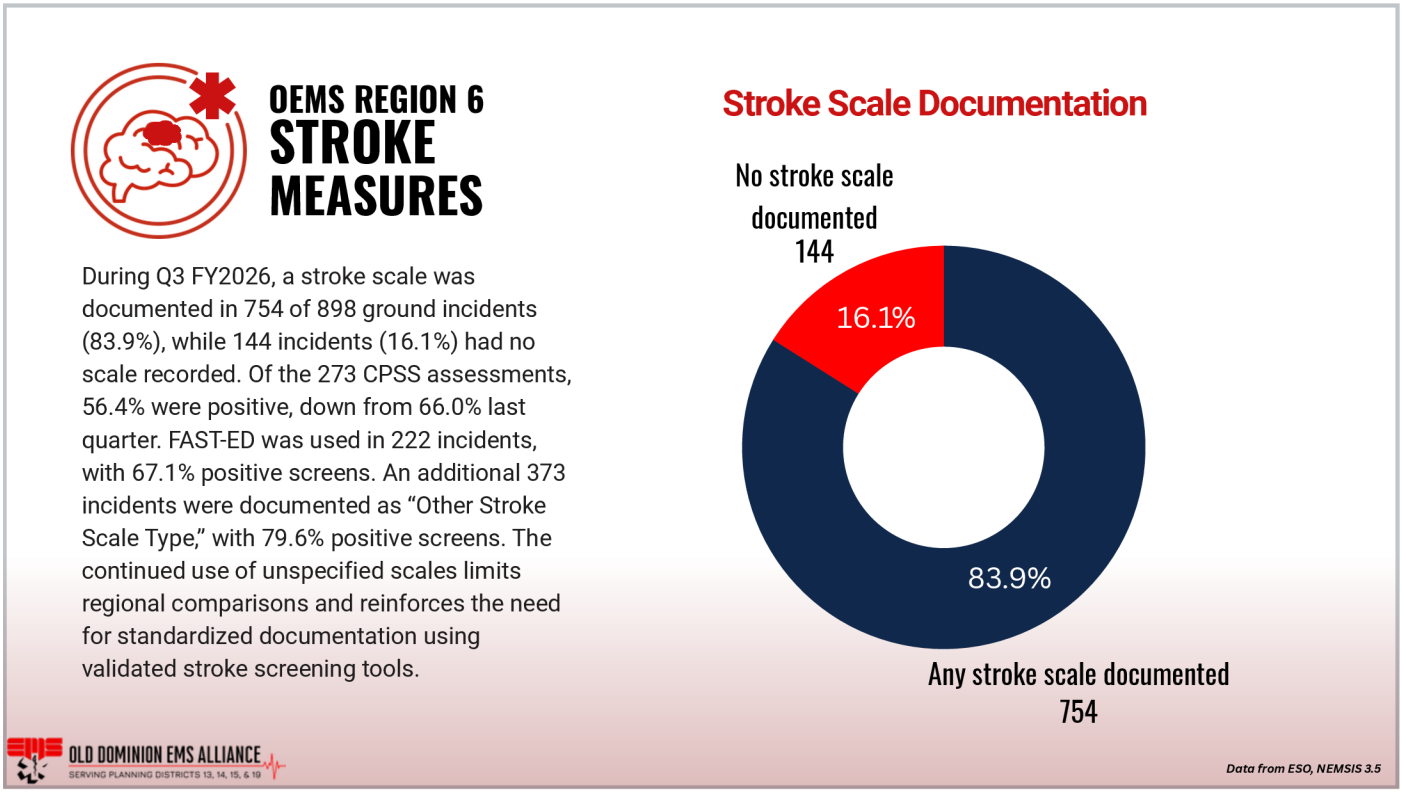

This chart looks at pre-arrival stroke alerts for the quarter. A Yes-Stroke alert was documented on 70.8% of qualifying transports.

It's possible some alerts were communicated to the hospital, but only documented in the narrative rather than the structured field. Consistent use of eDisposition.24 is something I've already added to my running list of documentation items to address with agencies moving forward.




This chart looks at Last Known Well documentation. About 78% of incidents had LKW documented in the structured field, while the remaining 22% did not.

