Central Shenandoah EMS Council, Inc.

Regional EMS Performance Improvement Plan

2312 W. Beverley Street
Staunton, VA 24401
Phone 540-886-3676 • Fax 540-886-3735

www.csems.org

csems@vaems.org

Updated October 24, 2016

Table of Contents

Purpose

The Central Shenandoah Emergency Medical Services Council's Performance Improvement Committee (PI), under direction of its Medical Control Review Committee (MCRC), is responsible for assuring and improving the quality of pre-hospital medical care within CSEMS region by assessing adherence to regional patient care protocols; identify and a resolving educational needs of the region's EMS providers; and monitoring and making recommendations to the Performance Improvement Committee related to EMS system issues.

Definitions

1. **Quality Assurance (QA):** is the retrospective review or inspection of services or processes that is intended to identify problems.
2. **Quality Improvement (QI):** is the continuous study and improvement of a process, system or organization
3. **Performance Improvement (PI):** A systematic process of discovering and analyzing human performance improvement gaps, planning for future improvements in human performance, designing and developing cost-effective and ethically-justifiable interventions to close performance gaps, implementing the interventions, and evaluating the financial and non-financial results.
4. **Medical Incident Review (MIR)**: A process by which an EMS provider or EMS agency can review a questionable incident and report that incident to the CSEMS Council, have that incident reviewed by the regional PI Committee, and receive feedback from the Committee.
5. **Prehospital Patient Care Report (PPCR):** That report used by an agency to record details of out-of-hospital EMS patient

Primary Objectives

1. Conduct regional Incident Reviews (QA) and encourage local agency Medical Incident Reviews as required by state regulation.
2. Collect patient care statistics to evaluate system effectiveness and identify trends (QI).
3. Provide constructive feedback on medical quality improvement to all hospital and out-of-hospital EMS professionals within the CSEMS Council region.

PI Committee Composition

The CSEMS PI Committee shall fairly represent the municipalities that comprise the CSEMS Council region. The committee shall, at least, consist of the following representatives, each of whom shall serve in only one role on the committee:

- CSEMS Council Regional Medical Director (RMD).
- One representative from each hospital in the region (four members).
- One representative from each CSEMS air medical agency (paramedic, nurse, or administrator).
- One representative from a fire-based EMS agency (combination agency).
- One representative from a career EMS agency (not affiliated with a fire-based or air medical agency).
- Three representatives who are volunteer EMS providers.
- One representative from an Emergency Communications Center.

- One representative from Rockbridge County.
- One representative from Bath/Highland Counties.
- CSEMS Council staff.

When conducting case reviews, meeting attendance will be restricted to Committee members or designees, Operational Medical Directors and personnel directly involved in the case being reviewed.

Member Guidelines

1. Members of the PI Committee are charged with the responsibility of assuring that reasonable standards of care and professionalism are met.
2. It is recommended that members participate in an ongoing PI Program including patient care and patient transfer audits and data collection within their respective EMS agency or hospital.
3. Members must maintain strict confidentiality of patient information, personnel and all case review information discussed or reviewed in the QA/QI process.

Committee Guidelines

The PI Committee will meet quarterly to review the input from the EMS agencies and report significant events. The committee will identify needs based on review of PI information, plan a course of corrective action to resolve/improve the identified deficit and reassess the deficit to "close the loop" on issues.

The Chair of the PI Committee will be appointed by the Committee. The Chair will serve 12-month terms or until a replacement is named. The Chair's responsibilities will include:

1. Uphold decisions and actions of the PI Committee.
2. Approve all letters of recommendations to local EMS agencies, Operational Medical Directors or hospitals.
3. Approve all proposals for changes to PI policies and guidelines.
4. Serve as liaison to local EMS agencies, Operational Medical Directors and other physicians involved emergency and trauma care.
5. Serve as liaison to the CSEMS Council Medical Control Review Committee.

The CSEMS Regional Medical Director shall serve the co-chair. The co-chair shall act in the absence of the Chair, and shall serve as liaison to all local EMS agencies.

