OLD DOMINION EMERGENCY MEDICAL SERVICES ALLIANCE

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Performance Improvement Committee

May 13, 2026, 02:00 PM to 04:00 PM
Chair: Mike Watkins, PD15/Goochland Fire
Vice-Chair: Vacant

Members and Guests Present: N/A
Virtual Attendees: Beth Broering, Whitney Cipriani, Ashley Fitzwater, Danielle Geronimo, Brittany Jones, Nicole Laurin, Hannah Lawrence, Tom Ludin, Greg Neiman, Kelly Schaaf, Kate Schulz, Melody Spivey, Emma Spruill, Abby Touch, Ami Watkins, Mike Watkins, Marquita Whisonant, Allen Yee
ODEMSA Staff: Heidi Hooker and Ryan Scarbrough
Minutes Scribed by: Ryan Scarbrough
Materials Provided: Previous meeting minutes, agenda, and Q3 FY2026 / Q1 CY2026 PI Quarterly Report

Topic / Subject	Discussion	Recommendations, Action / Follow-up; Responsible Person
Meeting Called to Order	**The meeting was called to order at 2:04 PM by Chair Mike Watkins.** Introductions were conducted. Due to a lack of quorum, the meeting proceeded as a working session. Quorum requirements and bylaws language were reviewed later in the meeting (see Committee Representation below).	No action required.
Previous Meeting Minutes	Chair Watkins asked if there were any questions or challenges with the previous meeting minutes. No issues were raised. As quorum was not established, the minutes could not be formally approved.	Minutes approval tabled to a future meeting when quorum is achieved.
Agency Reports		
Goochland County Fire-Rescue	**Mike Watkins** The agency has been very active in its blood program, reporting its busiest month on record in April 2026 without any specific event driving the increase — attributed to overall rising call volume. Goochland is adding five new positions this year and is planning to launch its own paramedic program beginning in October 2026.	No action items identified.

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Richmond Fire and Emergency Services	**Tom Ludin** Starting next week, Richmond Fire will self-sanction its own first aid, CPR, and AED teaching license renewal courses in partnership with the Department of Education, bypassing AHA and Red Cross. This is expected to reduce costs for teachers. The department is also planning to open a pharmacy in the future, beginning with Schedule 6 medications only, and is considering a jurisdictional CSR for the entire City of Richmond. The department is evaluating adoption of the iGel airway device at the BLS level — no final decision has been made.	Tom Ludin to report back on outcomes of the teaching license renewal initiative.
Henrico County Division of Fire	**Kelly Schaaf** No report for this meeting.	None.
Richmond Ambulance Authority	**Danielle Geronimo** No report for this meeting.	None.
Chesterfield Fire and EMS	**Dr. Allen Yee** No report for this meeting.	None.
Charles City County EMS	**Melody Spivey** No report for this meeting.	None.
Hospital Reports		
Bon Secours Mercy Health	**Brittany Jones / Kate Schulz** No report provided. A question was raised about whether trauma bays were open; no specific update beyond standard operations was shared.	None.
HCA Healthcare	**Hannah Lawrence / Ashley Fitzwater** Hannah Lawrence reported that the HCA trauma department will be distributing t-shirts to EMS crews during EMS Week on the following Thursday. EMS providers in the area were invited to stop by. Ashley Fitzwater had no additional items to report. Whitney Cipriani and Emma Spruill were present but had no report.	None.
VCU Health Systems	**Greg Neiman / Beth Broering** VCU sent its EMS Week schedule for all four facilities; providers who did not receive it were asked to contact Greg Neiman directly. Construction has begun on the waiting room of the adult emergency department at VCU Medical Center (Main). The direct EMS access path to the waiting room is temporarily closed. EMS crews should route past the yellow, green, and blue zones to	Ryan Scarbrough / Committee leadership to formulate language for a formal written request to VDH/OEMS requesting the addition of

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	access the waiting room from the rear. The walk-in patient entrance has been shifted to the old Children's Hospital entrance during Phase 1 of construction. Greg Neiman raised a concern about the limited availability of pediatric data from the VDH Office of EMS data portal. He noted that while call summary data is available through December 2025, there are no dedicated pediatric visualizations or dashboards, and the data has not been updated with graphic visualizations since 2024. He suggested that the committee formulate a formal request to VDH/OEMS for the addition of pediatric dashboards. Beth Broering reiterated her invitation for EMS agencies to submit abstracts for the upcoming annual VCU Trauma Symposium at the end of June.	pediatric data dashboards to the state data visualization portal. EMS agencies interested in presenting at the VCU Trauma Symposium to submit abstracts through the registration process; contact Greg Neiman for logistics information.
OEMS Region 6 / Old Dominion EMS Alliance Report		
ODEMSA	**Ryan Scarbrough / Heidi Hooker** Since the last meeting, ODEMSA has hired two new staff members: Chris Vernovai joined as Training Director in early April, and Heather Nelson joined as Field Coordinator in late February. ODEMSA is now fully staffed and onboarding is underway. EMS Week is the following week; ODEMSA is preparing related activities. Work is ongoing on the regional whole blood program; more information will be provided as the program moves forward. ODEMSA is working with Dr. Yee and other councils on the SS4A (Safe Streets and Roads for All) grant. Agencies were surveyed about participation in both the whole blood program and the SS4A grant; agencies that had not yet responded were being followed up with directly. A new ticket system has been established for all ACE Division (Accreditation, Certification, and Education) inquiries and issues. Cam Critton is currently out on medical leave; Ron Passmore is filling in. The positions for Debbie Akers and Chris Venovai have been posted through the Office of EMS.	Agencies that have not responded to the whole blood program and SS4A grant survey to do so promptly. Agencies with ACE Division questions to use the new ticket system.
Committee Representation and Quorum Discussion	**Mike Watkins** Chair Watkins read Article 4, Section 2 of the Committee Bylaws aloud for the group. The bylaws establish that voting membership shall consist of one representative from agencies answering over 20,000 EMS calls annually, one representative from each hospital system, one representative from the EMS Subcouncil and PD-15, two representatives from EMS Subcouncils in Planning Districts 13, 14, and 19, and	Mike Watkins and Heidi Hooker to meet offline to clarify bylaws interpretation regarding quorum requirements, particularly for EMS Subcouncil representation in PDs 13, 14, and 19.

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	representatives from the Regional Medical Director and designated ODEMSA committees. It was determined that quorum could not be established primarily due to missing representation from two EMS Subcouncil representatives in Planning Districts 13, 14, and 19. Discussion occurred regarding how to interpret representation from agencies exceeding 20,000 annual calls. Ryan Scarbrough noted that after re-filtering call volume data by scene zip code (removing hospital-to-home transports), AMR remained above the 20,000-call threshold with 29,912 calls attributed to Region 6 scenes. Whether AMR and other agencies should be counted toward the agency representative slot was discussed but not resolved. Kate Schulz offered to represent Planning District 19 due to her location. Options for dual-counting Dr. Yee as both Regional Medical Director and agency (Chesterfield) representative were also discussed.	ODEMSA to continue outreach to subcouncils in Planning Districts 13, 14, and 19 to secure committee representation.
Old Business		
PI Quarterly Report Review (Q3 FY2026 / Q1 CY2026)	**Ryan Scarbrough presented** the Q3 FY2026 / Q1 CY2026 Quarterly Performance Improvement Report, covering January through March 2026. *He prefaced the presentation by asking the committee to consider how the PDSA (Plan, Do, Study, Act) cycle could be applied to the data — moving beyond chart review toward meaningful action.* **EMS Call Summary** 74 agencies submitted records. Total calls: 70,788, with 69,893 documented as emergency responses. Transport by EMS unit accounted for approximately 68% of dispositions. No transport and patient refusal each represented approximately 12%. Ongoing documentation inconsistencies noted in transport disposition fields. **Submissions by Vendor** ImageTrend and ESO continue to account for the majority of regional submissions. Elevos showed significant improvement this quarter: failed records were reduced from over 2,000 last quarter to 265, with passing records increasing from 6 to 1,687, following outreach to the agency and vendor.	

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	Top Impressions and Call Volumes Weakness continues to lead primary impressions, consistent with state trends. General Examination Without Complaint remains near the top, likely used as a catch-all when providers cannot find a more specific dropdown option. Top agencies by call volume: Richmond Ambulance Authority, Henrico County Division of Fire, and Chesterfield Fire and EMS. **Transport Destinations *(1)*** VCU, HCA/Chippenham, and Bon Secours facilities received the highest in-region transport volumes. Chippenham Hospital was inadvertently omitted from the in-region destination slide due to a mapping error; an updated report will be distributed. Free-text hospital entries continue to cause destination misclassification. Out-of-region transports to facilities such as Bluefield and Pulaski remain difficult to fully explain and are being investigated. **Medications and Procedures** Per the committee's prior request, normal saline and sodium chloride 0.9% were combined into a single medication category. Duoneb was retained as a separate entry as some agencies carry and administer it as a combination drug; it was also noted that some providers may be selecting Duoneb as a shortcut rather than documenting albuterol and ipratropium separately. ECG monitoring, vascular access, and physical assessment were the highest-volume procedure categories. **Cardiac Measures** 142 MI-related incidents documented. STEMI of unspecified site was the most common at 47 incidents, followed by STEMI of inferior wall (38) and STEMI of anterior wall (28). 585 incidents documented with cardiac arrest as primary impression; 52 additional as secondary. 753 arrests occurred prior to EMS arrival; 105 after EMS arrival. **AED Use Prior to EMS Arrival** In 69% of applicable cases, no AED was applied before EMS arrived. A shock was delivered in approximately 8% of cases; in 23%, pads were applied but no shock was advised. Rural access limitations were noted as a contributing factor. Discussion included whether alternatives to police-carried AEDs exist for rural areas. Tom Ludin noted that even in urban areas, public AED usage is rare, with most use occurring through public safety responders. **Pediatric Activity**	**(1)** Ryan Scarbrough to distribute an updated version of the PI report with Chippenham Hospital correctly reflected in the in-region transport destinations slide. *(Update Attached)* Agencies to be educated on correct use of structured documentation fields for: transport disposition, pre-arrival stroke alert (eDisposition.24), last known well, stroke scale selection, and response to medication. Ryan Scarbrough to maintain a running list of documentation education topics to be addressed in future provider outreach.

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	2,238 pediatric calls this quarter, including 26 pediatric cardiac arrests. Average scene-to-transport time for pediatric cardiac arrest was approximately 10 minutes; average time to first epinephrine administration was approximately 9.5 minutes. Greg Neiman noted these metrics align with the broader discussion about the need for better pediatric dashboards at the state level. **Stroke Measures** 894 stroke-related transports this quarter. Approximately 46% were transported to a comprehensive stroke center and 42% to a primary stroke center. Higher-level transports were concentrated in Planning Districts 15 and 19; lower volumes in PDs 13 and 14, consistent with geographic proximity to available stroke center resources. **Stroke Blood Glucose Documentation *(2)*** 92.7% compliance, up from 91.2% last quarter. The committee agreed performance in this area is stable and adequate; continued monitoring at the current level of detail was endorsed. **Stroke Alert and Last Known Well Documentation** Pre-arrival stroke alerts documented on 70.8% of qualifying transports. Last known well (LKW) was documented in the structured field for approximately 78% of incidents; 22% lacked structured LKW documentation, though times may exist in the narrative. Committee discussion noted that for patients presenting from nursing facilities or with uncertain onset, LKW can be genuinely unknown, contributing to non-documentation. Consistent use of the eDisposition.24 pre-arrival notification field and the structured LKW field was identified as an ongoing education need. **Stroke Scale Documentation *(3)*** 84% of incidents had a stroke scale documented. The Cincinnati prehospital stroke scale was positive in 56% of cases; the FAST was positive in 67%. A large number of records documented the stroke scale as “Other.” It was suggested this may occur because providers performing the VAN assessment cannot select both Cincinnati/FAST and VAN, and default to “Other.” Current protocol calls for Cincinnati/FAST first, then VAN if positive to identify potential large vessel occlusion. **Pain Scale Documentation (Trauma) *(4)*** 79% of adult trauma patients with GCS ≥15 and documented as alert had a pain score recorded, up from the prior quarter. Pediatric pain documentation came in lower at 61%	**(2)** Committee to evaluate removing blood glucose from active monitoring given stable performance, or continue at current frequency — consensus to continue monitoring. **(3)** Address stroke scale “Other” documentation issue: consider whether the VAN scale should be formally added to regional ePCR platforms or whether provider education on multi-scale documentation is sufficient. **Responsible Person:** Ryan Scarbrough / Medical Direction. **(4)** Incorporate age-appropriate pediatric pain scale options and education (Wong-Baker FACES, FLACC) into future provider training. **Responsible Person:** Ryan Scarbrough / Committee.

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	(excluding patients aged 2 and under). The committee discussed the limited pain scale options available in ePCR platforms for pediatric patients and the need to include training on age-appropriate scales (Wong-Baker FACES, FLACC, etc.) in provider education. **Pain Management Effectiveness** Out of approximately 6,000 records reviewed using the eMedications.07 Response to Medication field: 14% documented as improved, 14% unchanged, and 72% documented as N/A. Zero records documented worsened pain. The high N/A rate was identified as a documentation issue rather than a clinical one, reinforcing the need for providers to document both a pre- and post-medication pain score and a formal response to medication. **Seizure Measures** Approximately 1,500 seizure-related records reviewed. Only 97 incidents (approximately 6%) were documented with status epilepticus, which is the impression that triggers the NEMSQA-02 seizure quality measures. Secondary impression documentation for seizure records was only 28% overall, with significant variation by planning district (PD13: 71%, PD15: 22%). **Seizure Benzodiazepine Administration** Of 95 eligible status epilepticus incidents, 46 patients received a benzodiazepine (48.4%). The national ESO benchmark is greater than 90%. It was noted that patients who were post-ictal on EMS arrival would not have received a benzodiazepine but are still captured in the denominator, potentially skewing the percentage lower. Pediatric status epilepticus patients received a benzo in 36% of cases vs. 50% for adults. Pediatric age was updated this quarter to align with state medical direction: 14 and under is pediatric; 15 and older is adult. March showed the highest single-month intervention rate in six months at 62.5%.	
Trauma Triage Plan Update	**Mike Watkins / Ryan Scarbrough** No changes have been made to the Trauma Triage Plan since the last meeting. The committee acknowledged the need to schedule dedicated time to update the plan to align with new state guidelines. The committee previously identified the need for representation from all trauma centers in the region to participate in a review workgroup. Ryan Scarbrough noted he would need to review prior meeting notes to confirm who volunteered to assist.	Trauma Triage Plan update tabled pending formation of a workgroup. Ryan Scarbrough to review prior meeting notes to confirm workgroup participants and coordinate scheduling of a workgroup session with

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		representatives from all regional trauma centers. Workgroup to focus on aligning triage criteria with current state guidelines.
Committee Representation / Bylaws Review	**Ryan Scarbrough / Mike Watkins** Ryan Scarbrough re-ran call volume data filtering by scene response zip code to exclude hospital-to-home and other non-911 transports. Under this filter, Hospital to Home was excluded from the over-20,000-calls threshold, while AMR recorded 29,912 scene responses within the region. Discussion ensued about whether the 20,000-call threshold applies to 911-response agencies only or includes non-emergency transport agencies. No consensus was reached. The committee also discussed how the bylaw language requiring "one representative from agencies which answer over 20,000 calls" should be interpreted — whether it means a single shared seat for all qualifying agencies or one seat per qualifying agency. It was acknowledged that the representation gap most impacting quorum is the absence of two representatives from EMS Subcouncils in Planning Districts 13, 14, and 19.	Mike Watkins and Heidi Hooker to meet offline to clarify bylaws interpretation and determine if a formal bylaw amendment is needed. Ryan Scarbrough to provide updated call volume data filtered by scene zip code to the full committee. ODEMSA to continue targeted outreach to PD 13, 14, and 19 subcouncils to recruit committee representation. **Responsible Person:** Heidi Hooker / Ryan Scarbrough.
New Business / Business from the Floor		
Whole Blood Program—ePCR Documentation	**Mike Watkins / Kelly Schaaf / Ryan Scarbrough** Mike Watkins raised the need to incorporate whole blood program data into the quarterly PI report as the program goes live. He emphasized the importance of ensuring blood product administration is accurately translated into ESO and ePCR systems. Kelly Schaaf noted that Henrico County is not purchasing the critical care ePCR module due to cost. As a result, only the three NEMSIS 3.5 blood product fields available in their ImageTrend build will be captured. All other blood administration documentation will be recorded on a paper worksheet. It was acknowledged that agencies without the critical care module will have limited data flowing into the statewide repository, which may affect the completeness of PI reporting for the blood program. Mike Watkins asked about the downstream effect on annual program review data.	Agencies participating in the whole blood program to confirm with their ePCR vendor which NEMSIS 3.5 blood product fields are available within their current module configuration. Ryan Scarbrough to plan for the incorporation of blood product data into future PI quarterly reports once the program is operational. Committee to revisit documentation completeness for the blood program at the next meeting once more agencies

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	Other agencies noted that ImageTrend does have a power tool that consolidates blood product fields; access to those fields is contingent on having the critical care module licensed.	have confirmed their ePCR field configurations.
Adjourn	Chair Watkins announced the next meeting will be held on August 12, 2026, from 2:00 PM to 4:00 PM. As quorum was not established, no formal motion to adjourn was required. **The meeting was adjourned at 3:01 PM.** Chair Watkins thanked all members for their participation.	**Next meeting: August 12, 2026, 2:00 PM – 4:00 PM.**

This is the Q3 FY2026 Performance Improvement Report, covering January through March of this year. The same data caveat applies — what's in here is what was submitted to the state repository as of the days the data was pulled. If something looks off, it's usually a documentation question, and I'll flag those as we go.