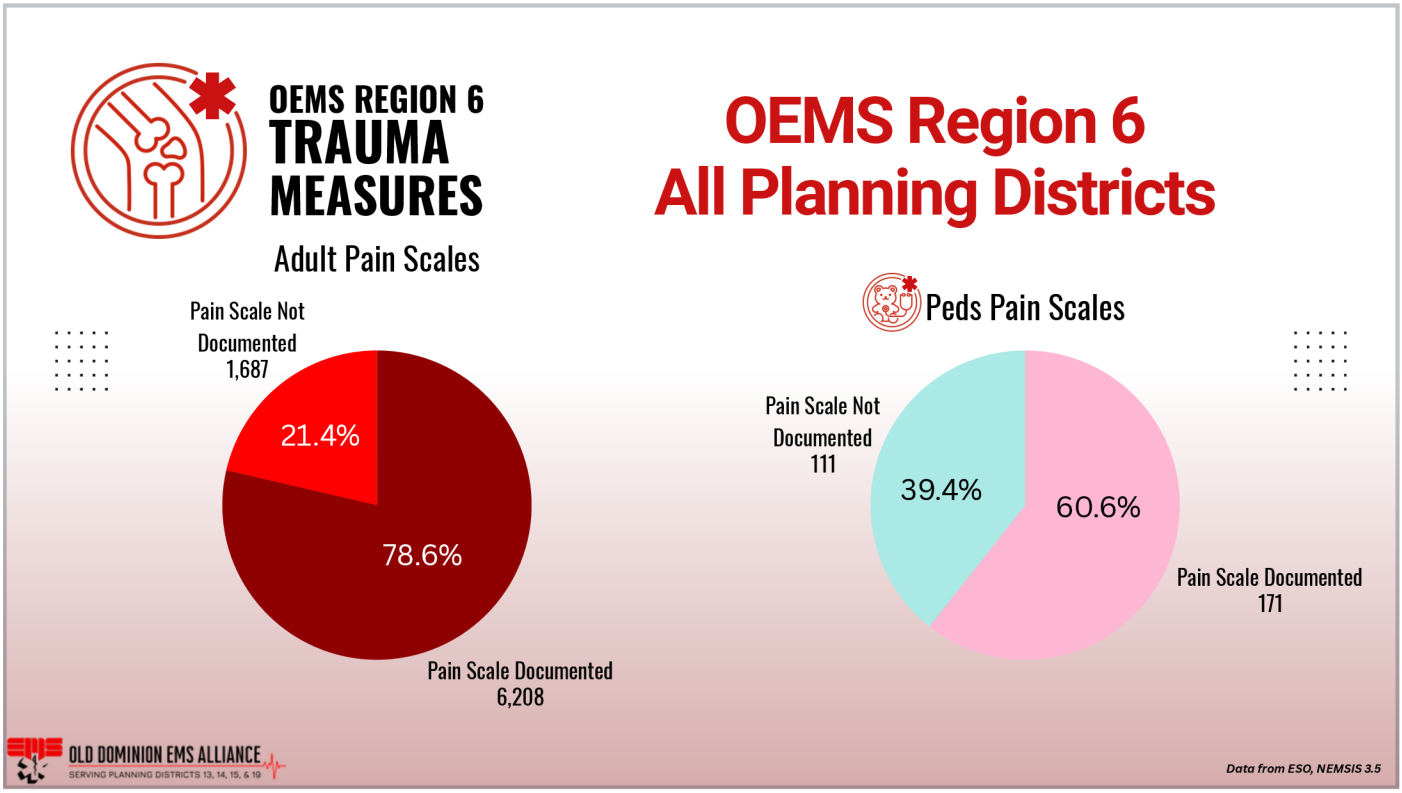
Some of those times may still exist in the narrative, but not in the designated field where we can reliably pull them. Consistent use of the structured field for this metric is another documentation item I've added to the list for follow-up education.




This chart looks at stroke scale documentation. A stroke scale was documented in about 84% of incidents. The Cincinnati Prehospital Stroke Scale was positive about 56% of the time, and FAST-ED was positive about 67% of the time.

