Table of Contents

Appendices

Executive Summary

State Trauma Triage Plan

Under *the Code of Virginia* **§** *32.1-111.3*, The Office of Emergency Medical Services (OEMS) acting on behalf of the Virginia Department of Health has been charged with the responsibility of developing a Statewide Trauma Triage Plan. This plan is to include prehospital and interhospital patient transfers.

The *Code* states that the State Trauma Triage Plan shall have a strategy for maintaining the statewide Trauma Triage Plan through formal regional trauma triage plans that incorporate each region's geographic variations and trauma care capabilities and resources, including hospitals designated as trauma centers pursuant to subsection A of this section. The regional trauma triage plans shall be reviewed annually. In addition, it provides specific guidance to EMS providers functioning within the TJEMS region.

Data Collection, Use and Discoverability

§ 32.1-116.1. Prehospital patient care reporting procedure; trauma registry; confidentiality.

A. In order to collect data on the incidence, severity and cause of trauma, integrate the information available from other state agencies on trauma and improve the delivery of prehospital and hospital emergency medical services, there is hereby established the Emergency Medical Services Patient Care Information System. The Emergency Medical Services Patient Care Information System shall include the Virginia Emergency Medical Services (EMS) Registry and the Virginia Statewide Trauma Registry.

All licensed emergency medical services agencies shall participate in the Virginia EMS Registry by making available to the Commissioner or his designees the minimum data set in the format prescribed by the Board or any other format which contain equivalent information and meets any technical specifications of the Board. The minimum data set shall include, but not be limited to, the type of medical emergency or nature of the call, the response time, the treatment provided and other items as prescribed by the Board.

Each licensed emergency medical services agency shall, upon request, disclose the prehospital care report to law-enforcement officials (i) when the patient is the victim of a crime or (ii) when the patient is in the custody of the law-enforcement officials and has received emergency medical services or has refused emergency medical services.

The Commissioner may delegate the responsibility for collection of this data to the Office of Emergency Medical Services personnel or individuals under contract to the Office. The Advisory Board shall assist in the design, implementation, subsequent revisions, and analyses of the data from the Virginia EMS Registry.

§ 32.1-116.2. Confidential nature of information supplied; publication; liability protections.

A. The Commissioner and all other persons to whom data is submitted shall keep patient information confidential. Mechanisms for protecting patient data shall be developed and continually evaluated to ascertain their effectiveness. No publication of information, research or medical data shall be made which identifies the patients by names or addresses. However, the

Commissioner or his designees may utilize institutional data in order to improve the quality of and appropriate access to emergency medical services.

B. No individual, licensed emergency medical services agency, hospital, Regional Emergency Medical Services Council or organization advising the Commissioner shall be liable for any civil damages resulting from any act or omission performed as required by this article unless such act or omission was the result of gross negligence or willful misconduct.

Trauma System

The Virginia Trauma System is an inclusive system and all hospitals participate in the Trauma Triage Plan. Establishing a comprehensive statewide emergency medical care system, incorporating healthcare facilities, transportation, human resources, communications, and other components as integral parts of a unified system will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality.

Decreasing morbidity, hospitalization, disability, and mortality can be achieved by reducing the time taken to identify acutely injured patients and to assist them in reaching definitive high quality trauma care. A coordinated effort between ground and air prehospital resources, as well as hospitals – whether trauma designated or not – can lead to getting the right patient to the right hospital in the shortest amount of time possible, all while maximizing resources.

Regional Trauma Triage Plan

This document will provide a uniform set of recommended criteria for prehospital and interhospital triage and transport of trauma patients in the TJEMS region. The development and monitoring of these criteria is performed by the State Trauma Triage Performance and Improvement Committee, a subcommittee of the Governor's Advisory Board's Trauma System Oversight and Management Committee, and the TJEMS Operational Medical Directors Committee. The State Office of EMS is the enforcement body for the State Trauma Triage Plan. As a planning and coordinating organization, TJEMS does not possess enforcement powers for the Regional Trauma Triage Plan but seeks compliance via a collaborative, consultative process.

Recognizing the variability of Virginia's demographics and geography, the State Trauma Triage Plan has been designed as a template for the Regional EMS Councils to develop, monitor and revise a regional trauma triage plan. In addition, problems, concerns and other issues related to trauma care on scene, in transit and within hospitals can be addressed through regional Trauma Performance Improvement Committee activities. These activities include, but are not limited to, conducting, promoting, and encouraging programs of education and training designed to enhance the knowledge, skills and abilities of healthcare providers involved in trauma care.