Before we jump into the data, I just want to frame what we're trying to accomplish today. As we go through these slides, I'd ask everyone to keep an eye out for areas where we can apply a PDSA approach — Plan, Do, Study, Act.

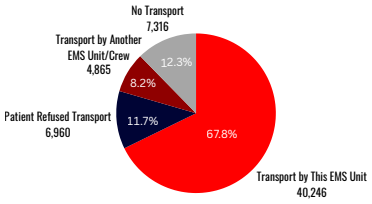
If we're only reviewing charts every quarter without identifying opportunities to improve documentation, workflows, or patient care processes, we're probably going to keep seeing many of the same trends.

Some of today's slides are more informational and help establish our baseline, while others may highlight opportunities where we can make meaningful changes. With that, I'll start with our overall EMS call summary data for the quarter.

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.'

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

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**

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%.

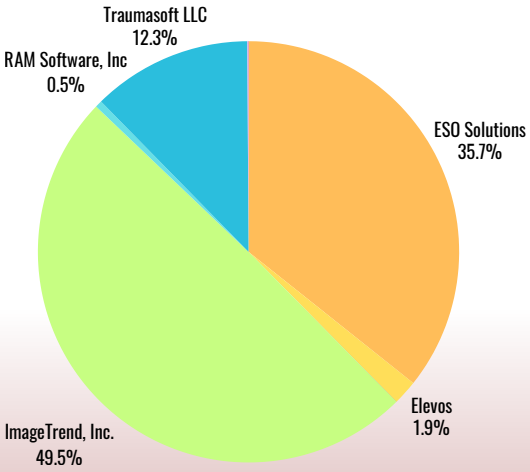
The remaining 8% reflects transports completed by another EMS unit or crew, which is still an area where we see some of the disposition documentation inconsistencies we've talked about in previous quarters.

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

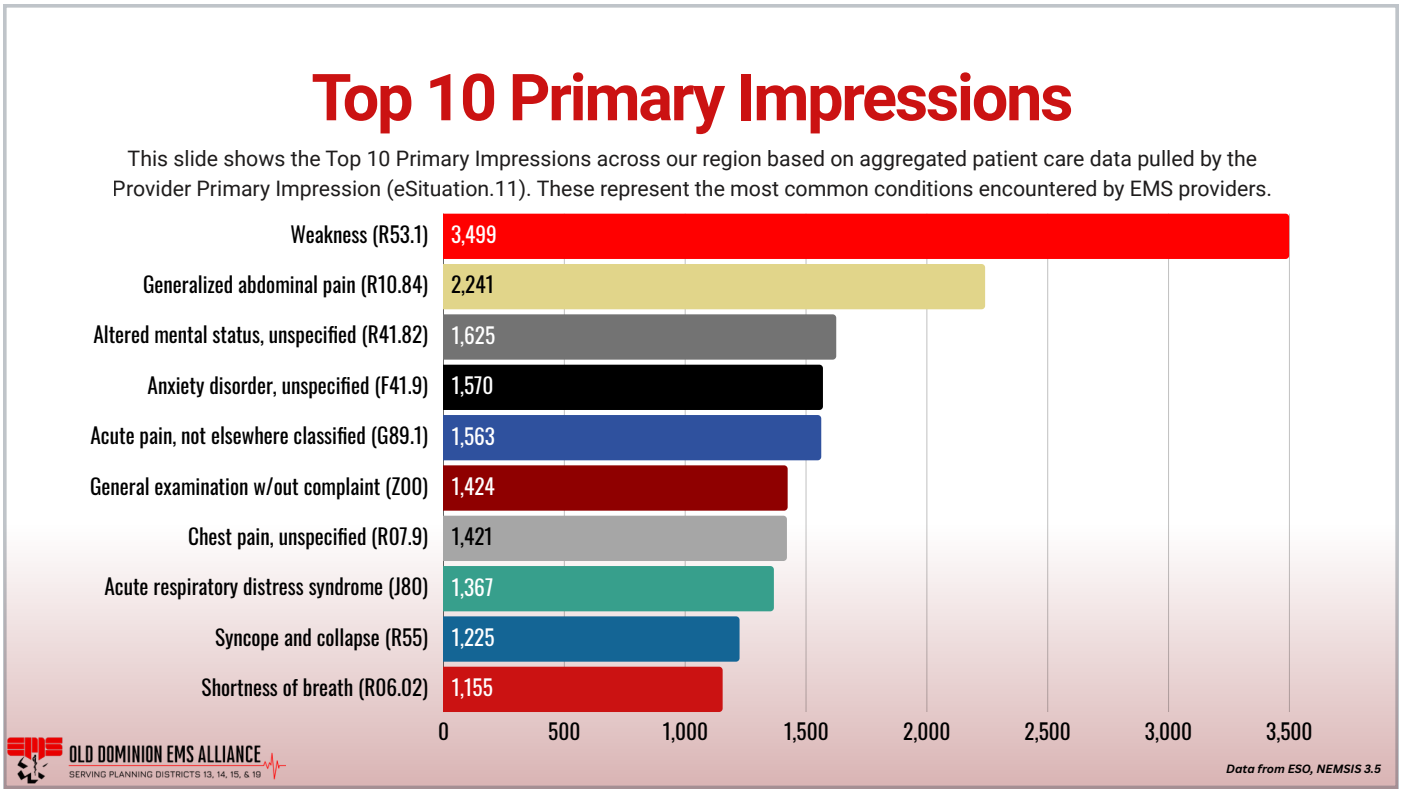


OLD DOMINION EMS ALLIANCE
SERVING PLANNING DISTRICTS 13, 14, 15, & 19

Data from ESO, NEMSIS 3.5

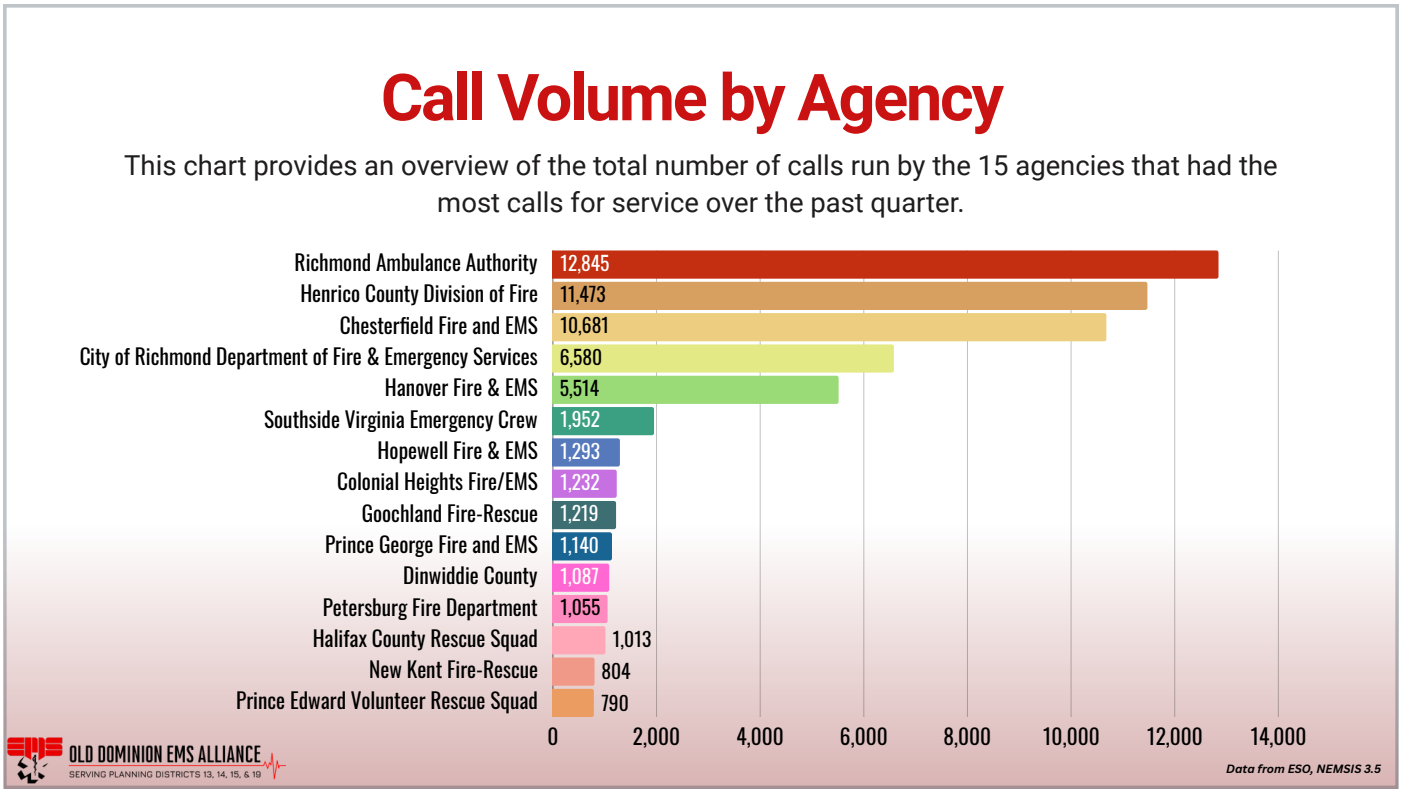
This chart shows record submissions by ePCR vendor. ImageTrend and ESO continue to account for most of the regional volume, and most records submitted passed validation.

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.



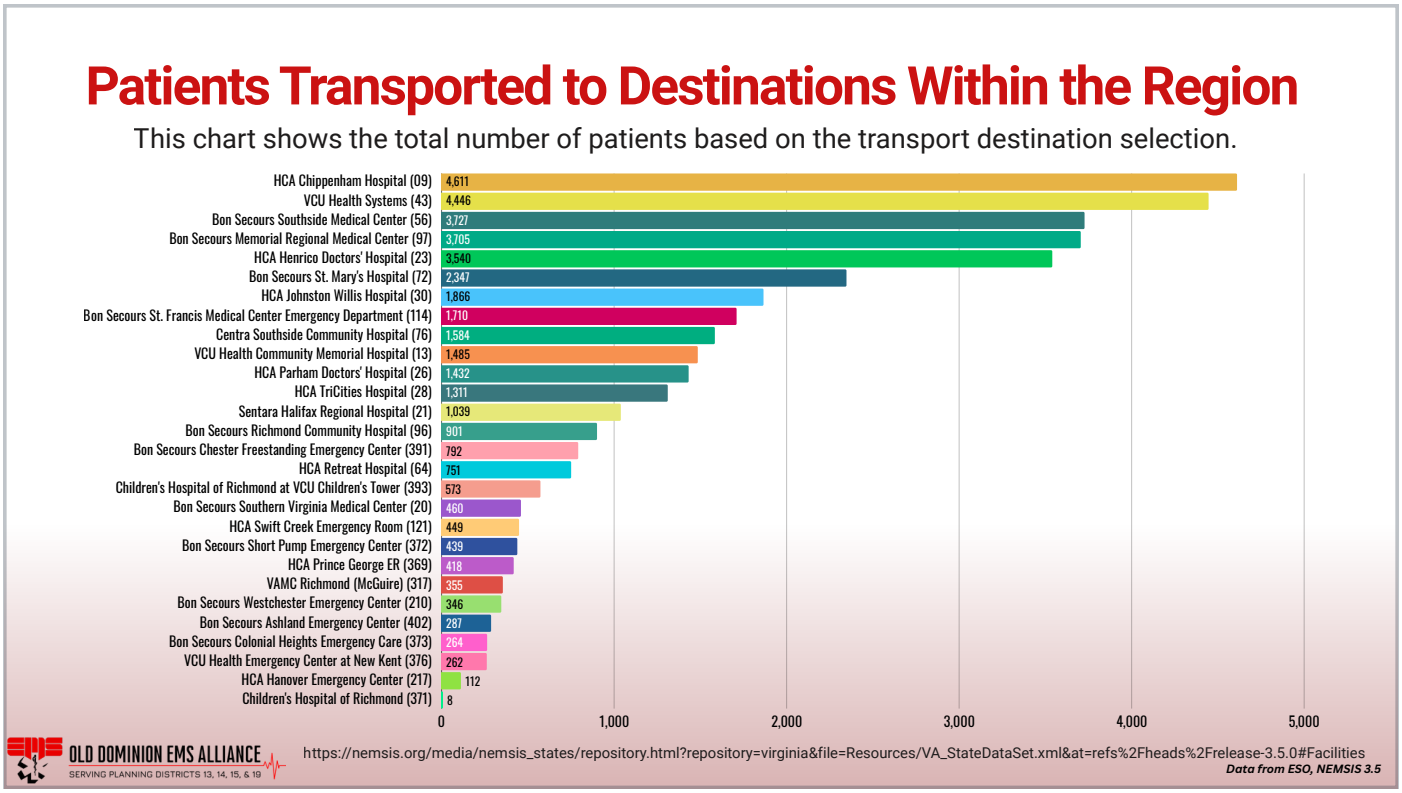
This chart shows the top ten primary impressions for the quarter. Weakness continues to lead the list, which is consistent with what we're still seeing at the state level.

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.