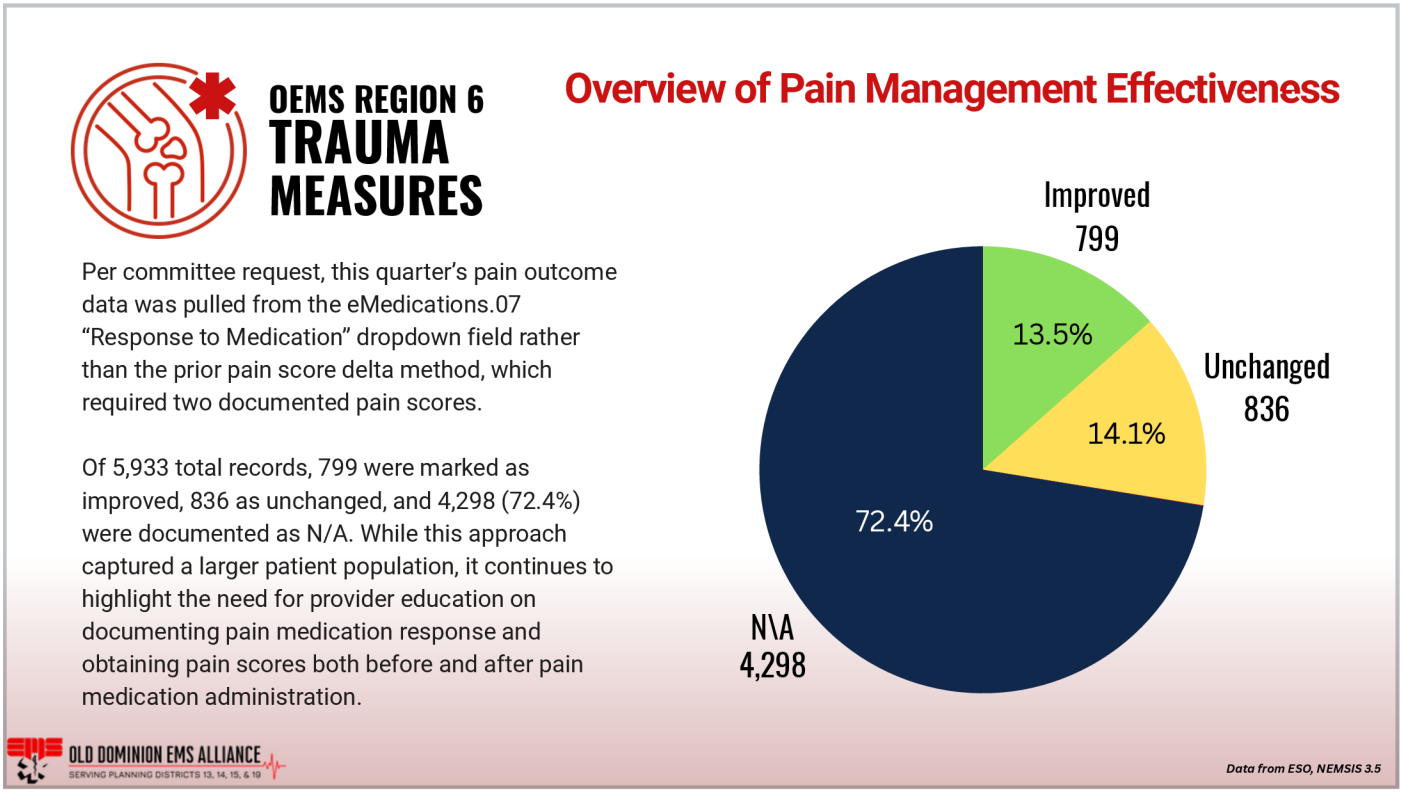
The reason that stands out is because it ties back to the conversation we had last quarter about which scales should be used and when. Our current protocol calls for providers to start with Cincinnati, FAST, or BEFAST, and if that initial screen is positive, they should then perform the VAN assessment to help identify a possible large vessel occlusion and guide destination decisions.

We're still seeing a large number of records documented as "Other," so this may be a documentation issue, a protocol clarity issue, or possibly both — and that may be something we need to revisit moving forward.




This slide breaks the same data out by adult and pediatric patients. Adult pain scale documentation was about 79%, while pediatric documentation came in lower at about 61%.