Confidentiality

In order to maintain the integrity of the PI Committee and protect patient and provider privacy, each member at all times will maintain strict confidentiality. However, communication with other entities of the system is essential. Specifically, when an issue is identified within the system involving such matters as skill performance, critical thinking, documentation, equipment, protocol deviation or other general issues, it is the responsibility of this committee to inform the appropriate agency leader and the agency's OMD, and elicit input for possible solutions. All reasonable efforts will be taken to sanitize records and maintain patient anonymity.

Medical Incident Review (QA)

Effective identification, analysis, and correction of deficiencies requires an objective review by qualified, appropriate representatives of EMS and hospitals within the CSEMS region, and must be protected by a process which ensures confidentiality.

1. EMS agencies, providers, and hospitals may refer any incidents for Medical Incident Review (MIR). This may include incidents with either positive or negative outcomes.
2. The PI Committee shall notify the affected OMD(s). The PI Committee may, at it's or the OMDs discretion and after review of the documentation provided, conduct a formal Medical Incident Review (MIR).
3. Submission of a Medical Incident Review
   - Only one MIR report is required to trigger a MIR. Such request may be made by any EMS agency, provider, or hospital.
   - A Medical Incident Review form and copy of the related PPCR(s) should be submitted to CSEMS. The form is available on the CSEMS website. The PPCR may be faxed, mailed, delivered, or scanned and emailed.
4. The agencies and/or facilities involved in the MIR will be notified of any incident that has been accepted for review. The involved personnel should be notified by their respective agency/facility of the initiation of the MIR process.
5. The MIR process may include:
   - A review of pertinent medical records including the PPCR, any radio or telephonic communications relating to the incident, and patient outcome data.
   - A formal interview with involved personnel to review the pertinent facts of the incident.
6. The PI Committee shall review all facts found during the review process, to identify and address the root cause and to recommend solutions. Examples of such causes are lack of knowledge or skill proficiency, limitation of resources, poor communications, personal conduct, etc.
7. The PI Committee shall provide the results of the MIR and recommendations or constructive feedback to the affected OMD, EMS agency or hospital officials.

   Recommendations may include, but are not limited to, any of the following:
   - Revisions to policy, produce, or protocols
   - Revisions to operational procedures or equipment.
   - System-wide retraining, individual counseling, individual knowledge and skills evaluation/refresher, and/or clinical monitoring

   For EMS agency and/or provider issues, all recommendations will be sent to the involved agency's leader, to the individual(s) involved, and to the OMD. For hospital issues, the letter shall be directed to the appropriate hospital personnel to include the hospital's quality assurance staff. Such letters will be approved by the PI Committee's chair.

8. The PI Committee shall track all MIRs and respond to trends and patterns, and shall develop recommendations to resolve any identified issues or deficiencies. All recommendations shall be forwarded to the CSEMS Medical Control Review Committee for final review and action.

9. The PI Committee will report to the Virginia Office of EMS any findings that are or could be in violation of Virginia Emergency Medical Services Regulations 12 VAC 5-31.

Regional EMS System Data Analysis (QI)

Quality Improvement is critical to the evaluation of the medical system in the CSEMS region. A broad look at what contributes to community health must include data from hospitals and prehospital agencies, so comprehensive care at the right time and at the right place can be ensured. Accurate regional data can provide specific information about the health of the region's medical and trauma systems and individual communities, facilities, and about prehospital services.

The QI goals of the CSEMS Council PI Committee are to:

- Design and implement PI projects addressing medical issues that are practical and will generate patient care statistics to evaluate system effectiveness and identify trends in patient care.
- Establish regional clinical benchmarks to measure the CSEMS Council regional system's effectiveness.
- Design and implement PI projects that monitor and assess adherence to regional patient care protocols.
- Design and implement PI projects that monitor and assess EMS system issues.
- Identify the educational needs of EMS providers in the region.
- Identify methods that will be used to resolve issues identified through the PI process.

The PI Committee will conduct region-wide PI projects to include three concurrent PI projects each quarter.

- General EMS patient care item.
- EMS system related item.
- Trauma patient care or trauma system related item.