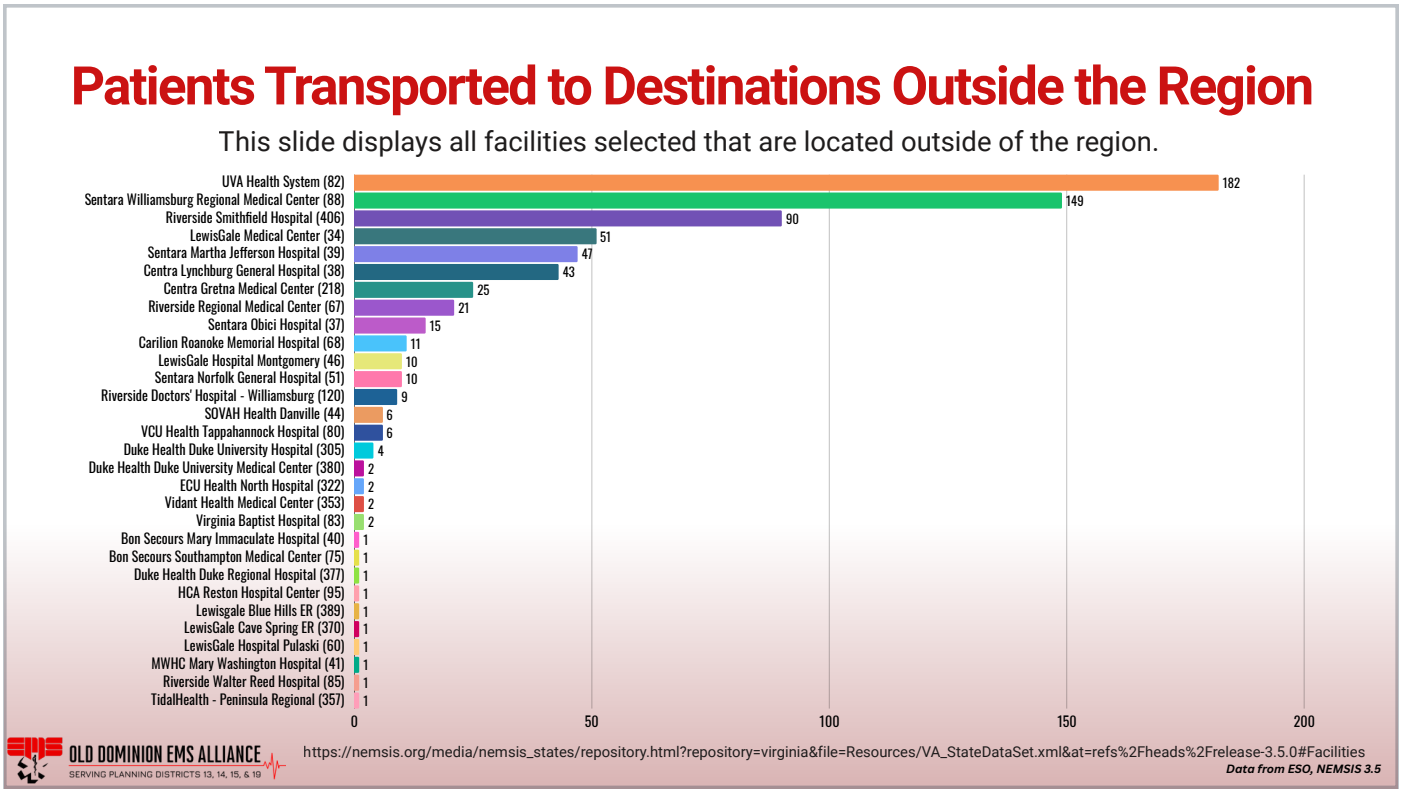
This chart shows the top fifteen agencies by call volume. The rankings are pretty much what you'd expect with Richmond Ambulance, Henrico, and Chesterfield at the top, followed by City of Richmond Fire and Hanover.

One quick reminder on dual-response jurisdictions — a single patient can generate two records because agencies are not sharing incident numbers across systems. I've had some brief discussions with individuals familiar with this issue, and right now, there is not a clean way to fully account for that duplication.



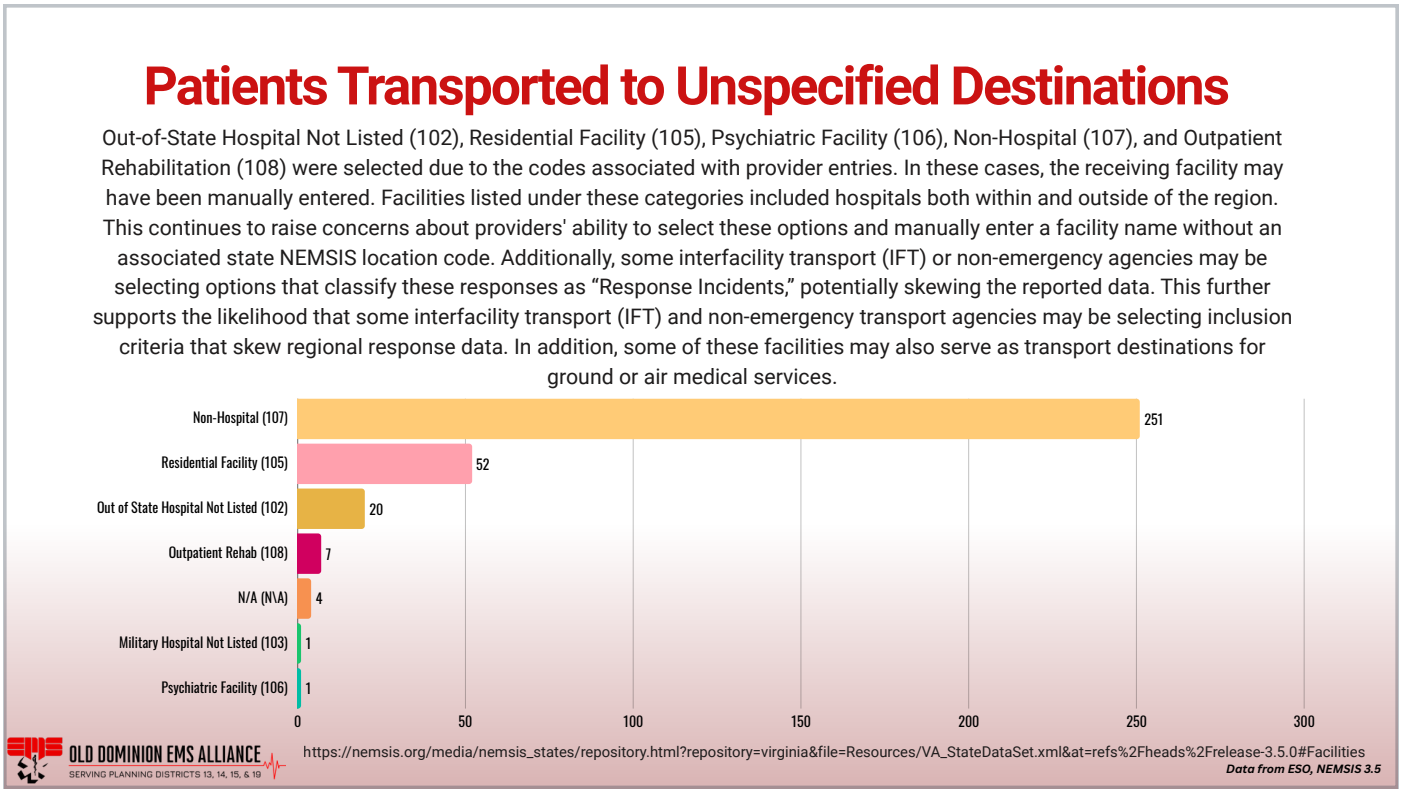
This chart shows in-region transport destinations for the quarter. VCU, HCA Chippenham, Bon Secours hospitals, and HCA Henrico Doctors' continue to receive the highest transport volumes, which is consistent with prior quarters.

We still run into occasional mapping issues when providers use free-text hospital entries instead of standardized destination fields, which can cause some destinations to be misclassified. That's something we need to continue improving, and we've been bringing it to agencies' attention when those conversations come up.



This chart shows out-of-region transport destinations. Some of this volume is expected, especially from border localities like Goochland, Cumberland, and New Kent, which regularly transport to facilities outside the region based on geography.

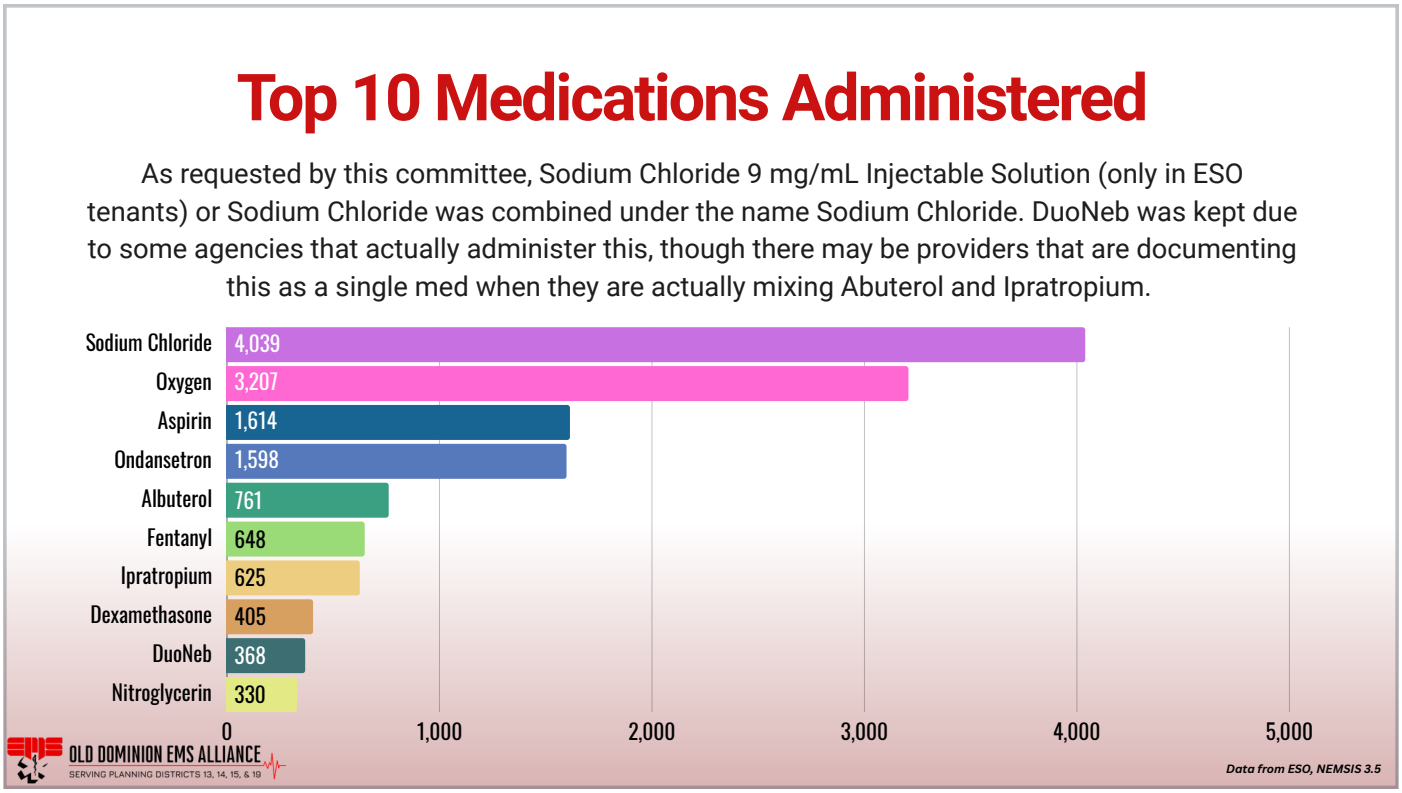
The transports to facilities like LewisGale Pulaski or Carilion New River Valley are a little harder to explain based on geography alone and may reflect interfacility transport records that are not being fully filtered out.



This chart shows transports that landed in non-standard destination codes, including categories like residential facility, non-hospital, and out-of-state not listed.

We're also seeing some in-region hospitals incorrectly assigned to these categories, along with landing zones and free-text entries, such as documenting that the patient was turned over to a flight crew. In many cases, this happens when providers manually enter destination information instead of selecting the correct destination code.

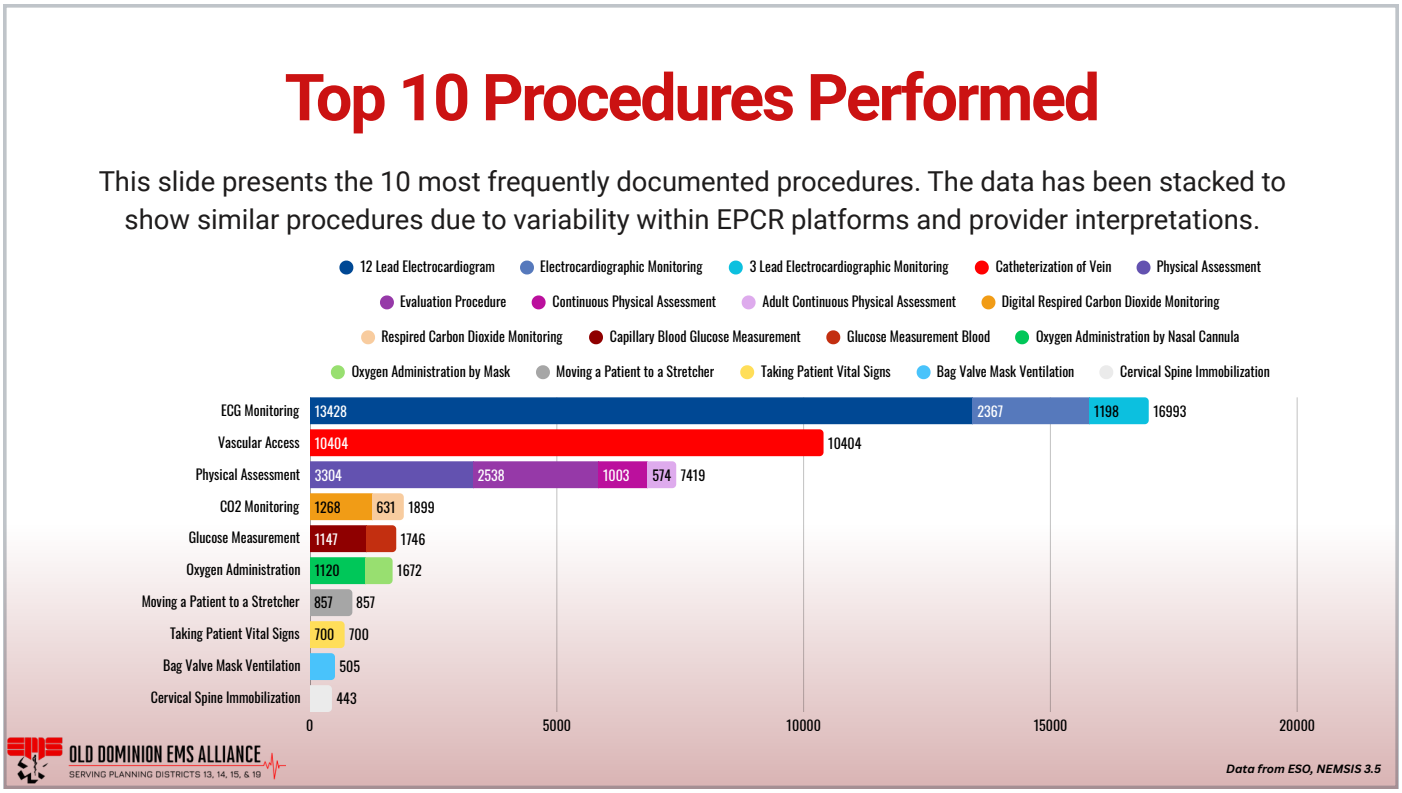
As we identify these documentation trends, I'm keeping a running list of them so we can address them more directly when we begin future provider education on properly using the documentation fields.



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.