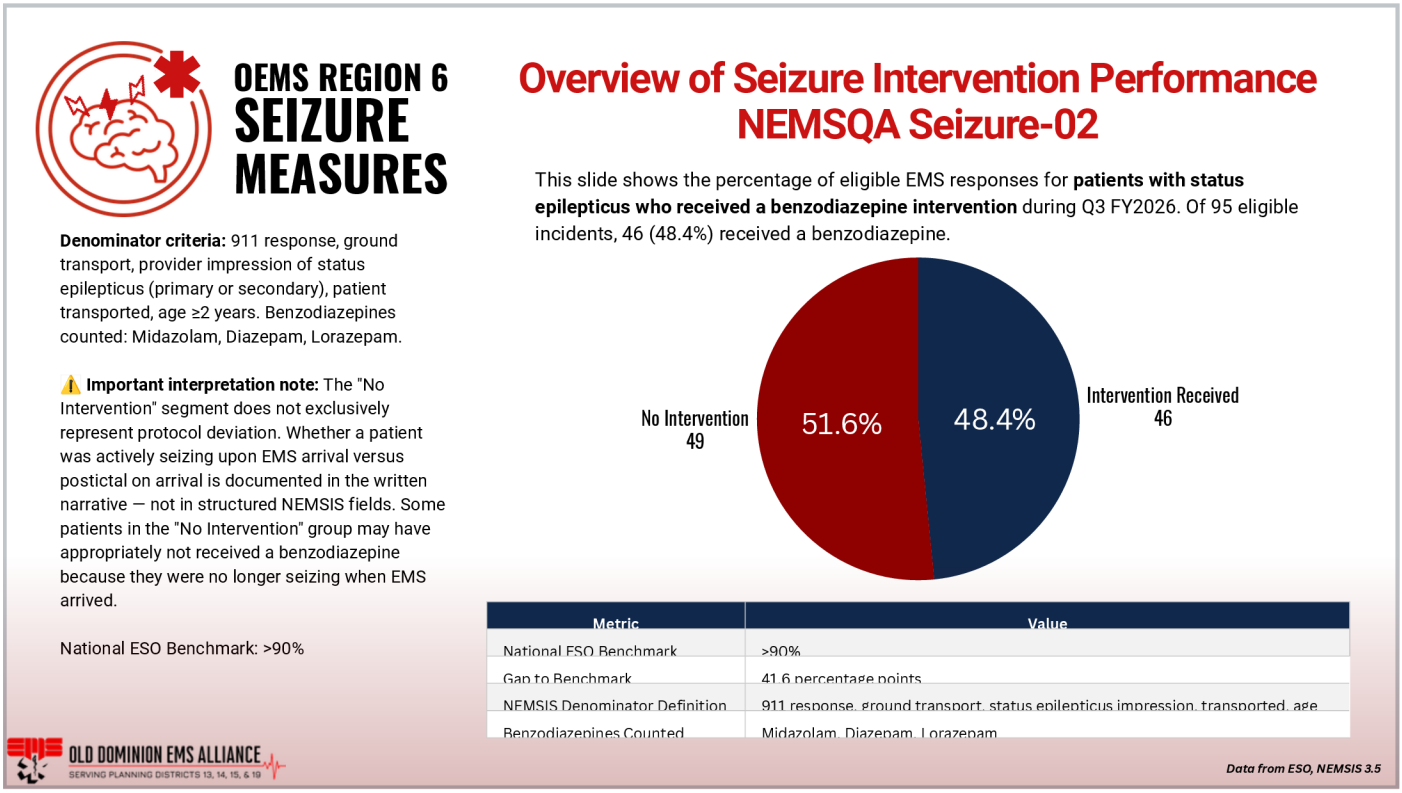
The pediatric group excludes patients 2 years old and younger, since it can be more difficult to obtain a pain score in that age group. The lower pediatric rate may reflect a mix of clinical challenges and documentation habits, and it's something we'll continue monitoring over time.




This chart looks at pain management effectiveness and, per committee request, this quarter was pulled from the eMedications.07 Response to Medication field instead of using pain score delta.