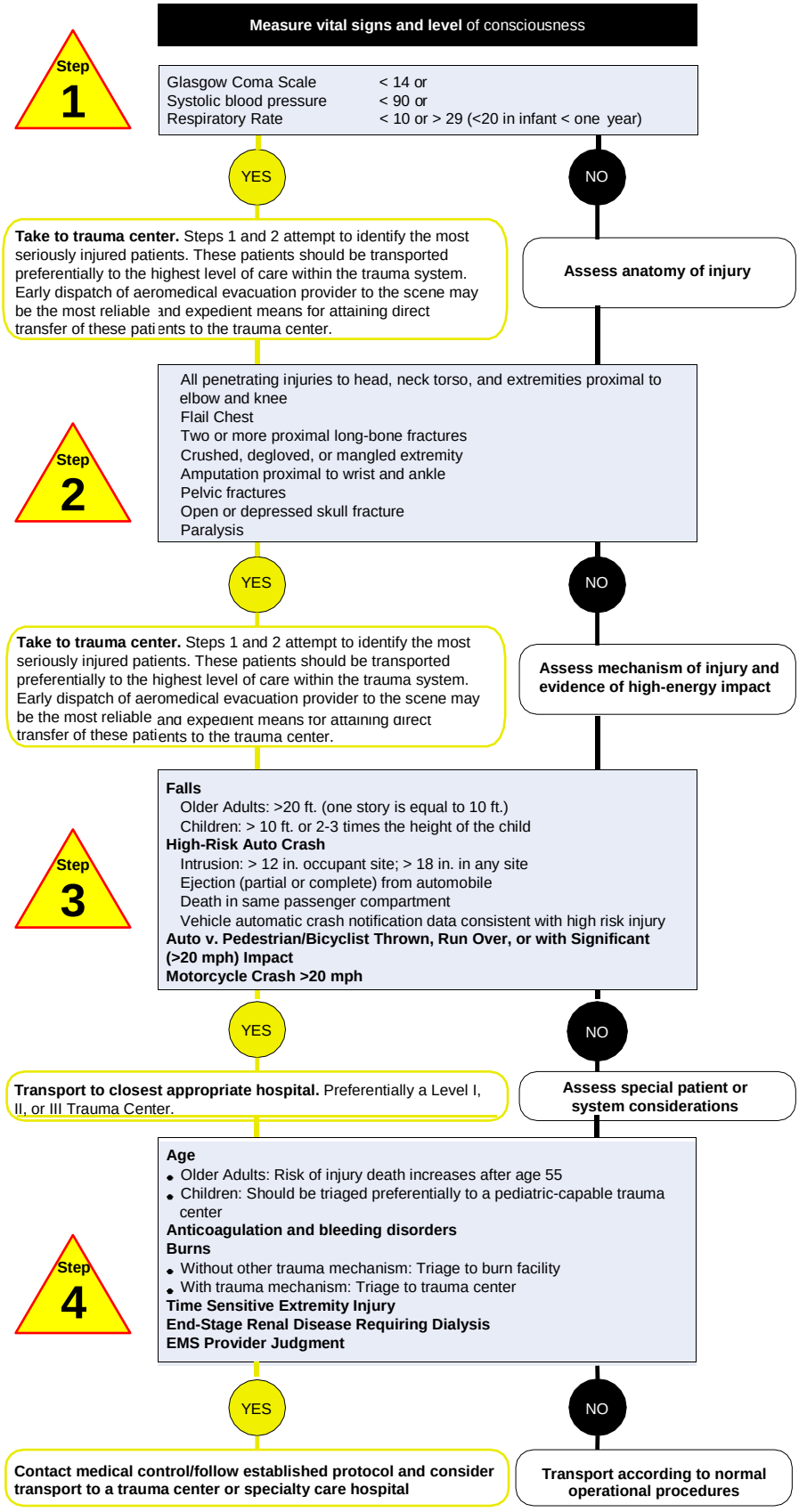
Definition of a Trauma Patient

Trauma Patient:
A person who has acquired serious injuries brought on by unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen. These injuries may affect one or more body systems and may be life altering, life threatening or ultimately fatal.

Two-tiered System for the recognition of a trauma patient:
- Initial triage in the prehospital setting.
- Secondary triage at local hospitals.

The purpose of the Statewide Trauma Triage Plan is to establish prehospital and hospital criteria for the purpose of identifying the trauma patient. The TJEMS Regional Trauma Triage Plan is intended to identify the best point of entry into the trauma system for these patients. Many factors including, but not limited to, geography, hospital capabilities and the availability of air medical services will help to guide where the identified trauma patient will be transported or transferred.

Trauma Patient Transport and Transfer Criteria
Prehospital Criteria



Trauma Patient Transport Considerations

Trauma patients are to be transported to the designated trauma center that can be reached in the shortest amount of time. The patient may be transported by ground or air medical service. In general, air medical transportation should be considered if the combined patient treatment and transport time to the trauma center will exceed 30 minutes. Medical control is a resource should there be a question of appropriate destination or transport modality.

For most transports originating in the TJEMS region, the **UVA Medical Center**, 1215 Lee Street, Charlottesville, VA is the most appropriate destination for trauma patients. The following trauma centers may also be appropriate in certain circumstances:

VCU Medical Center
1250 East Marshall Street, Richmond, VA

Lynchburg General Hospital
1901 Tate Springs Road, Lynchburg, VA

Inova Fairfax Hospital
3300 Gallows Road, Falls Church, VA

Chippenham Medical Center
7101 Jahnke Road, Richmond, VA

Mary Washington Hospital
1001 Sam Perry Boulevard, Fredericksburg, VA

Criteria for Air Medical Transport

Transport from the Incident Scene

Transport from the incident scene to a designated trauma center via helicopter should be made according to the following criteria:

1. Trauma patient transport and transfer criteria are met.
2. Patient requires a level of care greater than can be provided by the responding ground transport agency.