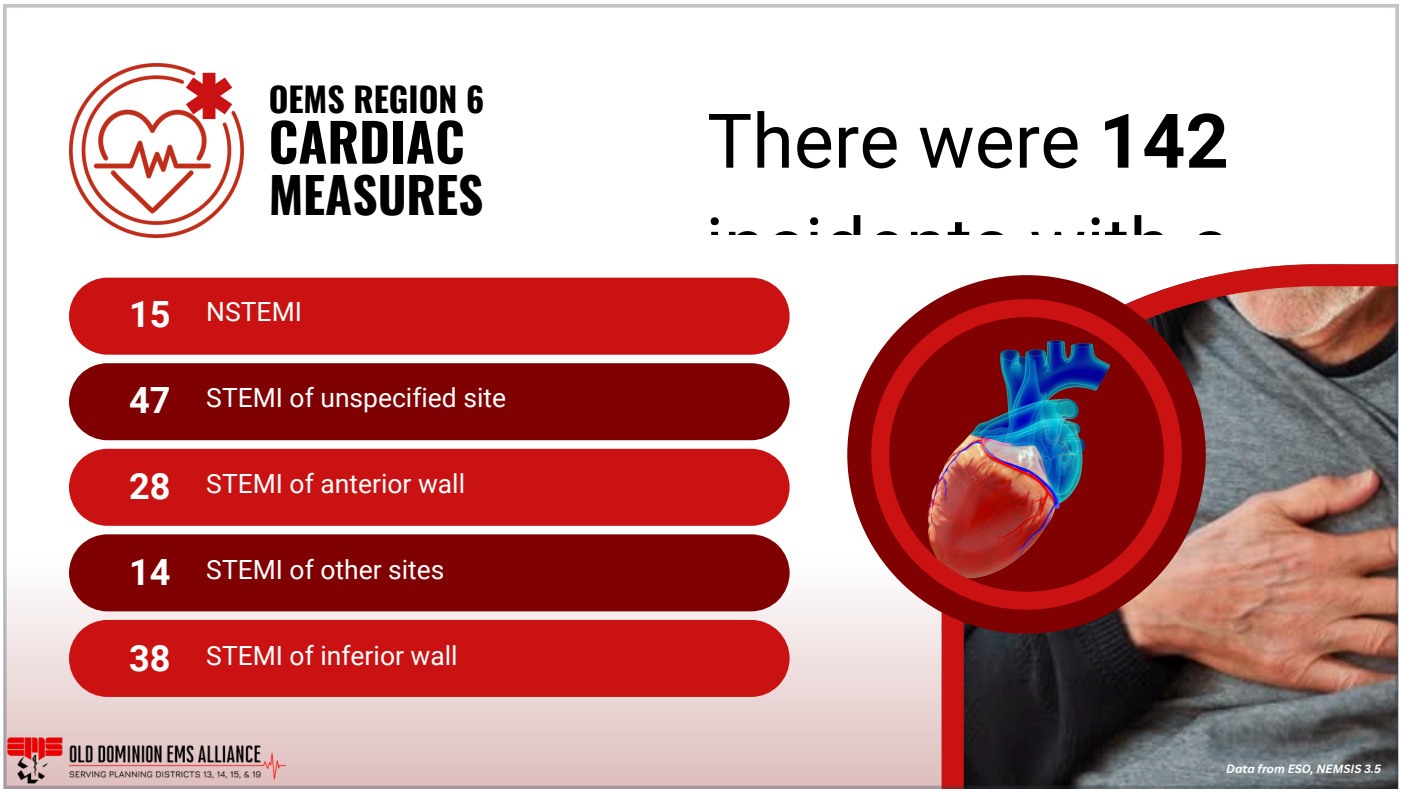
DuoNeb stayed separate because some agencies do carry and administer it as a brand-name combination medication. That said, it's also possible some providers are selecting DuoNeb when they administer albuterol and ipratropium separately, either because it's faster or they don't see a need to document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

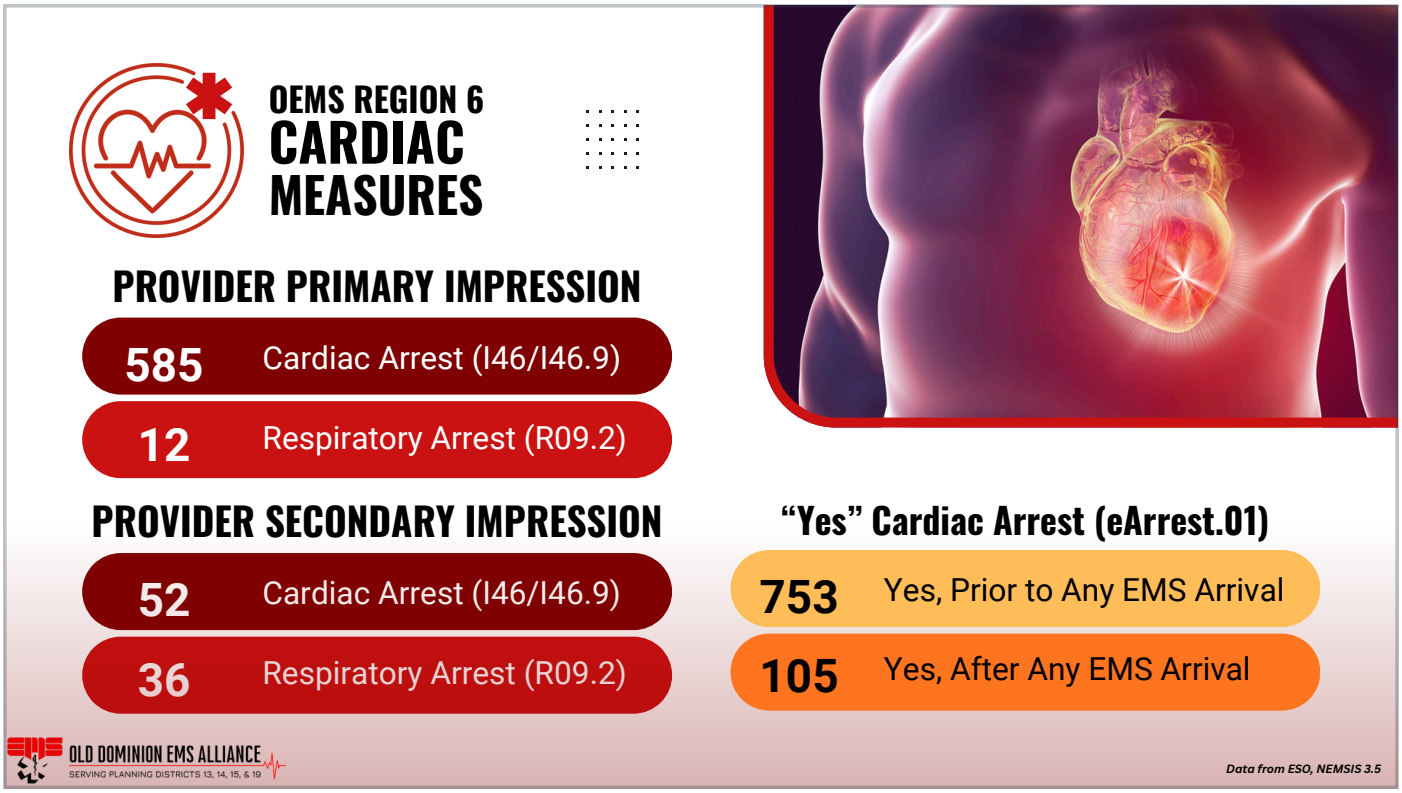
ECG monitoring, vascular access, and physical assessment continue to be the highest-volume categories. Grouping these similar procedures also gave us a broader picture of what providers are actually documenting as procedures performed.



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

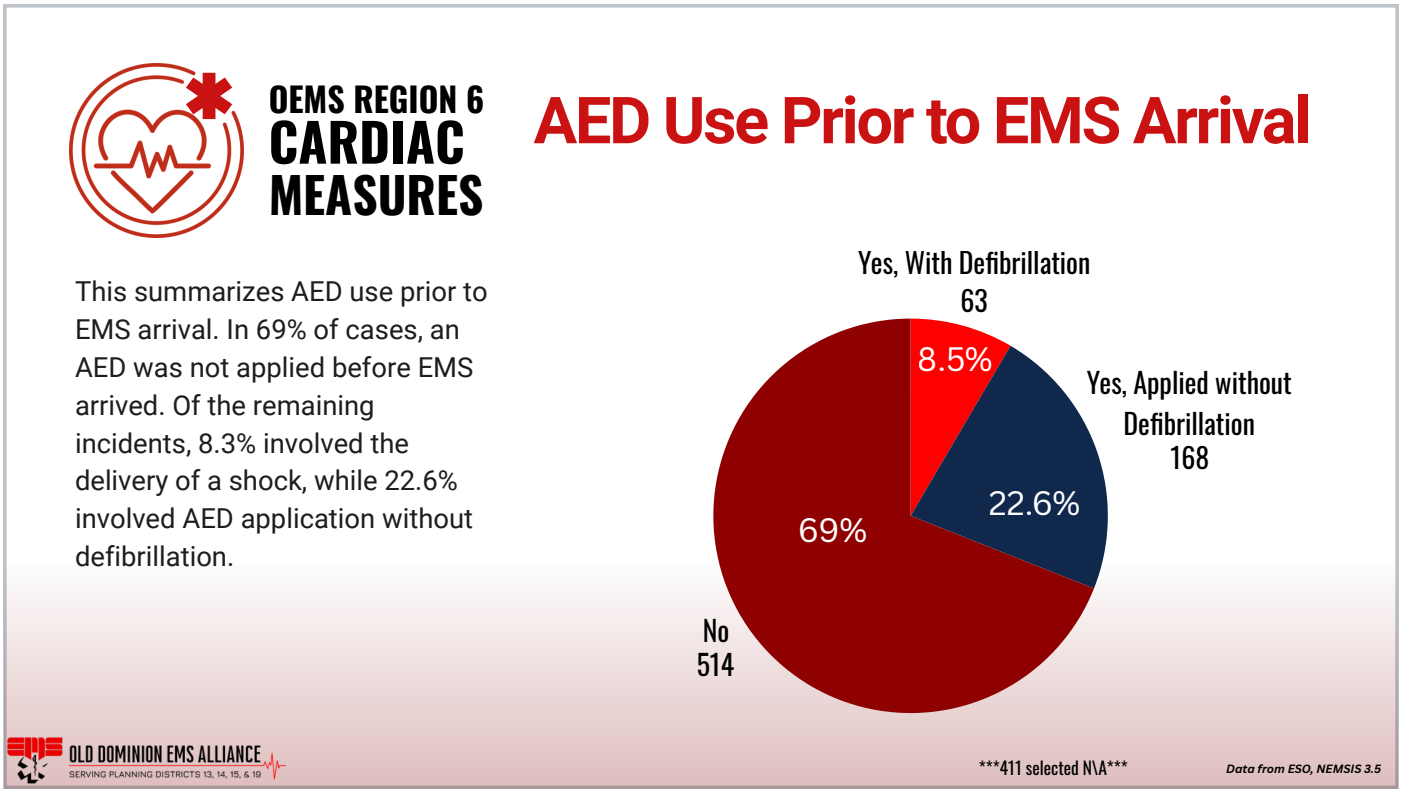
STEMI of unspecified site was the most commonly selected impression at 47 incidents, followed by STEMI of inferior wall at 38, and STEMI of anterior wall at 28.

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



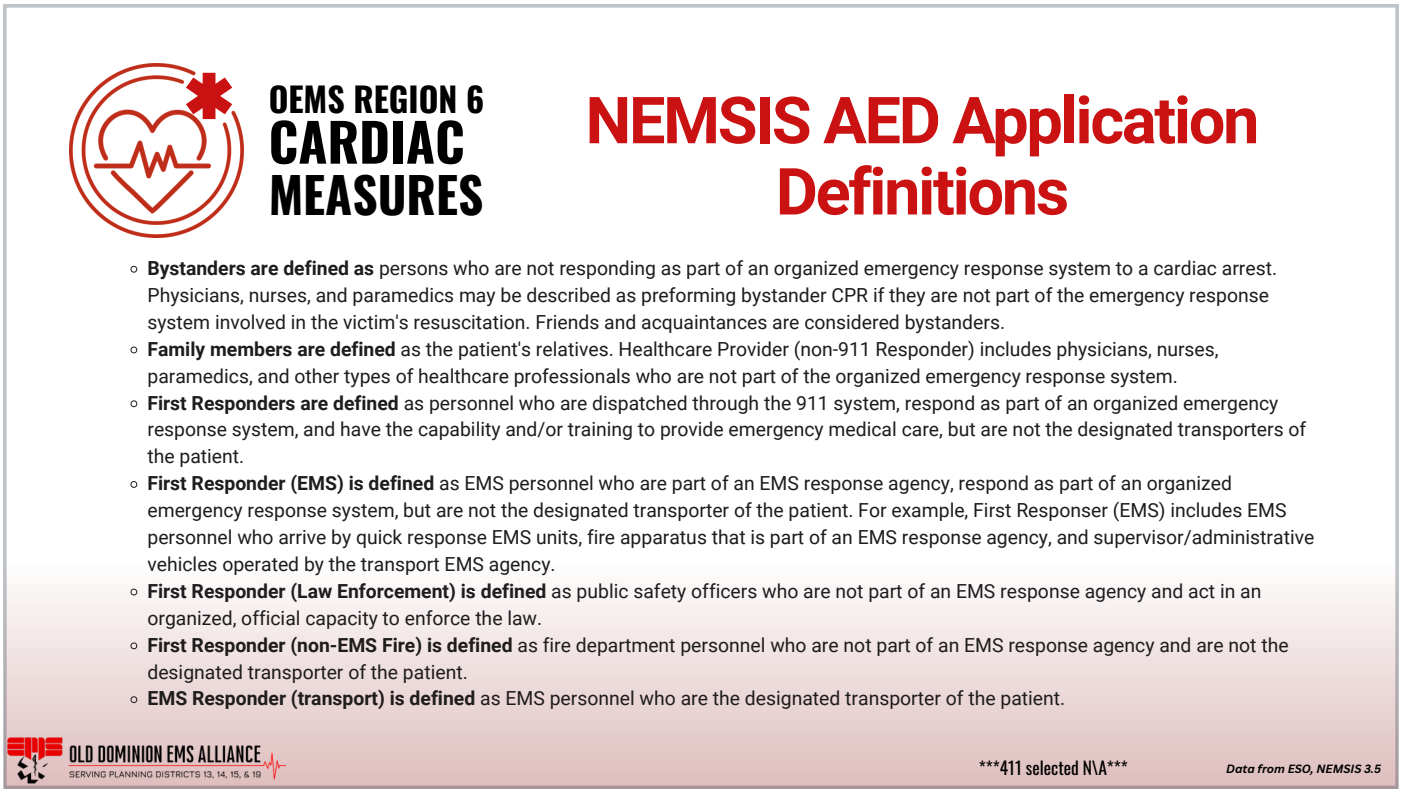
We had 585 incidents this quarter where providers selected cardiac arrest as the primary impression, along with another 52 incidents where it was documented as a secondary impression.

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



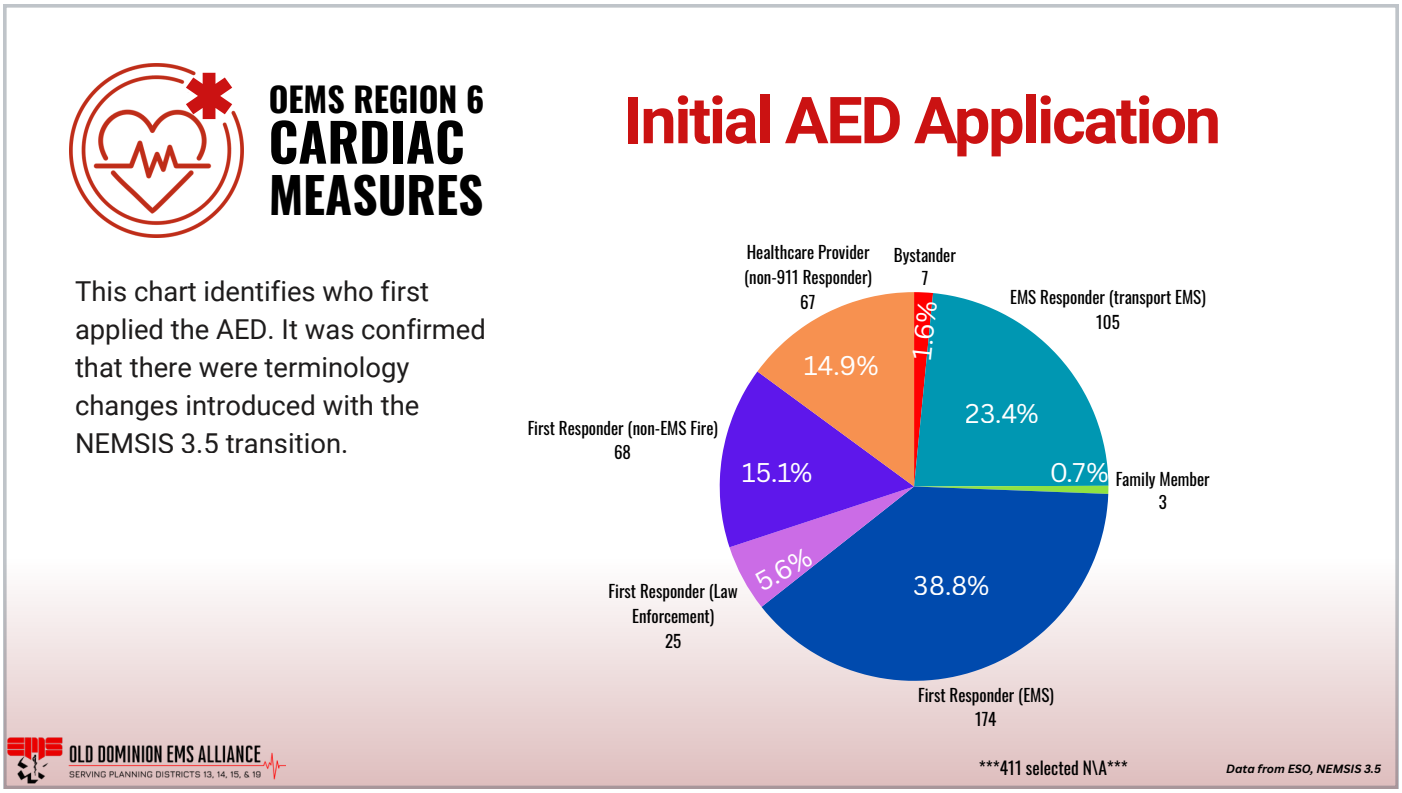
This looks at AED use prior to EMS arrival across the region. In 69% of cases, an AED was not applied before EMS arrived. In about 8% of cases, a shock was delivered, and in another 23%, the pads were applied but no shock was advised.