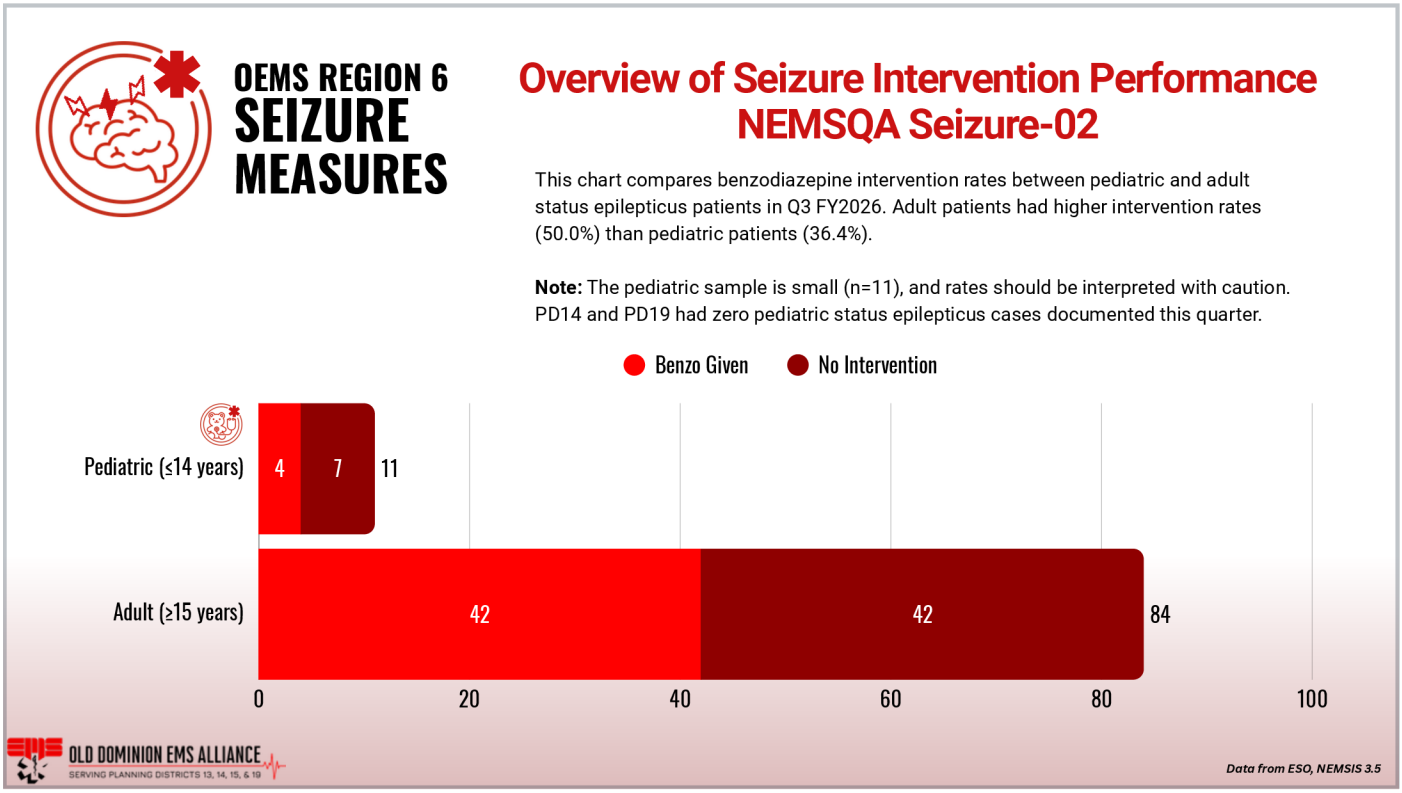
Out of nearly 6 thousand records, about 14% were marked as improved, 14% as unchanged, and 72% were documented as N/A. Notably, there were zero records documented as worsened pain this quarter.

That large N/A category continues to point more toward a documentation issue than a clinical one, and it reinforces the need to document both pain scores and medication response before and after pain medication is administered.




This chart looks at the Seizure-02 measure, which tracks patients documented with status epilepticus who received a benzodiazepine. Of 95 eligible incidents, 46 received a benzo, which comes out to 48.4%. The current national ESO benchmark is greater than 90%.