Requests or suggestions for PI projects may come from individuals, the Medical Control Committee, PI Committee, TPI Committee, EMS agencies or hospitals in the CSEMS Council region. If appropriate, the PI Committee will appoint a task force(s) to address an issue or project.

While CSEMS and its PI Committee have no statutory or regulatory authority to compel agencies and hospitals to participate in data submission, the Committee encourages all EMS agency Operational Medical Directors and hospitals to participate and comply with data submission specific to PI projects undertaken by the Committee.

Regional EMS agencies will be able to report PI data to the Committee in one of two ways.

- Submit the data quarterly on an Excel spreadsheet. Data reported using this method is due no more than 15 days after the end of each quarter.
- Permit the Committee access to the agency's electronic patient data collection software through QA/QI administrative access.

APPENDIX A – Authority, Protection from Discovery

Authority

EMS Agency Requirement to Conduct Quality Management

Virginia Emergency Medical Services Regulations

12 VAC 5-31-600: “An EMS agency shall have an ongoing Quality Management (QM) Program designed to objectively, systematically and continuously monitor, assess and improve the quality and appropriateness of patient care provided by the agency. The QM Program shall be integrated and include activities related to patient care, communications, and all aspects of transport operations and equipment maintenance pertinent to the agency’s mission. The agency shall maintain a QM report that documents quarterly PPCR reviews, supervised by the operational medical director.”

Regional EMS Council Protection from Discovery

§ 8.01-581.17. Privileged communications of certain committees and entities.

A. For the purposes of this section:
"Centralized credentialing service" means (i) gathering information relating to applications for professional staff privileges at any public or licensed private hospital or for participation as a provider in any health maintenance organization, preferred provider organization or any similar organization and (ii) providing such information to those hospitals and organizations that utilize the service.
"Patient safety data" means reports made to patient safety organizations together with all health care data, interviews, memoranda, analyses, root cause analyses, products of quality assurance or quality improvement processes, corrective action plans or information collected or created by a health care provider as a result of an occurrence related to the provision of health care services.
"Patient safety organization" means any organization, group, or other entity that collects and analyzes patient safety data for the purpose of improving patient safety and health care outcomes and that is independent and not under the control of the entity that reports patient safety data.

B. The proceedings, minutes, records, and reports of any (i) medical staff committee, utilization review committee, or other committee, board, group, commission or other entity as specified in § 8.01-581.16; (ii) nonprofit entity that provides a centralized credentialing service; or (iii) quality assurance, quality of care, or peer review committee established pursuant to guidelines approved or adopted by (a) a national or state peer review entity, (b) a national or state accreditation entity, (c) a national professional association of health care providers or Virginia chapter of a national professional association of health care providers, (d) a licensee of a managed care health insurance plan (MCHIP) as defined in § 38.2-5800, (e) the Office of Emergency Medical Services or any regional emergency medical services council, or (f) a statewide or local association representing health care providers licensed in the Commonwealth, together with all communications, both oral and written, originating in or provided to such committees or entities, are privileged communications which may not be disclosed or obtained by legal discovery proceedings unless a circuit court, after a hearing and for good cause arising from extraordinary circumstances being shown, orders the disclosure of such proceedings, minutes, records, reports, or communications. Additionally, for the purposes of this section, accreditation and peer review

records of the American College of Radiology and the Medical Society of Virginia are considered privileged communications. Oral communications regarding a specific medical incident involving patient care, made to a quality assurance, quality of care, or peer review committee established pursuant to clause (iii), shall be privileged only to the extent made more than 24 hours after the occurrence of the medical incident.

C. Nothing in this section shall be construed as providing any privilege to health care provider, emergency medical services agency, community services board, or behavioral health authority medical records kept with respect to any patient in the ordinary course of business of operating a hospital, emergency medical services agency, community services board, or behavioral health authority nor to any facts or information contained in such records nor shall this section preclude or affect discovery of or production of evidence relating to hospitalization or treatment of any patient in the ordinary course of hospitalization of such patient.