1 or 2 above PLUS any of the following:

- Difficult access situations:
  - ✱ Wilderness rescue
  - ✱ Ambulance egress or access impeded at the scene by road conditions, weather, or traffic.

Written: January 1998 **Revised:** **Approved:2021**

- Time/Distance Factors:
  - ✱ Transport time to the trauma center by ground is greater than transport time to the trauma center by helicopter.
  - ✱ Patient extrication time > 20 minutes.
  - ✱ Utilization of ground ambulances may leave locality without ground ambulance coverage for an extended period of time.

Interfacility Transport by Helicopter

Transport from a non-trauma center hospital to a designated trauma center via helicopter should be made according to the following criteria:

1. Trauma patient transport and transfer criteria are met.
2. Patient requires a level of care greater than can be provided by the non-trauma center hospital.
3. Patient requires time critical intervention, out-of-hospital time needs to be minimal, or time/distance to definitive care is long.
4. Utilization of ground ambulance may leave locality without ground ambulance coverage for an extended period of time.

Hospital Criteria

Adult Patient	Pediatric Patient
	Any pediatric patient with a Pediatric Trauma Score ≤6 (see Pediatric Trauma Score below).
Airway • Bilateral thoracic injuries. • Significant unilateral injuries in pt's >60 (e.g. pneumothorax, hemo/pneumothorax, pulmonary contusion, >5 rib fractures) • Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease • Respiratory compromise requiring intubation • Flail chest	**Airway** • Bilateral thoracic injuries • Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease • Flail chest
CNS • Unable to follow commands • Open skull fracture • Extra-axial hemorrhage on CT, or any intracranial blood • Paralysis • Focal neurological deficits • GCS ≤12	**CNS** • Open skull fracture • Extra-axial hemorrhage on CT • Focal neurological deficits
Cardiovascular • Hemodynamic instability as determined by the treating physician • Persistent hypotension • Systolic B/P <100 without immediate availability of surgical team	
Injuries • Any penetrating injury to the head, neck, torso or extremities proximal to the elbow or knee without a surgical team immediately available • Trauma patient with burn injuries • Significant abdominal or thoracic injuries in patients where the physician in charge feels the level of care needed exceeds the capabilities of the medical center	**Injuries** • Any penetrating injury to the head, neck, chest, abdomen or extremities proximal to the knee or elbows without a surgical team immediately available • Trauma patient with burn injuries • Any injury or combination of injuries where the physician in charge feels the level of care needed exceeds the capabilities of the medical center
Special Considerations • Trauma in pregnancy (≥24 week gestation) • Geriatric Patient • Bariatric Patient • Special Needs Patient	

Pediatric Trauma Score

COMPONENT	+2	+1	-1
Size	Child/adolescent, >20kg.	Toddler, 11-20kg.	Infant <10kg.
Airway	Normal	Assisted O_2, mask, cannula	Intubated: ETT, King/Combitube, Cric
Consciousness	Awake	Obtunded; loss of consciousness	Coma; unresponsiveness
Systolic B/P	>90 mm Hg; good peripheral pulses	51-90 mm Hg; carotid pulse palpable	<50 mm Hg; no pulses
Fracture	None seen or suspected	Single closed fracture anywhere	Open, multiple fractures
Cutaneous	No visible injury	Contusion, abrasion; laceration <7 cm; not through fascia	Tissue loss; any GSW/Stabbing; through fascia

Burn Related Injuries

• Patients will be taken directly to VCU via air medical transport if they have more than 15 percent second- and third-degree burns or have an inhalation injury that requires intubation.
• If direct air medical transport to VCU for patients with major burns is not possible due to weather or distance, UVA will provide all necessary care at our trauma center to stabilize the patient. We will then transfer the patient from UVA to VCU.
• Patients with a combination of traumatic injuries and burns will be evaluated at UVA, and UVA's care team will determine whether to transfer the patient following the evaluation. Patients not covered by these criteria will be stabilized and evaluated at UVA. If they require burn center care, we will transfer them to VCU after stabilization. Burn patients in Charlottesville and Albemarle County will still come directly to UVA for evaluation and stabilization.

The American Burn Association has identified the following injuries that usually require referral to a burn center.

- Partial thickness and full thickness burns greater than 10% of the total body surface area (BSA) in patients under 10 or over 50 years of age.
- Partial thickness burns and full thickness burns greater than 20% BSA in other age groups.
- Partial thickness and full thickness burns involving the face, eyes, ears, hands, feet, genitalia or perineum or those that involve skin overlying major joints.
- Full thickness burns greater than 5% BSA in any age group.
- Electrical burns, including lightning injuries; (significant volumes of tissue beneath the surface may be injured and result in acute renal failure and other complications).
- Significant chemical burns.
- Inhalation injuries.
- Burn injury in patients with pre-existing illness that could complicate management, prolongs recovery, or affects mortality.
- Any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be treated initially in a trauma center until stable before transfer to a burn center.
- Children with burns seen in hospitals without qualified personnel or equipment for their care should be transferred to a burn center with these capabilities.
- Burn injury in patients who will require special social and emotional or long term rehabilitative support, including cases involving child abuse and neglect.