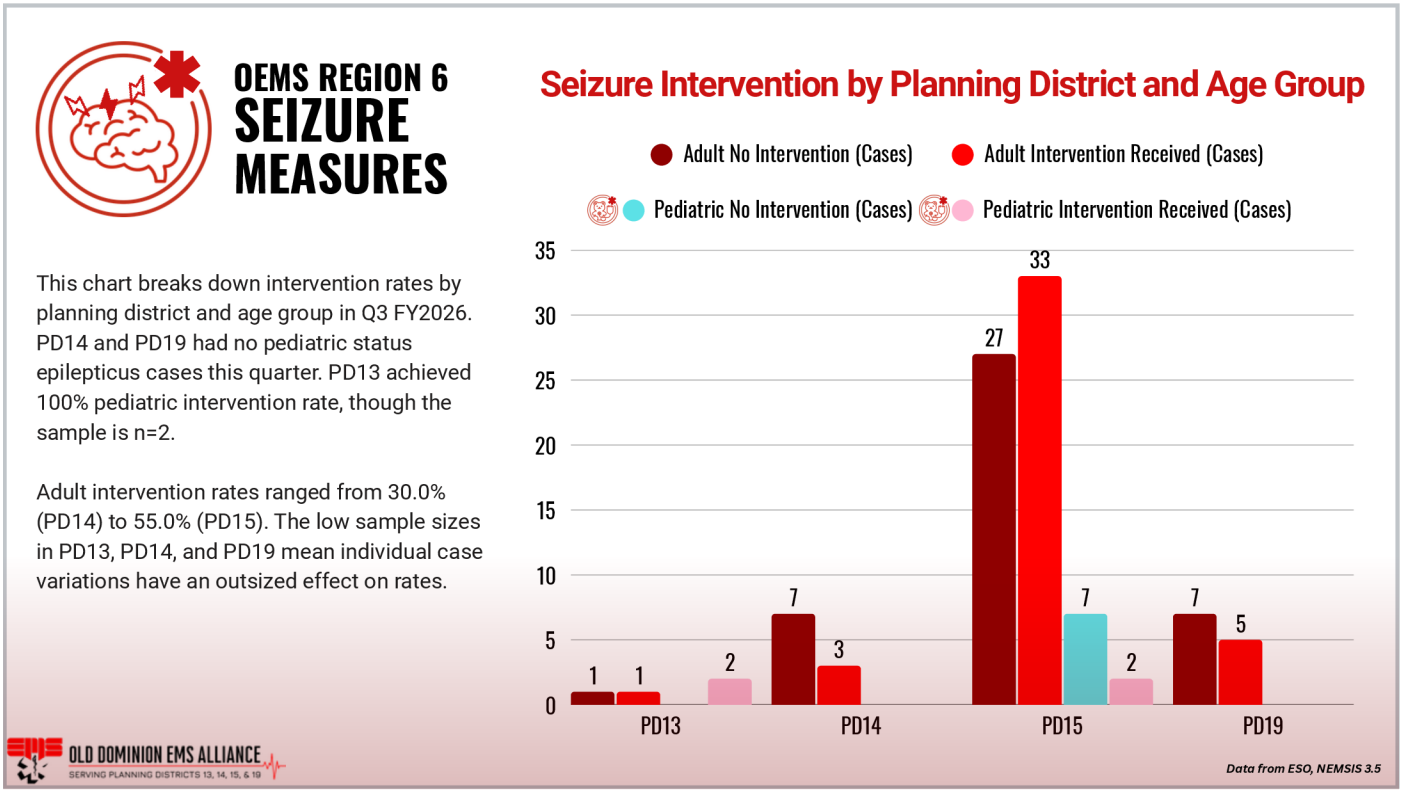
Whether the patient was actively seizing when EMS arrived often lives in the narrative and not in a structured field. That means some of the “No Intervention” group may have already been postictal when crews arrived, and in those cases not giving a benzo may have been completely appropriate.




This chart looks at Seizure-02 by age group. Adults came in at about 50%, while pediatrics came in at 36%.

Just as a reminder from our discussion last quarter, we updated the pediatric age definition so it now aligns with State Medical Direction, using 14 and under as pediatric and 15 and older as adult.

The pediatric group only included 11 patients this quarter, and PD 14 and PD 19 had no pediatric status epilepticus cases. With numbers this small, even a few cases can cause large swings in the percentage from quarter to quarter.




This chart adds the age breakdown to the planning district view using actual case counts instead of percentages.

PD14 and PD19 had no pediatric status epilepticus cases this quarter. PD13 shows 100% pediatric intervention, but that was based on only two cases.