Northern Virginia
Prehospital and Inter-facility
Regional Stroke Triage Plan

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Executive Summary

Under the *Code of Virginia* § *32.1-111.3*, The Office of Emergency Medical Services acting on behalf of the Virginia Department of Health has been charged with the responsibility of maintaining a Statewide Stroke Triage Plan. The Northern Virginia EMS Council is responsible for establishing a strategy through a formal regional stroke triage plan that incorporates the region's geographic variations and acute stroke care capabilities and resources, including hospitals that are Certified Stroke Centers. This includes Acute Stroke Ready, Primary and Comprehensive facilities that have gained certification by the Joint Commission or a comparable process consistent with the recommendations of the Brain Attack Coalition. The Regional Stroke Triage Plan is to include guidelines for prehospital patient care as well as inter-hospital patient transfers.

Purpose: The purpose of the Northern Virginia Regional Stroke Triage Plan (hereinafter known as the Regional Plan) is to establish a uniform set of criteria for the prehospital and inter-hospital triage and transport of acute stroke patients. The Regional Plan will augment the state stroke triage plan to recognize and address variations with the regional EMS and hospital resources. The Regional Plan addresses patients experiencing an "acute stroke," defined as "any patient suspected of having an acute cerebral ischemic event or stroke with the onset of any one symptom within an eight hour period.

Focus: The primary focus of the Regional Plan is to provide guidelines to facilitate the early recognition of patients suffering from acute stroke and to expedite their transport to a Certified Stroke Center able to provide definitive care within an appropriate time window.

If agency protocols do not provide direction, on-line medical control should be used to discuss cases outside the eight hour window due to the continuing evolution of scientific evidence indicating successful management of acute stroke greater than the historical four and one-half hour time window. Patients may be candidates for interventional treatments up to an 8 hour window and even beyond this time window in certain cases. It may be determined that expeditious transfer or transport directly to a Comprehensive Stroke Center may be beneficial for a specific patient.

Regardless of time of onset the sooner an acute stroke is treated, the better the potential outcome ("Time is Brain"). In some cases patients may benefit from intervention *up to 24 hours* following symptom onset. Incorporating patient's time of onset and constellation of symptoms, the mode of transport and destination may be altered based on collaboration with on-line medical control or jurisdictional OMD protocols.

Goal: The primary goal of the Regional Plan is: **To develop a Stroke Emergency Care System that, when implemented, will result in decreased stroke mortality and morbidity in the Northern Virginia Region.**

In order to accomplish this, a number of specific processes are essential. These are:

1. The ability to rapidly and accurately identify patients suffering from a stroke-like presentation.

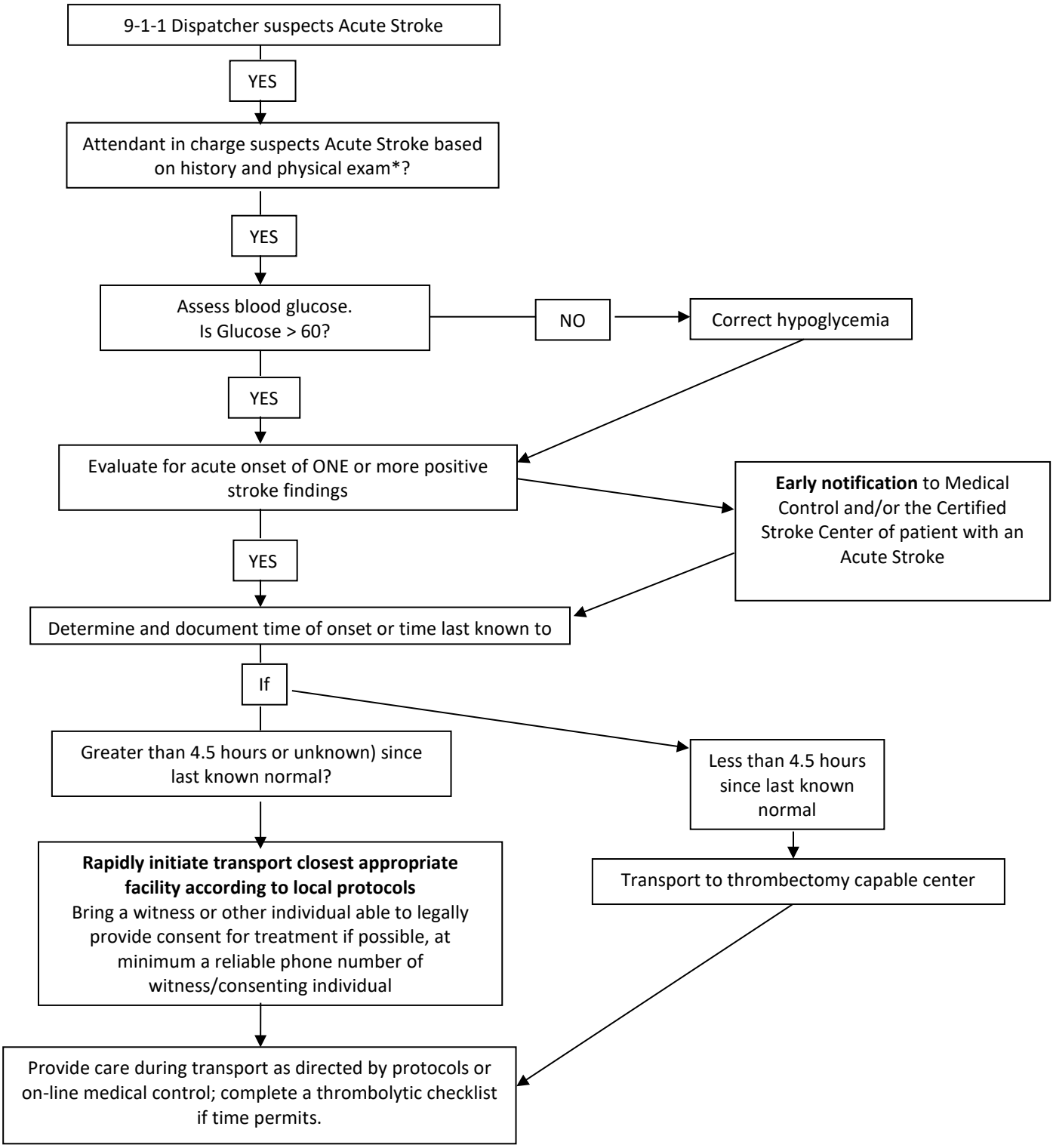
2. Patients who have sustained an acute stroke event should preferably be transported to a Certified Stroke Center, capable of providing immediate and comprehensive assessment, resuscitation, intervention, and definitive care.

3. The Northern Virginia EMS Council will provide continuous and effective region-wide coordination of prehospital and hospital care resources so stroke patients will be most expeditiously transported to definitive stroke care. To accomplish this process there must be a method of tracking the care capability for stroke patients in both the prehospital realm and in hospital realm while reviewing the quality of the process itself.

4. Provide quality EMS service and patient care to the citizens of each EMS System.

5. Continuously evaluate the EMS System based on established EMS performance measures for stroke. This is encouraged through both in-house performance evaluation and participation with the Northern Virginia EMS Council's Performance Improvement Committee. Hospital Stroke Centers' reports have been added to the agenda for this committee.

Field Stroke Triage Decision Scheme



(*) Modified from Virginia State Stroke Triage Protocols

Guidance Documents

Cincinnati Prehospital Stroke Scale (CPSS)

- All patients suspected of having an acute stroke should undergo a formal screening algorithm such as the CPSS, LAMS/LAPHSS, MEND or RAPID.
- Use of stroke algorithms has been shown to improve identification of acute strokes by EMS providers up to as much as 30 percent.
- The results of the CPSS should be noted on the prehospital medical record.
- ANY abnormal (positive) finding which is suspected or known to be acute in onset is considered an indicator of potential acute stroke.