Trauma Patient Transport Considerations

EMS Patient Care Protocols must address transport considerations. Each jurisdiction is unique in its availability of trauma resources. Consideration should be given to the hospital(s) that is/are available in the region and the resources that they have available to trauma patients when developing a point of entry plan. Pre-planning for times when the primary hospital is not available to receive trauma patients because of multiple patients, diversion, or loss of resources such as electric power need to be made in advance of being on scene with a critical trauma patient.

Consideration should also be given to prehospital resources including the level of care available by the ground EMS crews, the closest appropriate Medevac service [Helicopter EMS (HEMS)] available at the time of the incident, and other conditions such as transport time and weather conditions. Use of Medevac services can assist with trauma patients reaching definitive trauma care in a timely fashion. The developers of this plan identified the following criteria to initiate field transports by helicopter of trauma patients as defined in this plan. Field transport of trauma patients by helicopter would be expected to:

1. Lessen the time from on scene to a hospital compared to ground transport;
2. Bypass a non-trauma designated hospital to transport directly to a trauma center in not greater than 30 minutes;
3. Meet the clinical triage criteria for transport to the closest Level I Trauma Center, or when appropriate the closest Level II Trauma Center;
4. Meet the greater level of care needed by the patient, provided that the Medevac unit can be on scene in a time shorter than the ground unit can transport to the closest hospital; and/or,
5. Document extenuating circumstances such as safety, egress/access similar to other “extraordinary” care scenarios.

Regional EMS Mass Casualty Incident (MCI) Plans and Disaster/Weapons of Mass Destruction (WMD) Plans

Both prehospital and hospital providers should become familiar with other related Regional EMS/public health emergency plans. These plans represent a tiered response to increasing numbers of patients:

- MCI Plan
- Disaster/WMD Plan
- Surge Capacity Plan

These plans are designed to complement one another. The Regional Trauma Triage Plan is intended to guide transport and transfer destinations for a limited number of patients that can be managed by resources available during normal daily operations. The MCI and Disaster/WMD Plans provide additional guidance to agencies, municipalities and medical facilities when the numbers of patients exceed that which can be managed by regularly available resources. The Surge Capacity Plan is currently being developed by the Northwest Regional Emergency Management Committee, a multi-region collaboration of public safety officials, hospital representatives and regional planning and health agencies, to meet the need of large-scale events that may require caring for hundreds or even thousands of patients.

Trauma Performance Improvement (TPI)

The Office of EMS will coordinate a program for monitoring the quality of trauma care. This program will provide for the collection and analysis of data on emergency medical and trauma services from existing validated sources, including but not limited to the Prehospital Patient Care Report (PPCR) Program and the Trauma Registry.

The Office of EMS, acting on behalf of the Commissioner of Health, will report aggregate findings of the analysis annually to each Regional EMS Council. The findings

of the report shall be used by the Councils to improve their Regional Trauma Triage Plan, including triage, transport and trauma center designation criteria.

The State Trauma Performance Improvement (TPI) Committee will also review such data on a quarterly basis and report its findings to the Health Commissioner and the EMS Advisory Board. The program for monitoring and reporting the results of trauma services data analysis will be the sole means of encouraging and promoting compliance with the trauma triage criteria.

A de-identified version of the report will be available to the public and will include, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region.