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 is really just a reference slide before the next breakdown. There was quite a bit of discussion during the last meeting around these definitions, so I wanted to put them in front of everyone before we move on.

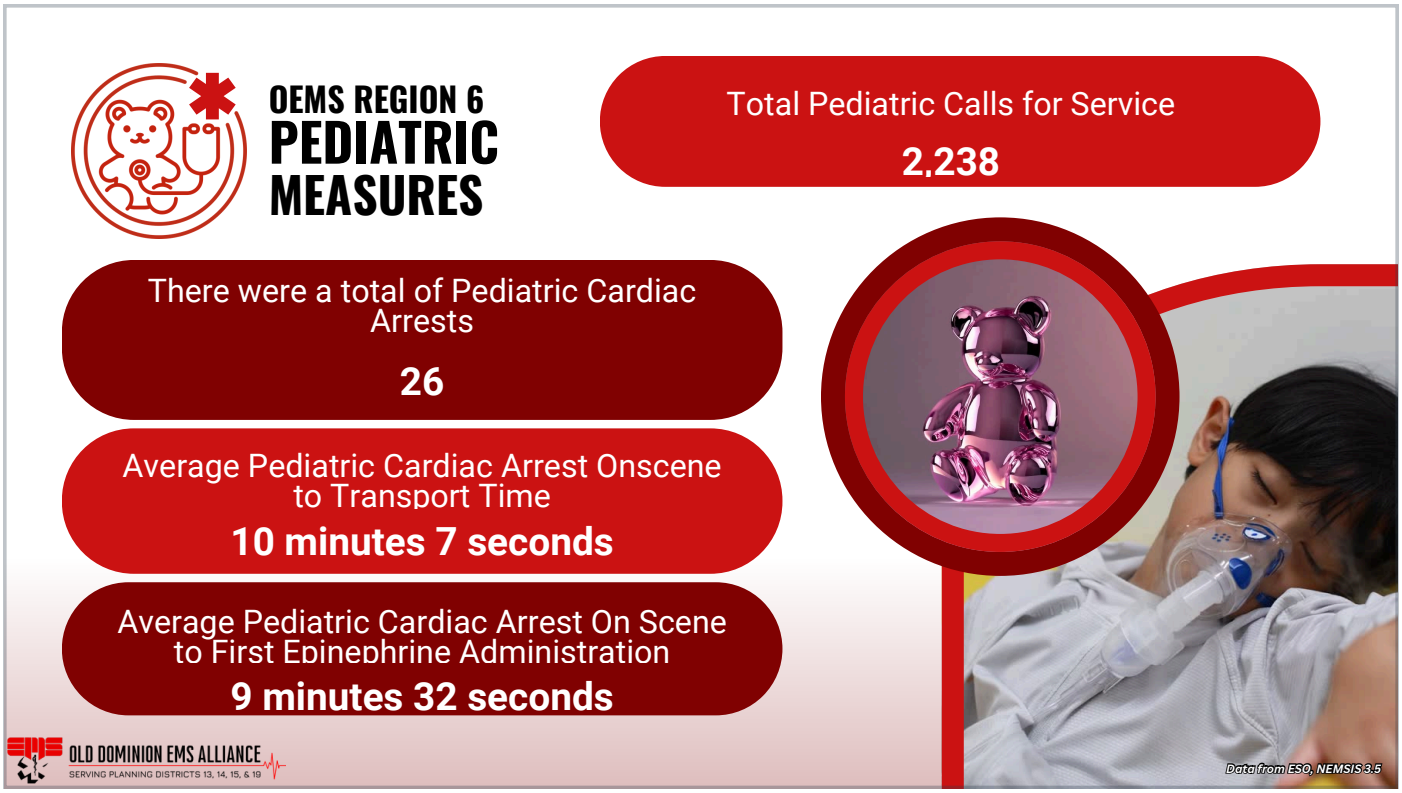
Most providers are likely selecting these fields based on what they think the category means in the moment, and many probably are not aware of the formal definitions tied to these selections. A lot of that comes down to documentation habits and how quickly people are moving through charts. It’s also something I’ve added to the running list for future documentation education.



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.

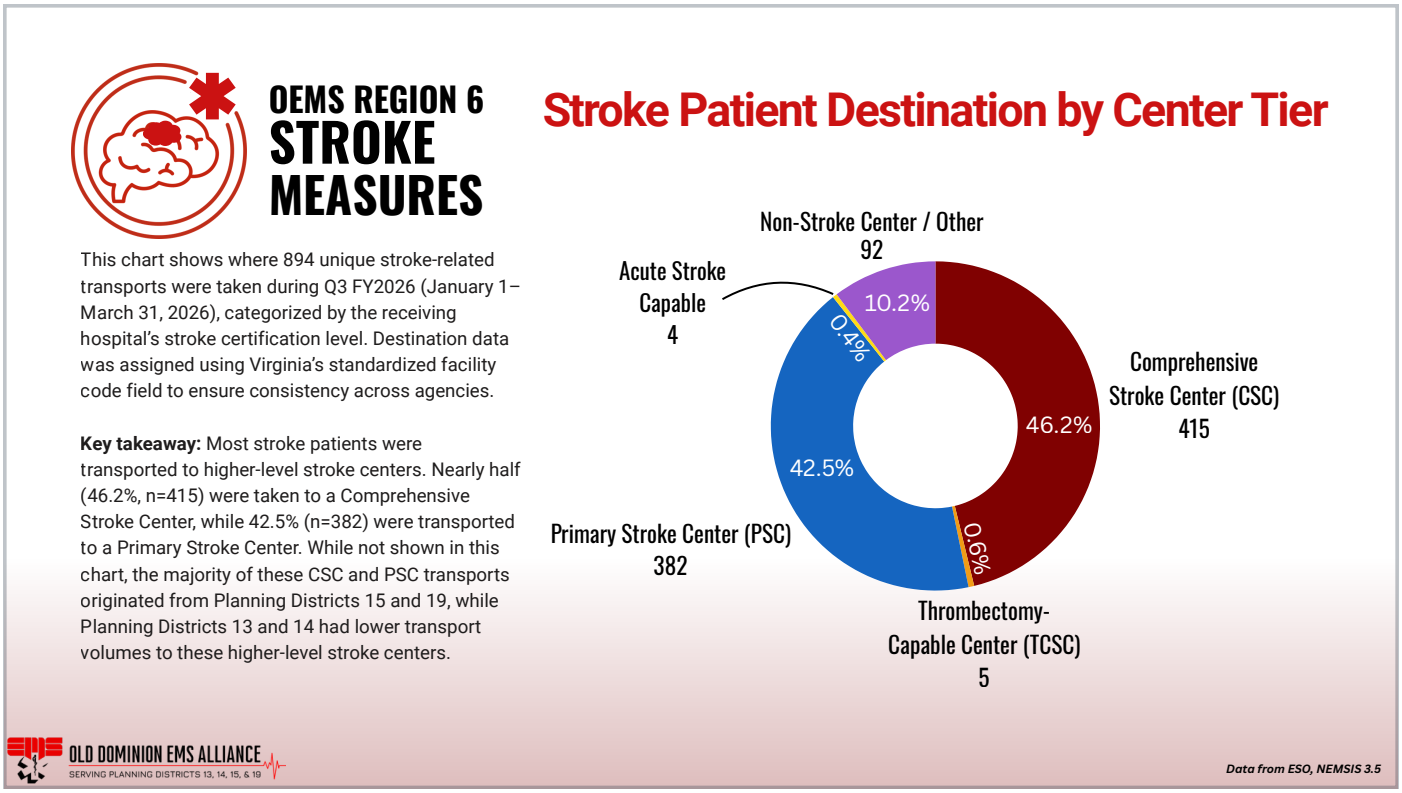
I do have the planning district breakdowns available if the committee wants to continue reviewing them, but if the group feels we've gotten what we need from that level of detail, I'm also fine moving past those slides going forward.



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

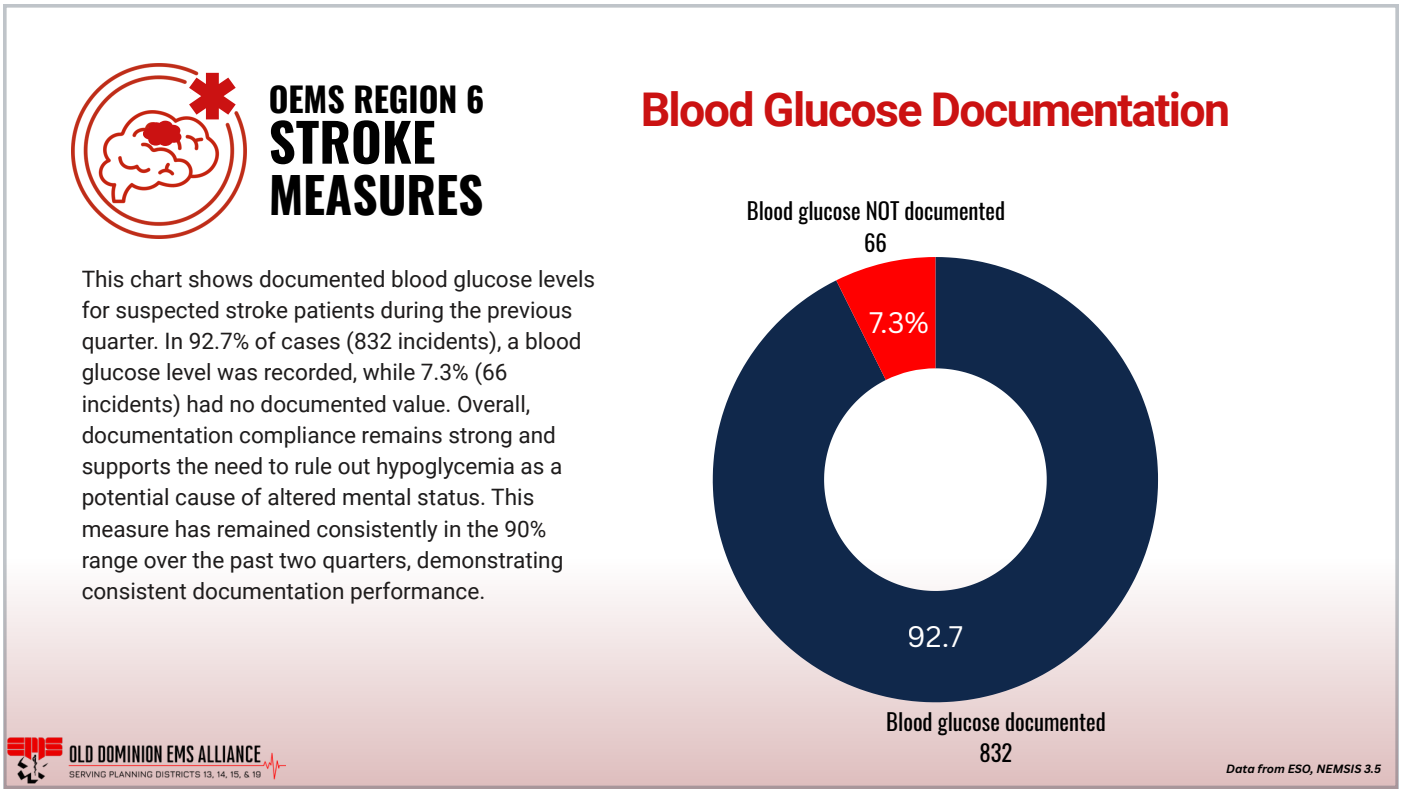
Average on-scene to transport time for pediatric cardiac arrest was about 10 minutes, and average on-scene to first epinephrine administration was about 9 and a half minutes.

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.



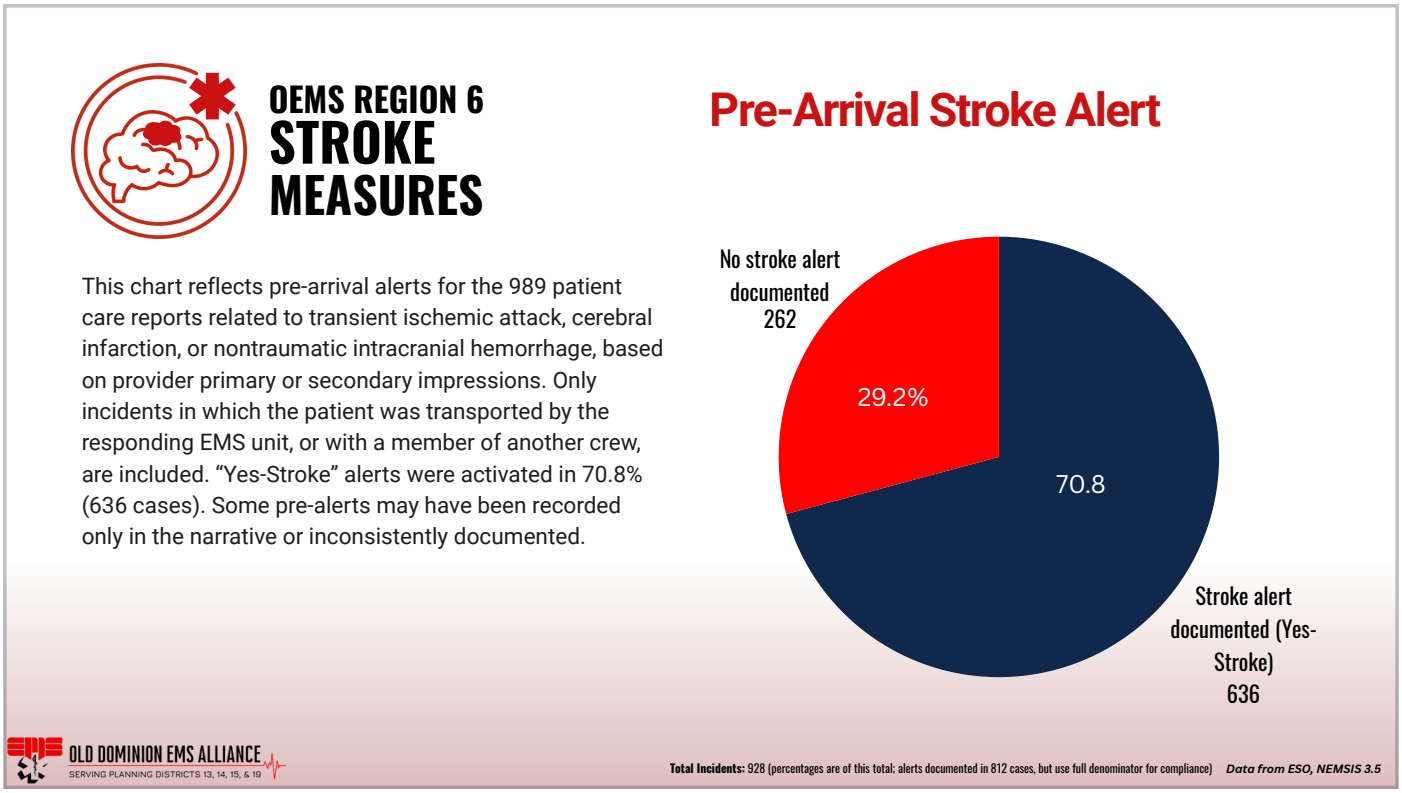
This slide looks at where 894 stroke-related transports went this quarter based on the receiving hospital's stroke certification level. About 46% were transported to a Comprehensive Stroke Center, and another 42% went to a Primary Stroke Center.