Cincinnati Prehospital Stroke Scale (CPSS)

-if one parameter is abnormal, the stroke is considered positive

	Normal	Abnormal
Facial Droop	Both sides of face move equally	One side of face does not move at all
Arm Drift	Both arms move equally or not at all	One arm drifts compared to the other
Speech	Patient uses correct words with no slurring	Slurred or inappropriate words or mute

Los Angeles Prehospital Stroke Scale

	Yes	Unknown	No
Age ≥45			
No history of seizures			
Symptoms ≤24 hours			
Ambulatory at baseline			
Glucose 60-400			

If the answer to any of the above is no, the Los Angeles Motor Screening Scale does not apply

Los Angeles Motor Screening Scale

	0	1	2
Facial Droop	Absent	Present	
Arm Drift	Absent	Drifts down	Falls rapidly
Grip Strength	Normal	Weak	No grip

A score of 3 or greater is considered strong potential for a large vessel occlusion (LVO)

Miami Emergency Neurologic Deficit

Status Check	Instructions	Abnormal
Level of consciousness	AVPU	Anything less than awake and alert
Speech	Repeat phrase “you can’t teach an old dog new tricks”	Slurring, inability to pronounce words or inability to remember the words and repeat correctly
Question/response	Ask a question and see if patient can return in context, example “what’s your name?”	Inappropriate response
Respond to a command	Ask patient to open and close eyes	Unable to understand or attempt to follow commands
Facial droop	Ask patient to smile	Unilateral asymmetry
Visual fields	Sit in front of patient looking directly at face with your eyes on same level, ask patient to stare at your nose, hold your fingers half way between the patients face and yours at eyebrow level (about 18 inches away from both you and patient) ask patient to tell you when they see your fingers, wiggle fingers one hand at a time, repeat at chin level	Unable to see fingers move
Horizontal gaze	Ask patient to hold head still, hold up your pointer finger and have them follow your finger with their eyes only, both eyes should track evenly to outer limit of vision	Unable to track, presence of nystagmus does not make an abnormal score
Arm Drift	Hold out arms with palms facing down, ask patient to close eyes and keep hands up and still	Downward drift of one arm
Leg Drift	Ask patient to lift leg several inches off bed and hold for five seconds	Weakness in one leg
Sensory	Ask patient to close their eyes and report when they feel you touch their limbs, touch backs of forearms and shins	Inability to feel your touch
Coordination- Arms	Hold your finger vertically about 18 inches in front of patient, ask patient to take their finger and touch your finger then touch their nose several times, repeat on both sides	Unable to find tip of finger or nose
Coordination-Legs	Ask patient to take heal of foot and run down opposite shin, demonstration may be necessary	Unable to track along one leg but able to track along the other

Regional Stroke Protocol Guidelines

* All patients should receive a general patient assessment.

* Patients with signs and symptoms of **acute stroke syndrome** should be assessed to identify and define the following:

    - Last seen normal
    - Signs/symptoms
    - Glucose level checked
    - SAMPLE history to include:
        - Mention of acute stroke mimics (i.e. seizures, migraines, hypo/hyperglycemia and others as deemed appropriate)
        - Medications check with an emphasis on whether the patient is taking blood thinners and bring in actual medication bottles if able
    - Co-morbid conditions impacting short and long-term management
    - Identify and address causes of secondary insult – hypoxia, hypotension, hypoglycemia, trauma, coagulopathy, etc.

* Utilize a defined stroke screening tool

* Provide appropriate treatment for hypoglycemia, IV access, and cardiac monitoring if available, reassessment of neurologic exam and stroke scale

* Contact medical control and/or the receiving hospital as soon as possible to advise them that you are transporting a potential acute stroke patient.

* Transport stable acute stroke patients to Certified Stroke Centers if time of onset is within 8 hours of EMS assessment. If symptoms are acute, but over the 8 hour window, on-line medical control should be freely used to discuss the individual patient case to determine whether transport directly to a Certified Stroke Center would be of benefit in that specific patient.

* Adhere to jurisdiction specific protocols which should incorporate specific strategies appropriate to their area to assure that acute stroke patients evaluated more than 8 hours from symptom onset can still potentially access specialty resources for acute stroke intervention and management. Examples may include partnerships with acute stroke specialists at the Comprehensive Stroke Center who can provide input on specific patient cases in a timely manner to either the on-line medical control physician or EMS provider/unit directly.

* Transport unstable patients to the closest appropriate medical facility.