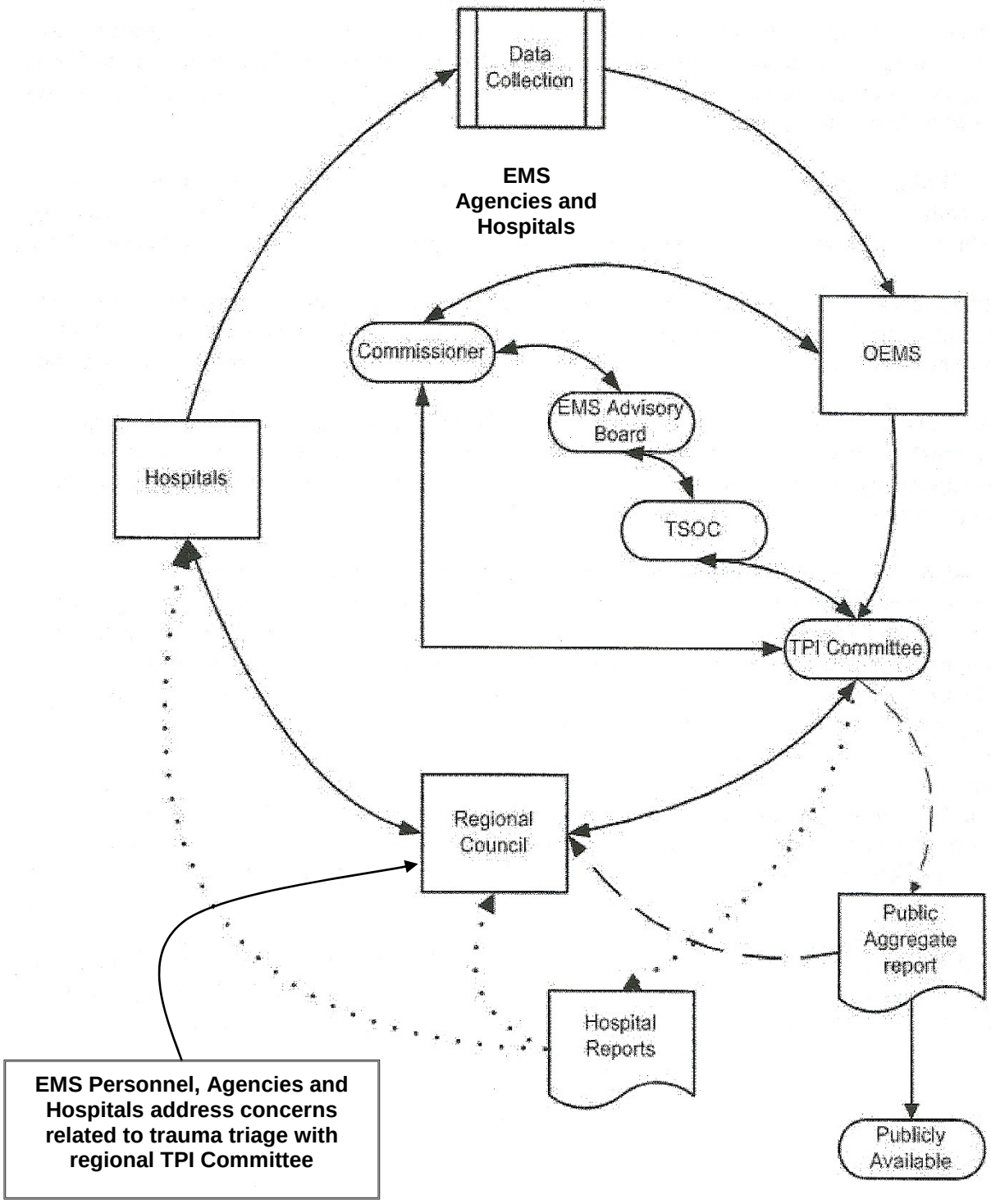
The program will ensure that each hospital or emergency medical services director is informed of any incorrect interfacility transfer or triage, as defined in the statewide plan, specific to the provider and will give the provider an opportunity to correct any facts on which such determination is based, if the provider asserts that such facts are inaccurate.

The Commissioner shall ensure the confidentiality of patient information, in accordance with § 32.1-111.3. Such data or information in the possession of or transmitted to the commissioner, the EMS Advisory Board, or any committee acting on behalf of the EMS Advisory Board, any hospital or prehospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings as is written in the *Code of Virginia*, unless a circuit court, after a hearing and for good causes shown arising from extraordinary circumstances, order disclosure of such data.

Methodology:
The Office of EMS biostatistician will provide a retrospective analysis of the previous calendar year's trauma triage activities to the EMS Advisory Board, by the Board's August quarterly meeting. This same report will be provided to the Regional Councils for use in satisfying their obligation to provide TPI initiatives for the fiscal year.