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.



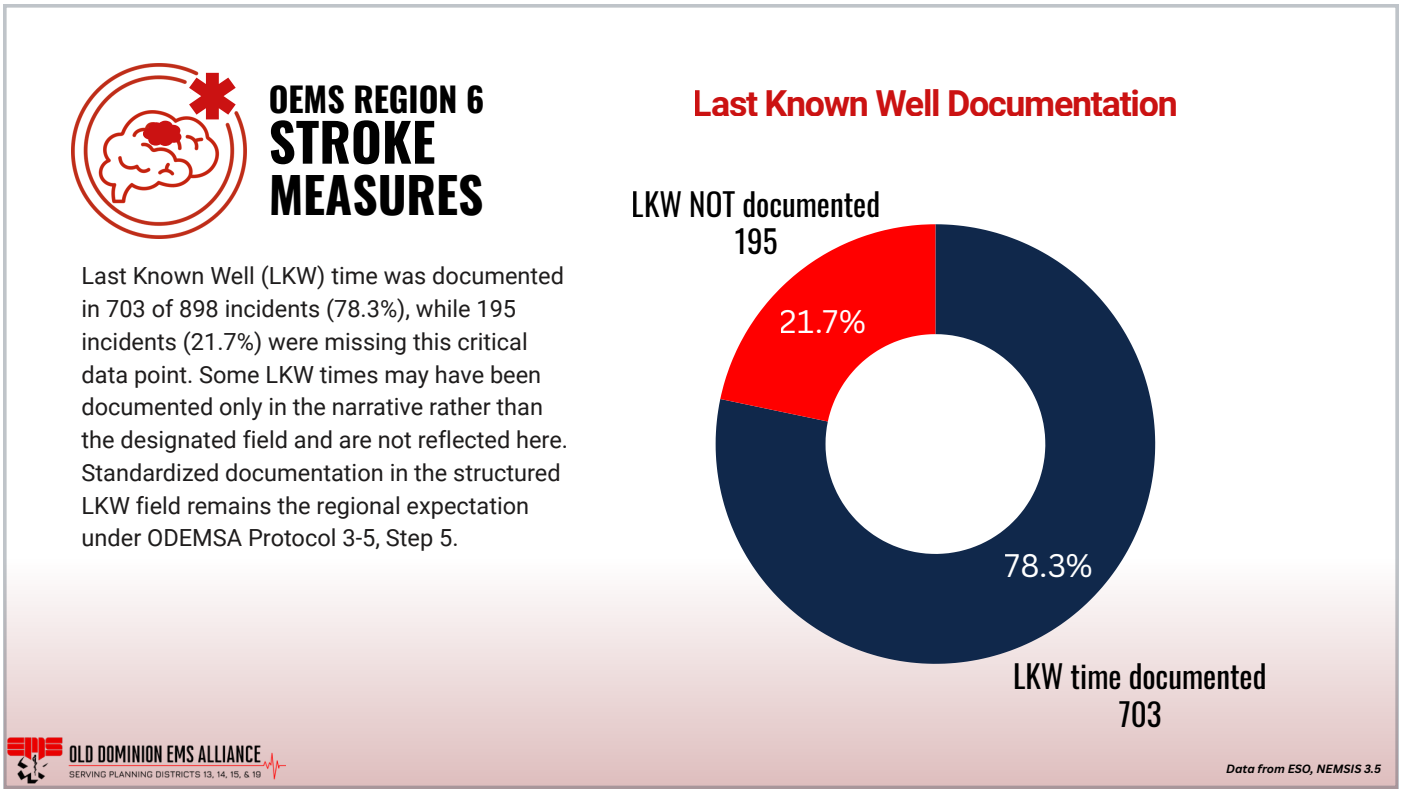
This chart looks at blood glucose documentation for suspected stroke patients. Compliance was 92.7% this quarter, which keeps us pretty consistent with the last two quarters.

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.



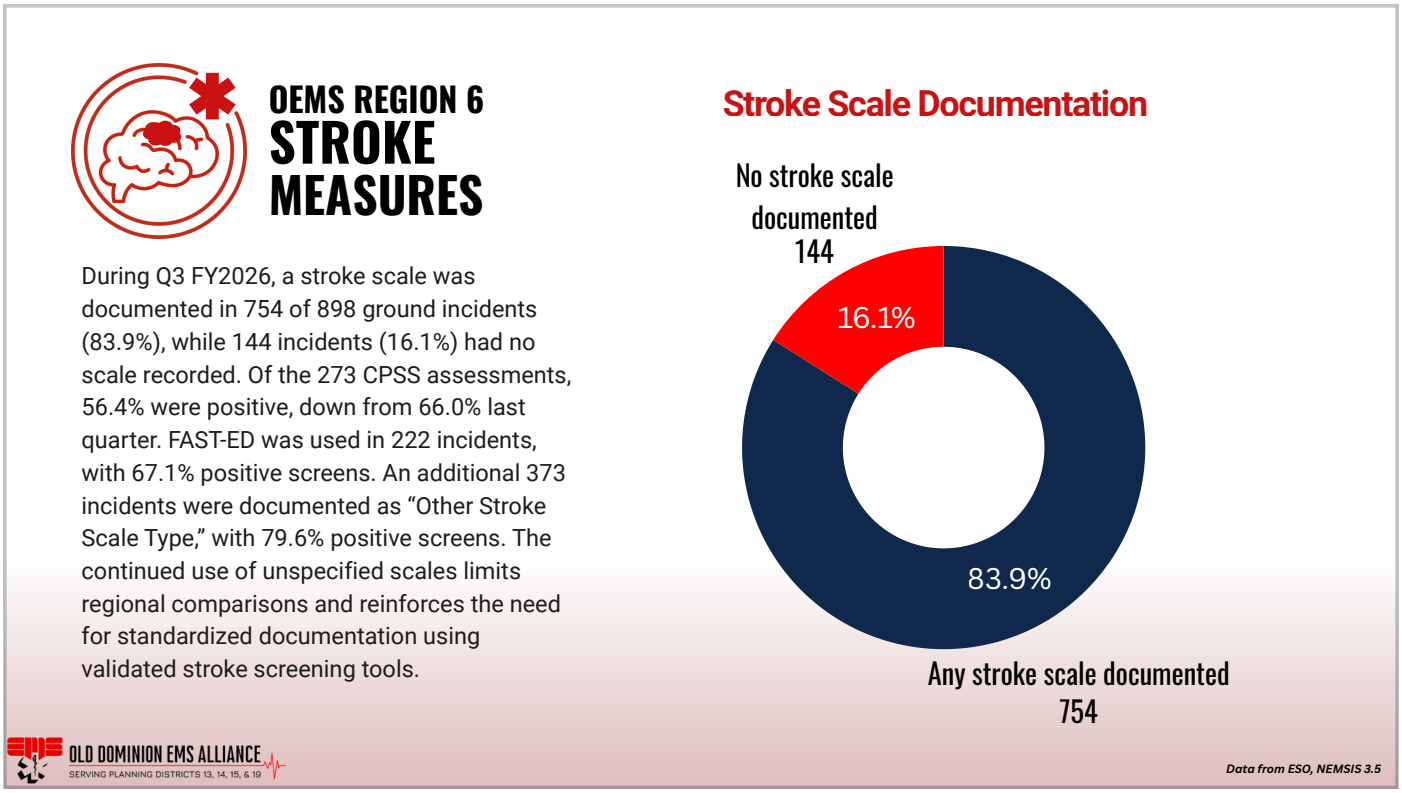
This chart looks at pre-arrival stroke alerts for the quarter. A Yes-Stroke alert was documented on 70.8% of qualifying transports.

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.

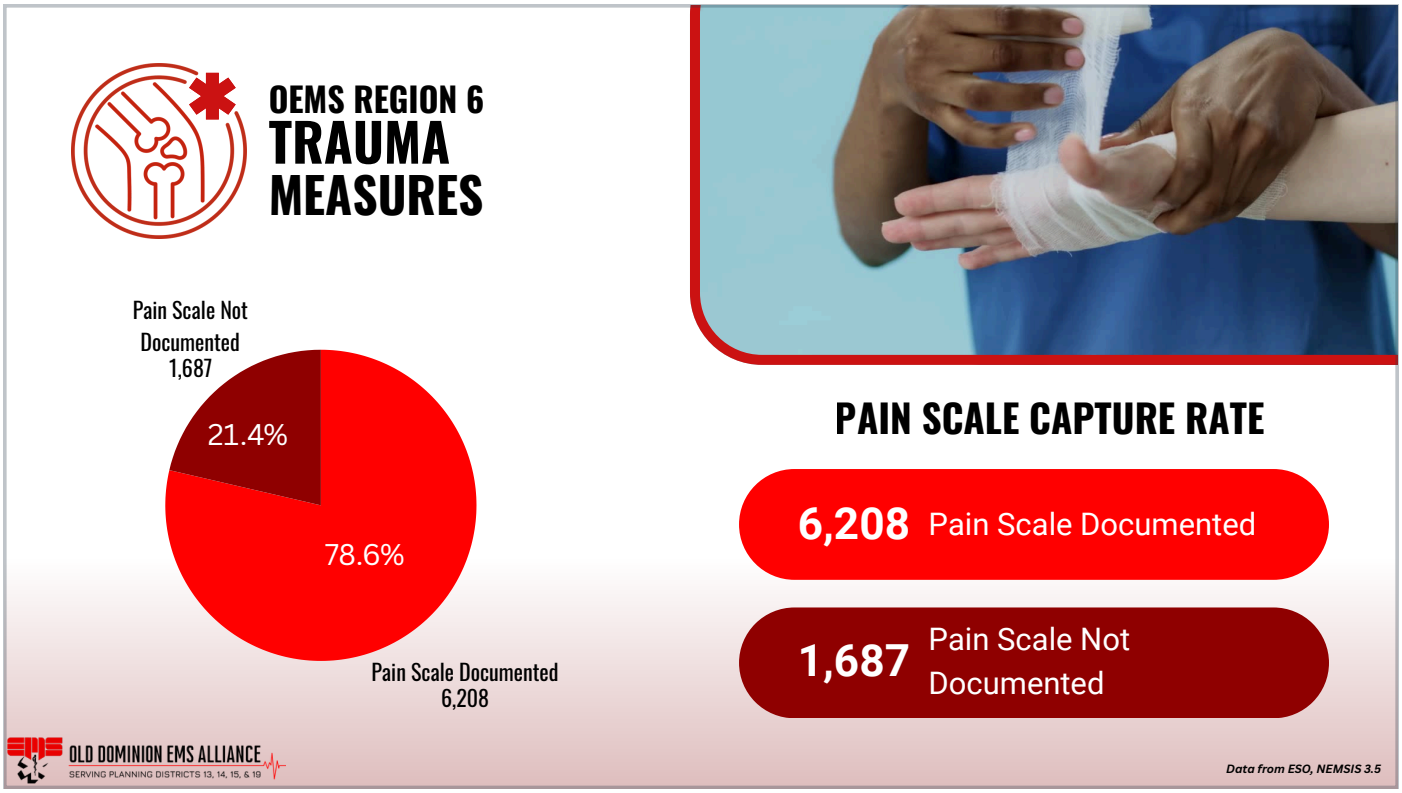
Some of those times may still exist in the narrative, but not in the designated field where we can reliably pull them. Consistent use of the structured field for this metric is another documentation item I've added to the list for follow-up education.



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.

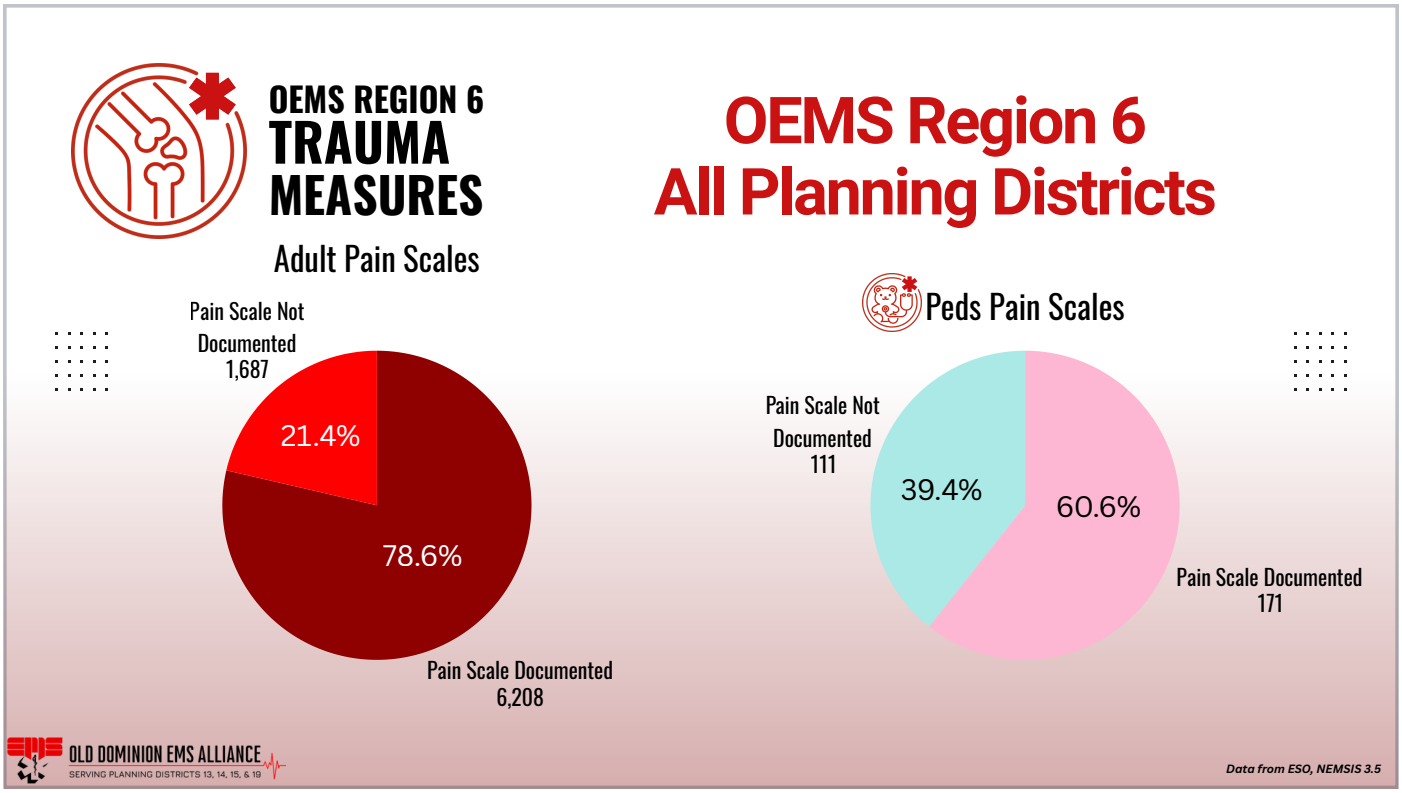
The reason that stands out is because it ties back to the conversation we had last quarter about which scales should be used and when. Our current protocol calls for providers to start with Cincinnati, FAST, or BEFAST, and if that initial screen is positive, they should then perform the VAN assessment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