D. Notwithstanding any other provision of this section, reports or patient safety data in possession of a patient safety organization, together with the identity of the reporter and all related correspondence, documentation, analysis, results or recommendations, shall be privileged and confidential and shall not be subject to a civil, criminal, or administrative subpoena or admitted as evidence in any civil, criminal, or administrative proceeding. Nothing in this subsection shall affect the discoverability or admissibility of facts, information or records referenced in subsection C as related to patient care from a source other than a patient safety organization.

E. Any patient safety organization shall promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. Patient safety organizations shall maintain the confidentiality of all patient identifying information and shall not disseminate such information except as permitted by state or federal law.

F. Exchange of patient safety data among health care providers or patient safety organizations that does not identify any patient shall not constitute a waiver of any privilege established in this section.

G. Reports of patient safety data to patient safety organizations shall not abrogate obligations to make reports to health regulatory boards or other agencies as required by state or federal law.

H. No employer shall take retaliatory action against an employee who in good faith makes a report of patient safety data to a patient safety organization.

I. Reports produced solely for purposes of self-assessment of compliance with requirements or standards of the Joint Commission on Accreditation of Healthcare Organizations shall be privileged and confidential and shall not be subject to subpoena or admitted as evidence in a civil or administrative proceeding. Nothing in this subsection shall affect the discoverability or admissibility of facts, information, or records referenced in subsection C as related to patient care from a source other than such accreditation body. A health care provider's release of such reports to such accreditation body shall not constitute a waiver of any privilege provided under this section.

§ 8.01-581.16. Civil immunity for members of or consultants to certain boards or committees.

Every member of, or health care professional consultant to, any committee, board, group, commission or other entity shall be immune from civil liability for any act, decision, omission, or utterance done or made in performance of his duties while serving as a member of or consultant to such committee, board, group, commission or other entity, which functions primarily to review, evaluate, or make recommendations on (i) the duration of patient stays in health care facilities, (ii) the professional services furnished with respect to the medical, dental, psychological, podiatric, chiropractic, veterinary or optometric necessity for such services, (iii) the purpose of promoting the most efficient use or monitoring the quality of care of available health care facilities and services, or of emergency medical services agencies and services, (iv) the adequacy or quality of professional services, (v) the competency and qualifications for professional staff privileges, (vi) the reasonableness or appropriateness of charges made by or on behalf of health care facilities or (vii) patient safety, including entering into contracts with patient safety organizations; provided that such committee, board, group, commission or other entity has been established pursuant to federal or state law or regulation, or pursuant to Joint Commission on Accreditation of Healthcare Organizations requirements, or established and duly constituted by one or more public or licensed private hospitals, community services boards, or behavioral health authorities, or with a governmental agency and provided further that such act, decision, omission, or utterance is not done or made in bad faith or with malicious intent.

APPENDIX B – Medical Incident Review (MIR) Form

CSEMS Council Medical Incident Review (MIR) Form

The purpose of this referral is to improve the quality and efficiency of patient care in the Central Shenandoah EMS region. This form is intended to relay either positive or negative comments regarding EMS incidents in the region. Submission of this document triggers further review of the specific incident. All information obtained through this process will remain confidential. This information will be used by the EMS agency and it's Operational Medical Director (OMD) for the purposes of Quality Improvement (QI) to result in improved patient care. Provide as much of the requested information as possible.

This form may be submitted anonymously. However, if you would like us to contact you for additional information, we must have your contact information. All MIR information is confidential.

Section–1: REFERRER CONTACT INFORMATION *[PLEASE PRINT CLEARLY]*

_____ _____
Name *Agency*

_____ _____
Telephone Number *E-mail address*

Section–2: INCIDENT DETAILS *[PLEASE PRINT CLEARLY]*

_____ _____ _____ _____
Date of Incident *Time of Incident* *EMS PPCR Number* *Patient Record Number*

_____ _____
Agency/Facility Targeted for Review *Attendant-in-charge (if known)*

Section–3: DESCRIPTION OF EVENTS *[PLEASE PRINT CLEARLY]*

_____

_____

_____

_____

_____

_____

_____

*** CSEMS USE ONLY ***

Date Received:_____ **Date Referred to PI Committee:** _____

Comments: _____

_____