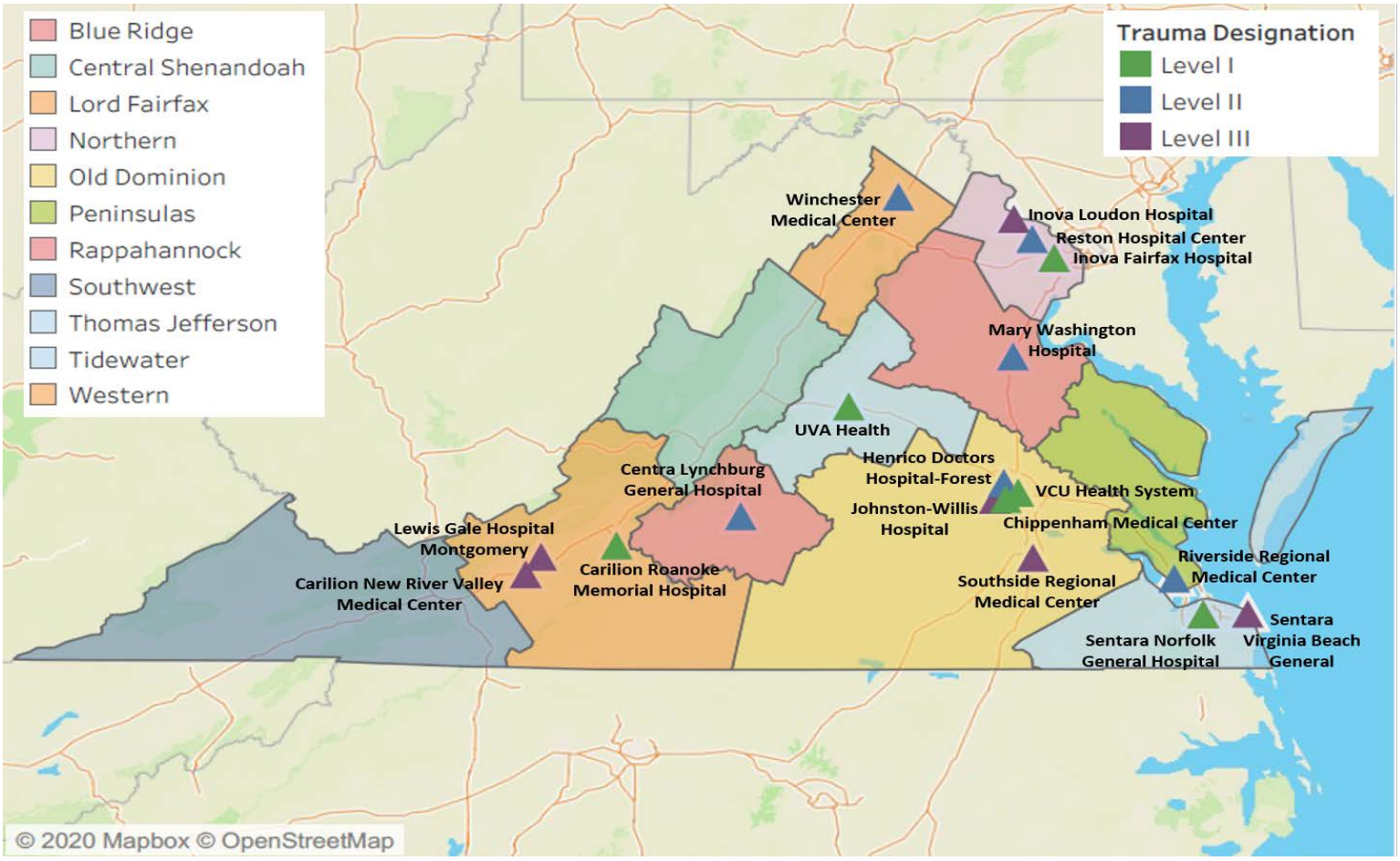
TJEMS intends to provide the Office of EMS with information that reflects the previous fiscal year's TPI activities including, but not limited to, the following: 1) topic of measurement 2) methodology of measurement 3) action taken following data analysis (loop closure).

Schematic of Trauma Performance Improvement



Appendix A

Trauma Center/Regional Council Map



Region	Level 1 Trauma Centers
Western Virginia	**Carilion Roanoke Memorial Hospital** 1906 Belleview Ave SE, Roanoke
Northern Virginia	**Inova Fairfax Hospital** 3300 Gallows Road, Falls Church
Tidewater	**Sentara Norfolk General Hospital** 600 Gresham Drive, Norfolk
TJEMS	**UVA Medical Center** 1215 Lee Street, Charlottesville
Old Dominion	**VCU Medical Center** 1250 East Marshall Street, Richmond
Old Dominion	**Chippenham Medical Center** 7101 Jahnke Rd, Richmond

Region	Level 2 Trauma Centers
Blue Ridge	**Lynchburg General Hospital** 1901 Tate Springs Road, Lynchburg

Peninsula	**Riverside Regional Medical Center** 500 J. Clyde Morris Blvd., Newport News
Lord Fairfax	**Winchester Medical Center** 1840 Amherst Street, Winchester
Rappahannock	**Mary Washington Hospital** 1001 Sam Perry Blvd., Fredericksburg

Old Dominion (cont.)	**Henrico Doctors' Hospital** 1602 Skipwith Rd, Richmond
Northern Virginia	**Reston Hospital Center** 1850 Town Center Pkwy, Reston
Region	**Level 3 Trauma Centers**
Western Virginia	**Carilion New River Valley Medical Center** 2900 Lamb Circle, Christiansburg
Old Dominion	**Johnston Willis Hospital** 1401 Johnston Willis Dr, Richmond
Western Virginia	**Montgomery Regional Hospital** 3700 South Main Street, Blacksburg
Tidewater	**Sentara Virginia Beach General Hospital** 1060 First Colonial Road, Virginia Beach
Old Dominion	**Southside Regional Medical Center** 200 Medical Park Blvd, Petersburg

Trauma Center Designation

Level I

Level I trauma centers have an organized trauma response and are required to provide total care for every aspect of injury, from prevention through rehabilitation. These facilities must have adequate depth of resources and personnel with the capability of providing leadership, education, research and system planning.

Level II

Level II trauma centers have an organized trauma response and are also expected to provide initial definitive care, regardless of the severity of injury. The specialty requirements may be fulfilled by on call staff, which is promptly available to the patient. Due to some limited resources, Level II centers may have to transfer more complex injuries to a Level I center. Level II centers should also take on responsibility for education and system leadership within their region.

Level III

Level III centers, through an organized trauma response, can provide prompt assessment, resuscitation, stabilization, emergency operations and also arrange for the transfer of the patient to a facility that can provide definitive trauma care. Level III centers should also take on responsibility for education and system leadership within their region.

