Western Virginia Emergency Medical Services Council, Inc.

PERFORMANCE IMPROVEMENT PLAN (GENERAL)

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- Virginia Administrative Code 12 VAC 5-31-600
- Code of Virginia § 8.01-581.17
- Code of Virginia § 8.01-581.16

Purpose

The Western Virginia Emergency Medical Services Council ‘s General Performance Improvement Committee (PI), under the direction of its Medical Direction Committee, is responsible for assuring and improving the quality of pre-hospital medical care within WVEMS region, and for monitoring compliance with the region’s Patient Destination Policy for field-to-hospital transfer of patients.

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)*** is the collective term used to refer to the entire QA/QI process in place in the Western Virginia EMS region.

Primary Objectives

Collect and analyze patient care statistics to evaluate system effectiveness and identify trends (QI)

1. Publish and distribute reports and recommendations resulting from #2(QI)
2. Conduct Medical Incident Reviews (QA)
3. Provide constructive feed back on quality improvement to all EMS professionals and Operational Medical Directors within the WVEMS Region.

PI Committee Composition

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

- WVEMS Regional Medical Director (RMD)
- Two additional current OMD's from across the region
- Three representatives from hospitals in the region (one from each PD)
- One representative from an air medical agency (paramedic, nurse, or administrator)
- One representative from a fire-based EMS agency (combination agency)
- One career EMS provider
- One volunteer EMS provider
- The overall committee makeup shall include one representative from each city and county in the region

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 (for hospitals) and data collection within their respective EMS agency or hospital. Members will assist in the development of a PI Program when requested by an agency in the area they represent.
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 Committee will be chaired by the WVEMS Regional Medical Director or another member of the Medical Direction Committee appointed by the RMD. The chair shall:

1. Uphold decisions and actions of the PI Committee.
2. Approve all letters of recommendations to local EMS agencies, Operating Medical Directors or hospitals.
3. Approve all proposals for changes to PI policies and guidelines.
4. Serve as liaison to local EMS agencies, OMD's and other physicians involved in emergency care.
5. Serve as liaison to the WVEMS Medical Direction Committee

A pre-hospital EMS provider shall be elected by the committee to serve as co-chair. The co-chair shall act in the absence of the Chair, and shall:

1. 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.

1. PCR Reviews (QA)
2. Patient Care Reports (PPCR's) may be reviewed by the PI Committee. These reviews may be random or specific.
3. Data extracted from PPCR may be evaluated and used for various PI projects and studies. Data may be provided by the Virginia Office of EMS, or collected locally.
4. PI projects will be conducted, at a minimum, in number and topics, as required in the WVEMS contract with the Virginia Office of EMS. Such studies and projects may focus on criteria determined by the PI committee and/or the Medical Direction Committee.

Medical Incident Review (MIR)

Effective identification, analysis, and correction of deficiencies requires an objective review by qualified, appropriate representatives of EMS and hospitals within the WVEMS 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 may, at its 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 WVEMS. The form is available on the WVEMS 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. The agency representative will be instructed to discuss the MIR with the agency's OMD. In 10 days, WVEMS PI staff will contact the OMD to determine what actions have taken place. The OMD may request a formal review, including referral of the event to the PI Committee.

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. If escalated to the PI Committee, the 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 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.

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

Performance improvement is critical to the evaluation of the EMS system in the WVEMS Region. A broad look at the contribution of the EMS system to community health must include evaluation of data from hospitals and EMS agencies. Accurate data from the region can provide specific information about the health of our EMS System and individual communities, facilities, and about prehospital services.

While WVEMS 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 OMD's and hospitals to participate and comply with data submission specific to PI projects undertaken by the Committee.

APPENDIX A

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.