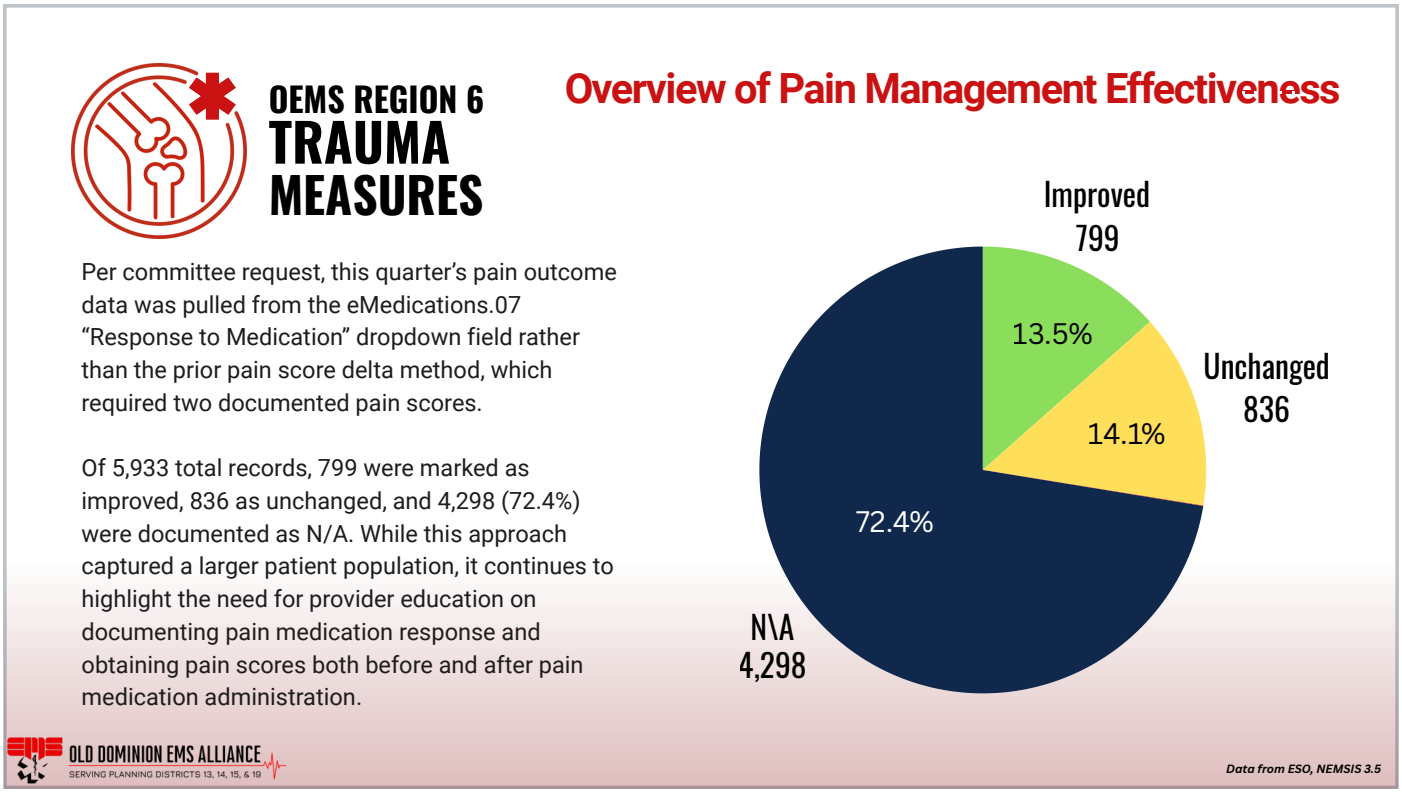
This chart looks at pain scale documentation for trauma patients. About 79% of trauma encounters had a documented pain score this quarter, which is an improvement from prior quarters.

For this measure, we did filter for patients whose lowest AVPU was documented as Alert and whose GCS was 15, so this is a more accurate reflection of patients who should have been able to report pain. Even with those filters in place, there's still room for improvement in consistent pain assessment documentation.



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%.

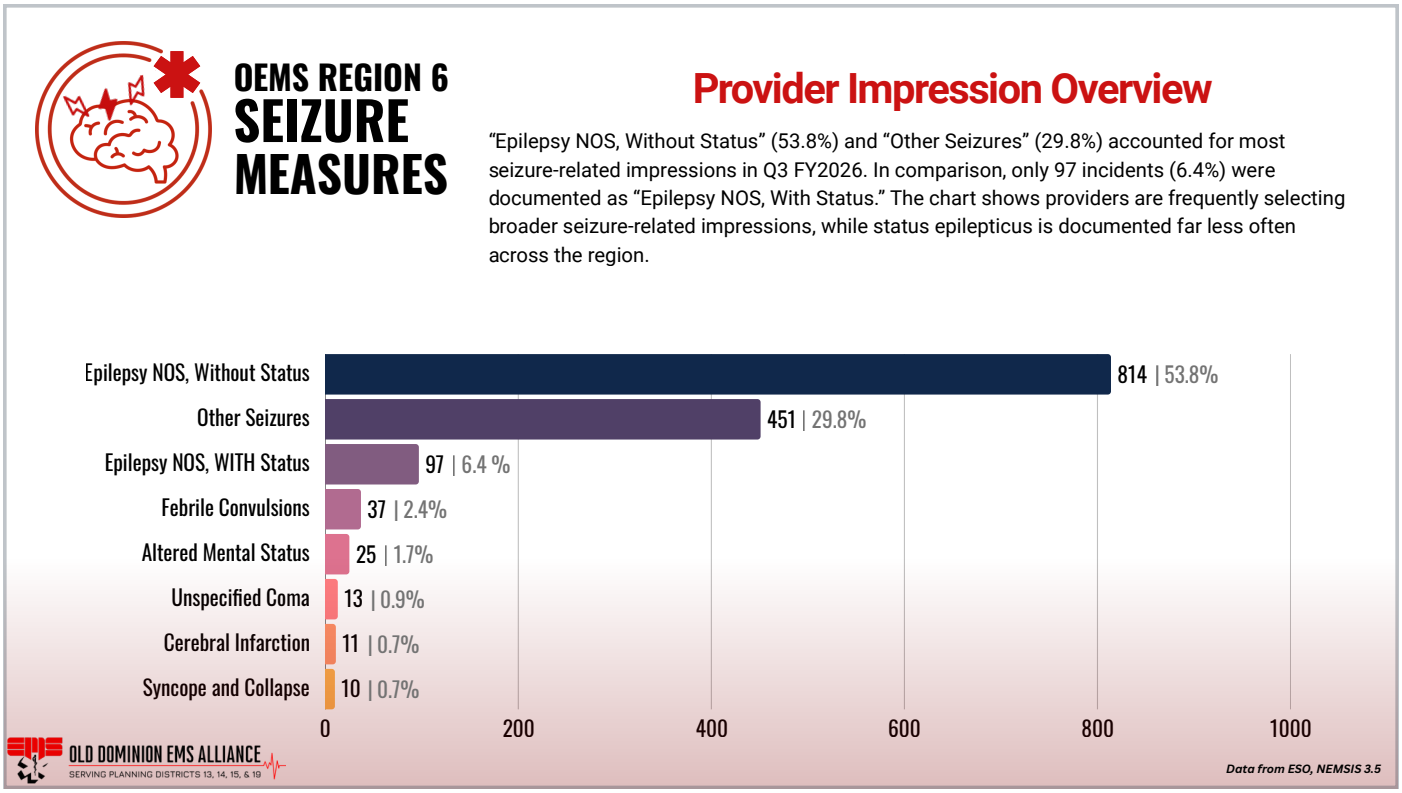
The pediatric group excludes patients 2 years old and younger, since it can be more difficult to obtain a pain score in that age group. The lower pediatric rate may reflect a mix of clinical challenges and documentation habits, and it's something we'll continue monitoring over time.



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.

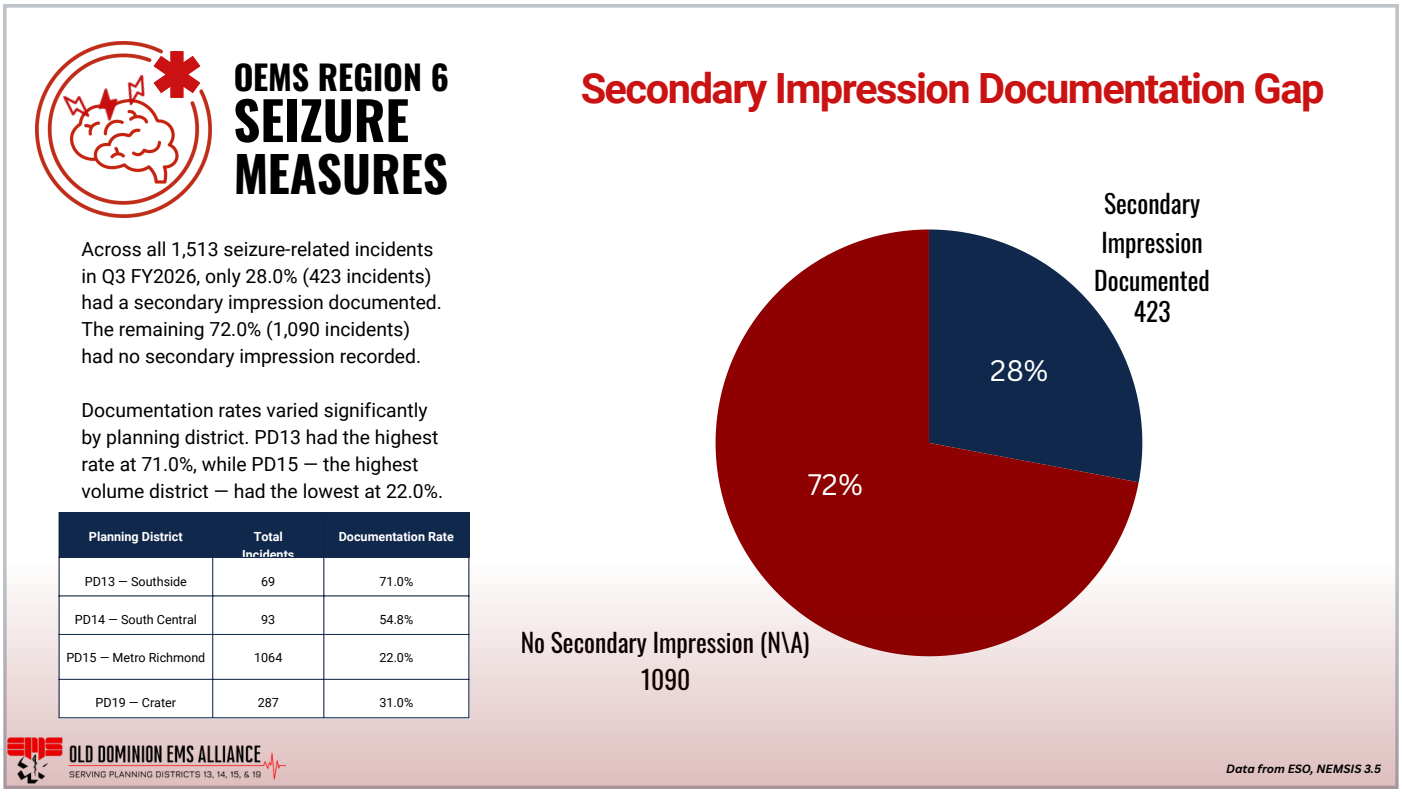
Out of nearly 6 thousand records, about 14% were marked as improved, 14% as unchanged, and 72% were documented as N/A. Notably, there were zero records documented as worsened pain this quarter.

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.



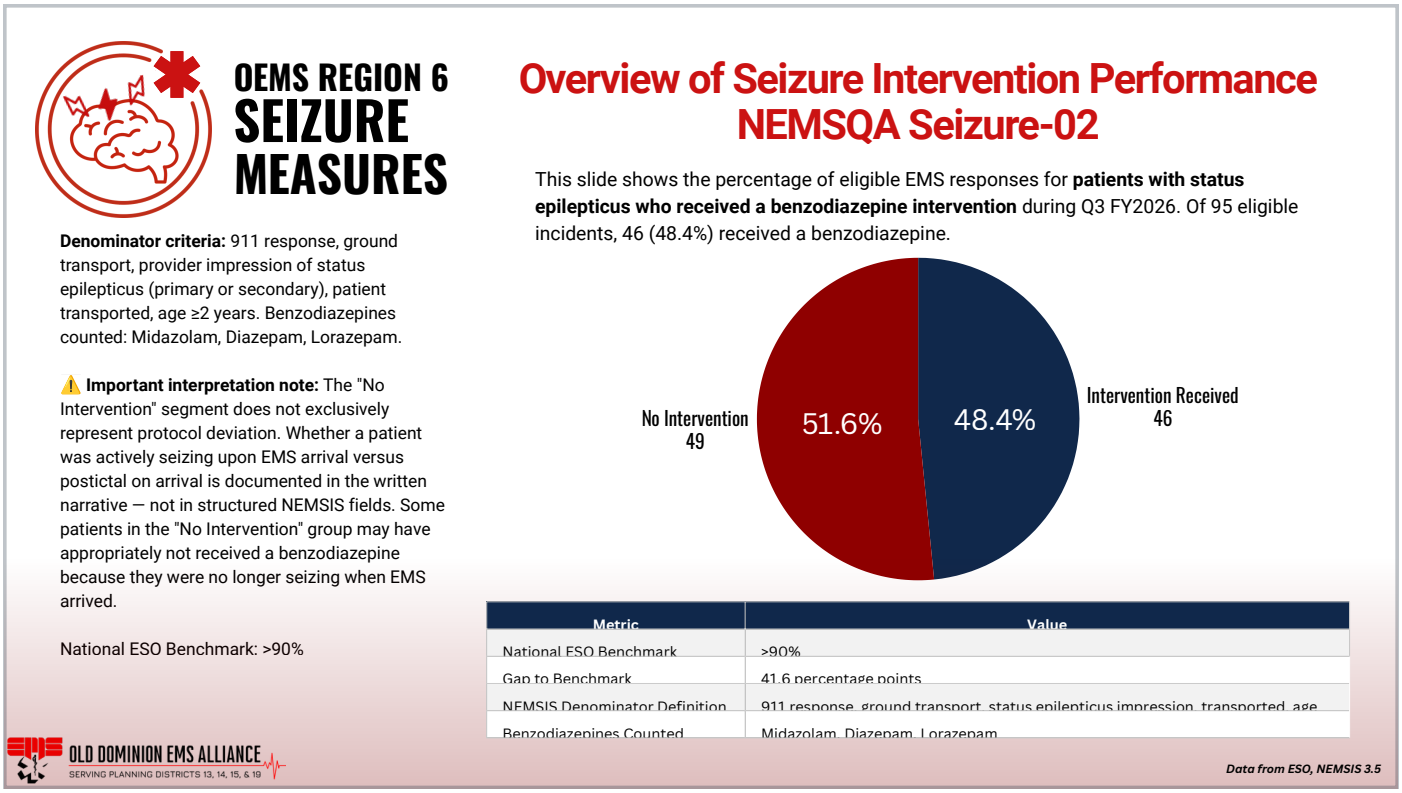
This chart looks at seizure-related impressions for the quarter. Epilepsy without status epilepticus and "Other Seizures" make up the majority of records.

Only 97 incidents, or about 6%, were documented as "with status epilepticus," which is the impression tied to the NEMSQA Seizure-02 measure. I just want to call that out now so the smaller denominator on the next few slides doesn't catch anyone off guard.