* Every effort should be made to minimize on scene times including initiate BLS transport and arrange rendezvous with ALS en route if needed

Acute Stroke Patient Transport Considerations

MODE OF TRANSPORTATION: The Northern Virginia region is unique in its availability of EMS and acute stroke care resources. Consideration should be given to hospitals available to the region and the resources they have available to treat acute stroke patients.

Stroke patients who meet the criteria indicative of an acute stroke, shall be preferentially transported to a Certified Stroke Center.
Transport of acute stroke patients, as defined in this plan, by helicopter EMS (HEMS) should:

1. Significantly lessen the time from scene to a Certified Stroke Center compared to ground transport

2. Be utilized to achieve the goal of having acute stroke patients expeditiously transported to a Certified Stroke Center, within 8 hours of symptom onset; unless consultation with on-line medical control has occurred.

NOTE: Any patient with a compromised airway or impending circulatory collapse must be transported to the closest hospital Emergency Department. Also, we recognize the significance of patients who may be experiencing a Transient Ischemic Attack (TIA) and encourage EMS agencies to develop appropriate transport policies for these patients.

RAPID TRANSPORTATION: Because stroke is a time-critical event, time is of the essence, and EMS providers should initiate ***rapid transport*** once acute stroke is suspected. Consideration should also be given to prehospital resources, including use of HEMS, available at the time of the incident, and other conditions such as transport time, road and weather conditions. Use of HEMS can facilitate acute stroke patients reaching Certified Stroke Centers in a timeframe that allows for acute treatment interventions.

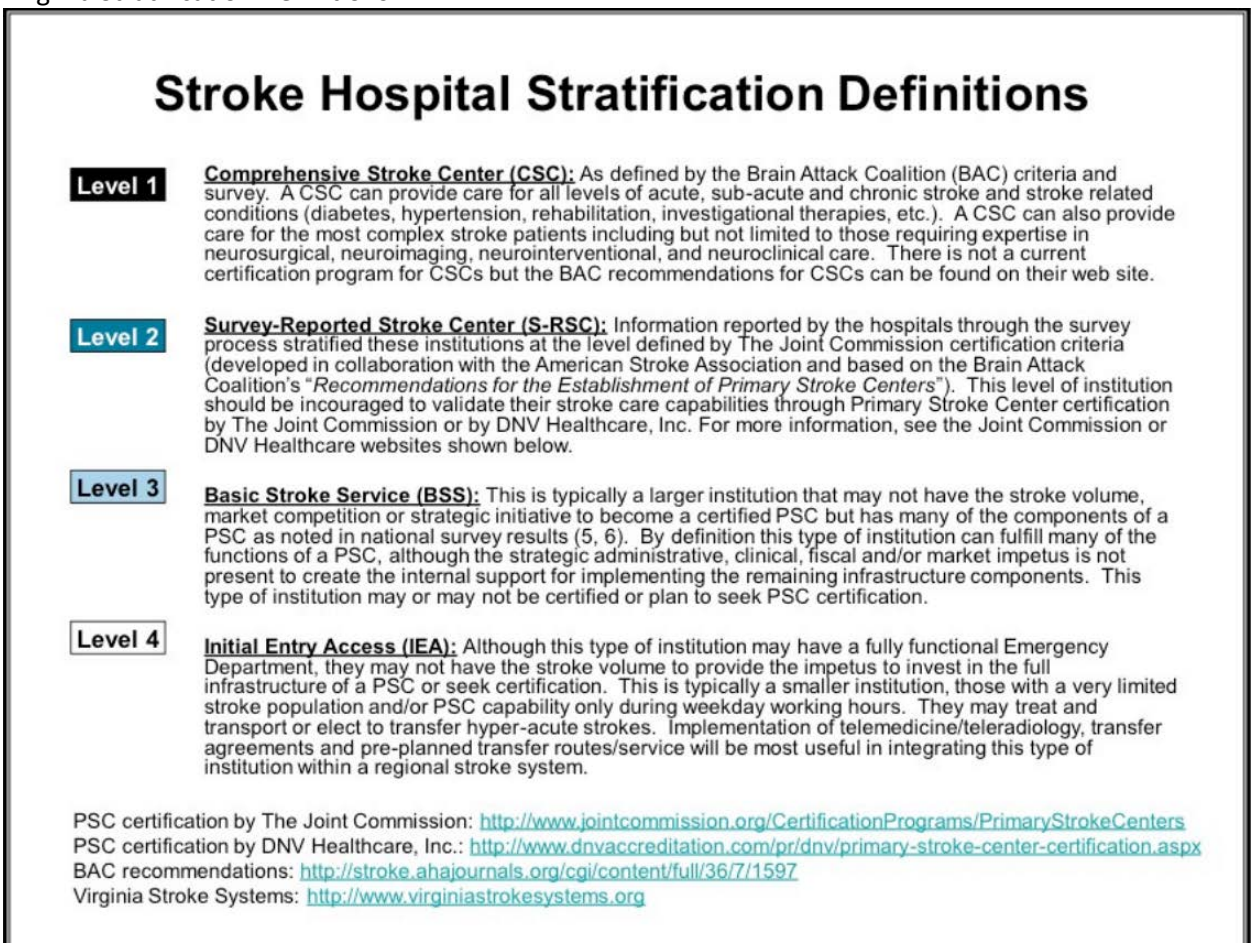
The likelihood of benefit of acute stroke therapy decreases with time, but there are several therapy options which offer definite benefit outside the standard 24 hour window; refer to local protocols.