Appendix B

Regional EMS Councils

• **Blue Ridge EMS Council** (BREMS) 1900 Tate Springs Road, Suite 14 Lynchburg, VA 24501	• **Central Shenandoah EMS Council** (CSEMS) 2312 West Beverley Street Staunton, VA 24401
• **Lord Fairfax EMS Council** (LFEMSC) 180 Prosperity Drive, Suite 1, Winchester, VA 22602	• **Northern Virginia EMS Council** (NOVA) 7250 Heritage Village Plaza Suite 102 Gainesville, VA 20155
• **Old Dominion EMS Alliance** (ODEMSA) 1421 Johnston-Willis Drive Richmond, VA 23235	• **Peninsulas EMS Council** (PEMS) PO Box 1297, Gloucester, VA 23061
• **Rappahannock EMS Council** (REMS) 435 Hunter Street Fredericksburg, VA 22401	• **Southwest Virginia EMS Council** (SWVAEMS) 306 Piedmont Ave Bristol, VA 24201
• **Thomas Jefferson EMS Council** (TJEMS) 400 Martha Jefferson Drive, Suite 100 Charlottesville, Virginia 22911	• **Tidewater EMS Council** (TEMS) 1104 Madison Plaza, Suite 101 Chesapeake, VA 23320
• **Western Virginia EMS Council** (WVEMS) 1944 Peters Creek Rd Roanoke, VA 24017	

Appendix C

State and Regional Demographics as of 02/2021

	Virginia	TJEMS
Residents	8,535,519	268,306
Square Miles	39,594.07	2,457.47
Localities	134	7
Trauma Centers		
Level I	6	1
Level II	6	0
Level III	6	0
Licensed Hospitals	106	2
Regional EMS Councils	11	1
Licensed EMS Agencies	584	36
Medevac Agencies	17	1
EMS Vehicles	4,309	154 Ambulances 170 Non-transport
EMS Providers	36,449	1376
First Responders	624	39
BLS Providers	23,901	863
ALS Providers	11,922	474

Appendix D

EMS Regulation

12 VAC 5-31-390. Destination/trauma triage.

An EMS agency shall participate in the Regional Trauma Triage Plan established in accordance with § 32.1-111.3 of the *Code of Virginia*.

§ 32.1-111.3. Statewide Emergency Medical Services Plan; Trauma Triage Plan; Stroke Triage Plan.

A. The Board of Health shall develop a Statewide Emergency Medical Services Plan that shall provide for a comprehensive, coordinated, emergency medical services system in the Commonwealth and shall review, update, and publish the Plan triennially, making such revisions as may be necessary to improve the effectiveness and efficiency of the Commonwealth's emergency medical services system. The Plan shall incorporate the regional emergency medical services plans prepared by the regional emergency medical services councils pursuant to § 32.1-111.4:2. Publishing through electronic means and posting on the Department website shall satisfy the publication requirement. The objectives of such Plan and the emergency medical services system shall include, but not be limited to, the following:

1. Establishing a comprehensive statewide emergency medical services system, incorporating facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;

2. Reducing the time period between the identification of an acutely ill or injured patient and the definitive treatment;

3. Increasing the accessibility of high quality emergency medical services to all citizens of Virginia;

4. Promoting continuing improvement in system components including ground, water, and air transportation; communications; hospital emergency departments and other emergency medical care facilities; health care provider training and health care service delivery; and consumer health information and education;

5. Ensuring performance improvement of the emergency medical services system and emergency medical services and care delivered on scene, in transit, in hospital emergency departments, and within the hospital environment;

6. Working with professional medical organizations, hospitals, and other public and private agencies in developing approaches whereby the many persons who are presently using the existing emergency department for routine, non-urgent, primary medical care will be served more appropriately and economically;

7. Conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of emergency medical services personnel, including

expanding the availability of paramedic and advanced life support training throughout the Commonwealth with particular emphasis on regions underserved by emergency medical services personnel having such skills and training;

8. Consulting with and reviewing, with agencies and organizations, the development of applications to governmental or other sources for grants or other funding to support emergency medical services programs;

9. Establishing a statewide air medical evacuation system which shall be developed by the Department of Health in coordination with the Department of State Police and other appropriate state agencies;

10. Establishing and maintaining a process for designation of appropriate hospitals as trauma centers and specialty care centers based on an applicable national evaluation system;

11. Maintaining a comprehensive emergency medical services patient care data collection and performance improvement system pursuant to Article 3.1 (§ 32.1-116.1 et seq.);
12. Collecting data and information and preparing reports for the sole purpose of the designation and verification of trauma centers and other specialty care centers pursuant to this section. All data and information collected shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.);
13. Establishing and maintaining a process for crisis intervention and peer support services for emergency medical services personnel and public safety personnel, including statewide availability and accreditation of critical incident stress management teams;

14. Establishing a statewide program of emergency medical services for children to provide coordination and support for emergency pediatric care, availability of pediatric emergency medical care equipment, and pediatric training of health care providers;

15. Establishing and supporting a statewide system of health and medical emergency response teams, including emergency medical services disaster task forces, coordination teams, disaster medical assistance teams, and other support teams that shall assist local emergency medical services agencies at their request during mass casualty, disaster, or whenever local resources are overwhelmed;

16. Establishing and maintaining a program to improve dispatching of emergency medical services personnel and vehicles, including establishment of and support for emergency medical services dispatch training, accreditation of 911 dispatch centers, and public safety answering points;

17. Identifying and establishing best practices for managing and operating emergency medical services agencies, improving and managing emergency medical services response times, and disseminating such information to the appropriate persons and entities;

18. Ensuring that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund shall be contacted immediately to deploy assistance in the

event there are victims as defined in § 19.2-11.01, and that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund become the lead coordinating agencies for those individuals determined to be victims; and
19. Maintaining current contact information for both the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund.