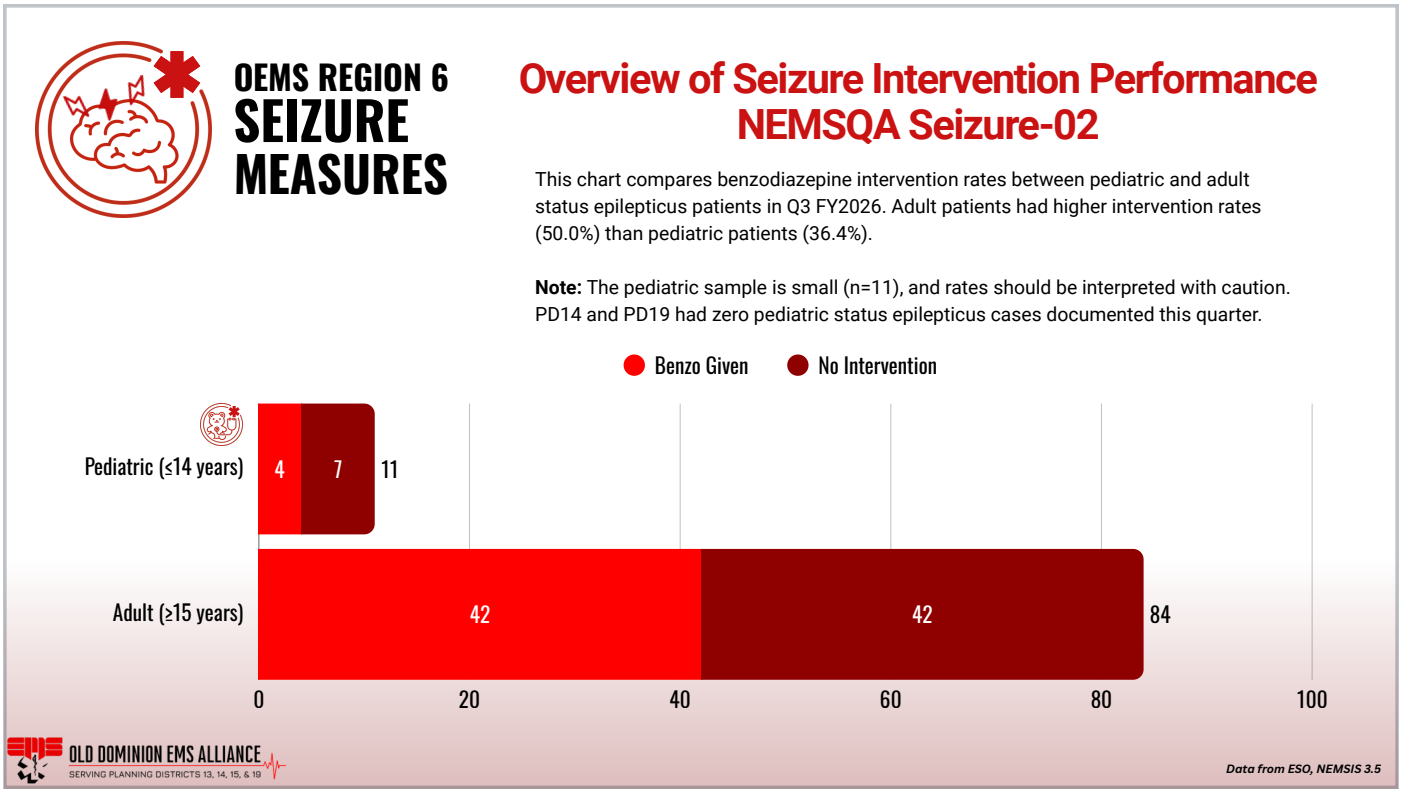
This chart highlights secondary impression documentation in seizure-related incidents. Across 1,513 records, only 28% had a secondary impression documented.

There's also pretty significant variation by planning district, with PD 13 at 71% and PD 15 at 22%. Secondary impressions are often where additional conditions or contributing factors get captured, so improving documentation here gives us a more complete clinical picture of these patients.



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%.

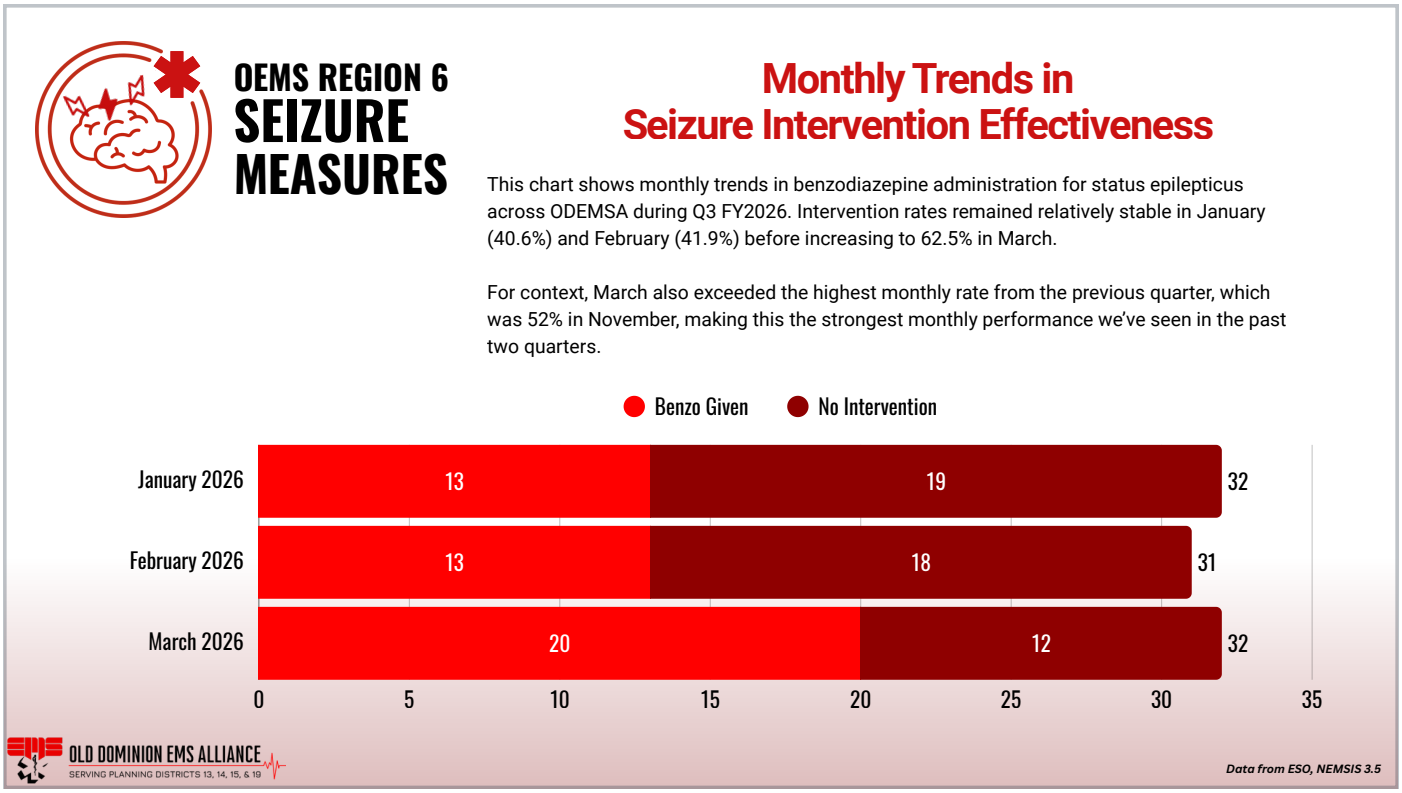
Whether the patient was actively seizing when EMS arrived often lives in the narrative and not in a structured field. That means some of the “No Intervention” group may have already been postictal when crews arrived, and in those cases not giving a benzo may have been completely appropriate.



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

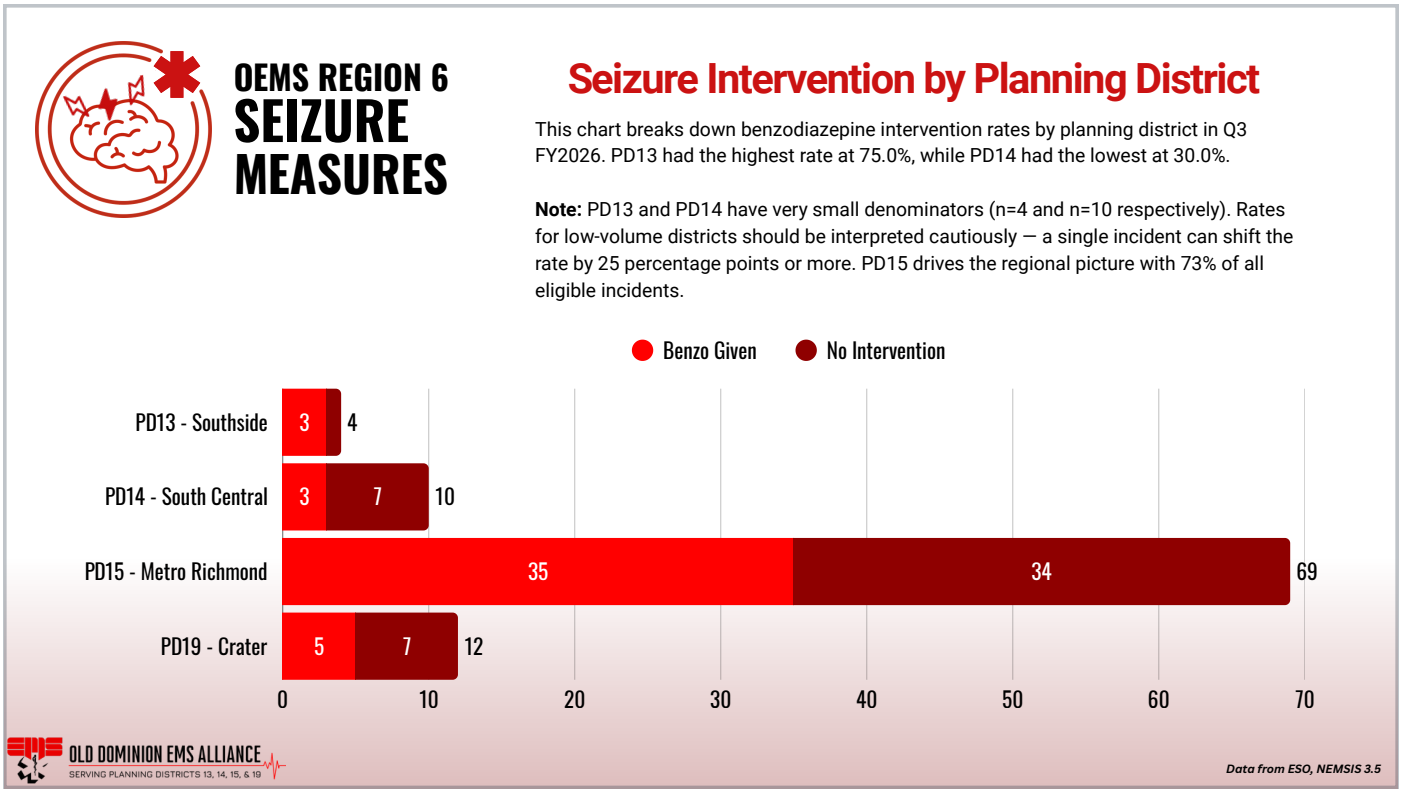
Just as a reminder from our discussion last quarter, we updated the pediatric age definition so it now aligns with State Medical Direction, using 14 and under as pediatric and 15 and older as adult.

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 looks at monthly intervention rates. January and February stayed in the low 40% range, while March increased to 62.5%.

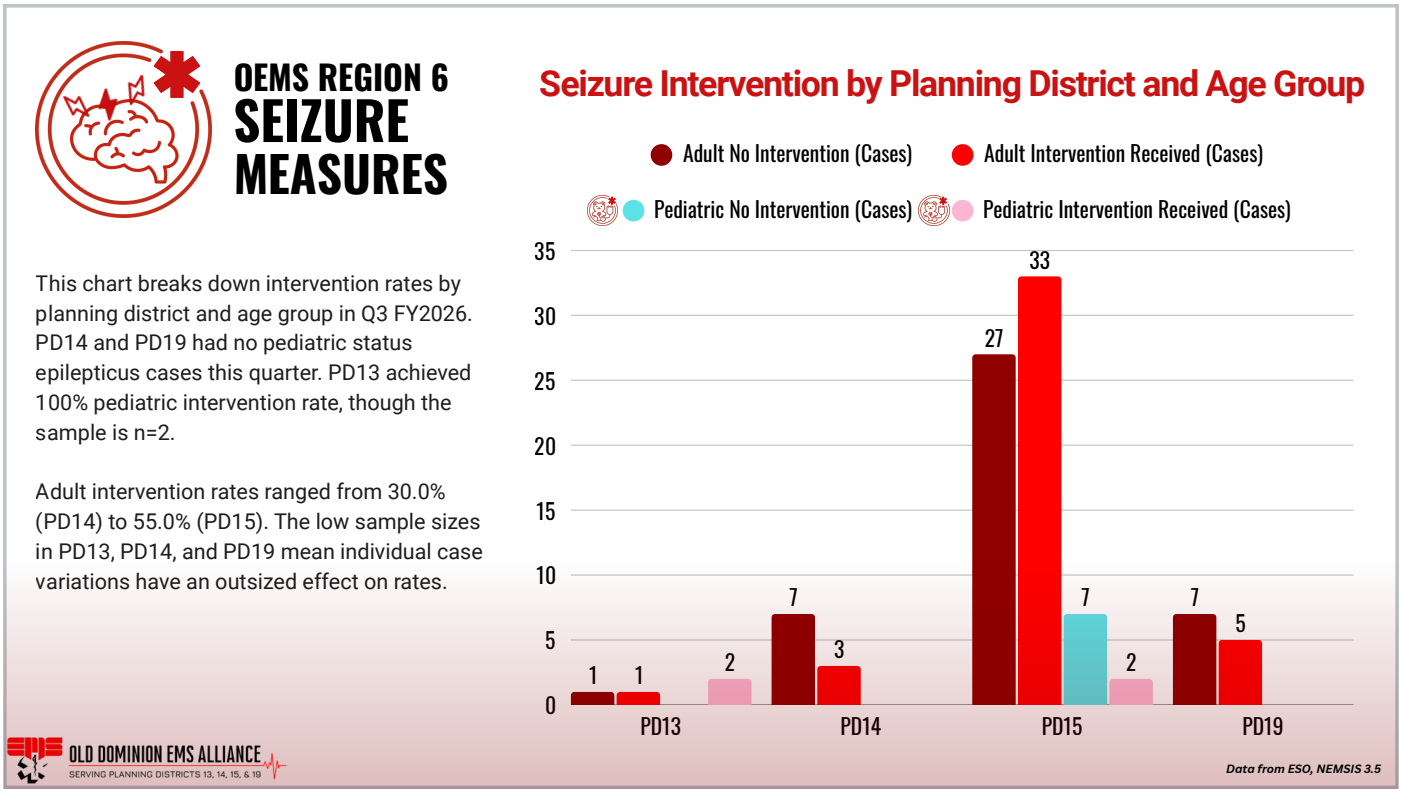
For context, the highest month from last quarter was November at 52%, so March was the strongest single month we've seen across the past two quarters. It's encouraging to see, but we'll need to see if that carries into Q4 before calling it a trend.



This chart breaks Seizure-02 down by planning district. PD 13 came in at 75%, while PD 14 was at 30%.

The biggest thing to keep in mind here is the denominator. PD 13 only had four eligible cases and PD 14 had ten, so one or two cases can move those percentages pretty quickly.

PD 15 makes up about 73% of all eligible incidents, so it continues to drive most of the regional picture for this measure.



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.

That wraps up the report. This slide highlights some of the bigger takeaways from this quarter, along with a few areas we're already tracking for follow-up.

I'd like the committee's feedback on a few things. Are there metrics here that continue to provide value? Are there any we should stop spending time on? Are there additional benchmarks or measures you'd like us to explore moving forward?

We've identified several documentation opportunities throughout this report, and I'm already keeping a running list so we can be more intentional about future education efforts rather than continually looking at the same issues every quarter.

I appreciate everyone's time and feedback.