B. The Board of Health shall also develop and maintain as a component of the Emergency Medical Services Plan a statewide prehospital and interhospital Trauma Triage Plan designed to promote rapid access for pediatric and adult trauma patients to appropriate, organized trauma care through the publication and regular updating of information on resources for trauma care and generally accepted criteria for trauma triage and appropriate transfer. The Trauma Triage Plan shall include:

1. A strategy for maintaining the statewide Trauma Triage Plan through development of regional trauma triage plans that take into account the region's geographic variations and trauma care capabilities and resources, including hospitals designated as trauma centers pursuant to subsection A and inclusion of such regional plans in the statewide Trauma Triage Plan. The regional trauma triage plans shall be reviewed triennially. Plans should ensure that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund shall be contacted immediately to deploy assistance in the event there are victims as defined in § 19.2-11.01, and that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund become the lead coordinating agencies for those individuals determined to be victims; and maintain current contact information for both the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund.
2. A uniform set of proposed criteria for prehospital and interhospital triage and transport of trauma patients developed by the Advisory Board, in consultation with the Virginia Chapter of the American College of Surgeons, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Advisory Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § 8.01-581.20. A decision by a health care provider to deviate from the criteria shall not constitute negligence per se.
3. A performance improvement program for monitoring the quality of emergency medical services and trauma services, consistent with other components of the Emergency Medical Services Plan. The program shall provide for collection and analysis of data on emergency medical and trauma services from existing validated sources, including the emergency medical services patient care information system, pursuant to Article 3.1 (§ 32.1-116.1 et seq.), the Patient Level Data System, and mortality data. The Advisory Board shall review and analyze such data on a quarterly basis and report its findings to the Commissioner. The Advisory Board may execute these duties through a committee composed of persons having expertise in critical care issues and representatives of emergency medical services providers. The program for monitoring and reporting the results of emergency medical services and trauma services data analysis shall be the sole means of encouraging and promoting compliance with the trauma triage criteria.

The Commissioner shall report aggregate findings of the analysis annually to each regional emergency medical services council. The report shall be available to the public and shall identify, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region.

The Advisory Board or its designee shall ensure that each hospital director or emergency medical services agency chief is informed of any incorrect interfacility transfer or triage, as defined in the statewide Trauma Triage Plan, specific to the hospital or agency and shall give the hospital or agency an opportunity to correct any facts on which such determination is based, if the hospital or agency asserts that such facts are inaccurate. The findings of the report shall be used to improve the Trauma Triage Plan, including triage, and transport and trauma center designation criteria.

The Commissioner shall ensure the confidentiality of patient information, in accordance with §32.1-116.2. Such data or information in the possession of or transmitted to the Commissioner, the Advisory Board, any committee acting on behalf of the Advisory Board, any hospital or prehospital care provider, any regional emergency medical services council, emergency medical services agency that holds a valid license issued by the Commissioner, or group or committee established to monitor the quality of emergency medical services or trauma services pursuant to this subdivision, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.
C. The Board shall also develop and maintain as a component of the Statewide Emergency Medical Services Plan a statewide prehospital and interhospital Stroke Triage Plan designed to promote rapid access for stroke patients to appropriate, organized stroke care through the publication and regular updating of information on resources for stroke care and generally accepted criteria for stroke triage and appropriate transfer. The Stroke Triage Plan shall include:

1. A strategy for maintaining the statewide Stroke Triage Plan through development of regional stroke triage plans that take into account the region's geographic variations and stroke care capabilities and resources, including hospitals designated as "primary stroke centers" through certification by the Joint Commission, DNV Healthcare, or a comparable process consistent with the recommendations of the Brain Attack Coalition, and inclusion of such regional plans in the statewide Stroke Triage Plan. The regional stroke triage plans shall be reviewed triennially.

2. A uniform set of proposed criteria for prehospital and interhospital triage and transport of stroke patients developed by the Advisory Board, in consultation with the American Stroke Association, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of §8.01-581.20. A

decision by a health care provider to deviate from the criteria shall not constitute negligence per se.
D. Whenever any state-owned aircraft, vehicle, or other form of conveyance is utilized under the provisions of this section, an appropriate amount not to exceed the actual costs of operation may be charged by the agency having administrative control of such aircraft, vehicle, or other form of conveyance.

1996, c. 899; 1997, c. 321; 1998, c. 317; 1999, c. 1000; 2005, cc. 632, 686; 2006, c. 412; 2007, c. 15; 2008, cc. 66, 567; 2009, cc. 222, 269; 2012, c. 418; 2014, c. 320; 2015, cc. 502, 503.