NOTE: The use of the term “rapid transport” is a reminder to reduce time on scene to minimize out of hospital time and does not relieve the operator of the vehicle from exercising due regard.

Certified Stroke Centers

The Commonwealth of Virginia defines a "Certified Stroke Center" as a hospital that has achieved Primary Stroke Center Certification or greater by the Joint Commission or a comparable process consistent with the recommendations of the Brain Attack Coalition. The process of Stroke Certification is entirely voluntary on the part of the hospitals and identifies hospitals that have established and maintain an acute stroke program which provides a specific level of medical, technical, and procedural expertise for acute stroke patients as Certified by the Centers for Medicare and Medicaid (CMS) through Joint Commission or other CMS deemed status accrediting bodies. Designation ensures that the hospital is prepared to provide definitive acute stroke care at all times and has an organized approach to providing clinical care, performance improvement, education etc.

Virginia Stratification Definitions



Stroke Hospital Stratification Definitions

Level 1 — **Comprehensive Stroke Center (CSC):** As defined by the Brain Attack Coalition (BAC) criteria and survey. A CSC can provide care for all levels of acute, sub-acute and chronic stroke and stroke related conditions (diabetes, hypertension, rehabilitation, investigational therapies, etc.). A CSC can also provide care for the most complex stroke patients including but not limited to those requiring expertise in neurosurgical, neuroimaging, neurointerventional, and neuroclinical care. There is not a current certification program for CSCs but the BAC recommendations for CSCs can be found on their web site.

Level 2 — **Survey-Reported Stroke Center (S-RSC):** Information reported by the hospitals through the survey process stratified these institutions at the level defined by The Joint Commission certification criteria (developed in collaboration with the American Stroke Association and based on the Brain Attack Coalition's "*Recommendations for the Establishment of Primary Stroke Centers*"). This level of institution should be incouraged to validate their stroke care capabilities through Primary Stroke Center certification by The Joint Commission or by DNV Healthcare, Inc. For more information, see the Joint Commission or DNV Healthcare websites shown below.

Level 3 — **Basic Stroke Service (BSS):** This is typically a larger institution that may not have the stroke volume, market competition or strategic initiative to become a certified PSC but has many of the components of a PSC as noted in national survey results (5, 6). By definition this type of institution can fulfill many of the functions of a PSC, although the strategic administrative, clinical, fiscal and/or market impetus is not present to create the internal support for implementing the remaining infrastructure components. This type of institution may or may not be certified or plan to seek PSC certification.

Level 4 — **Initial Entry Access (IEA):** Although this type of institution may have a fully functional Emergency Department, they may not have the stroke volume to provide the impetus to invest in the full infrastructure of a PSC or seek certification. This is typically a smaller institution, those with a very limited stroke population and/or PSC capability only during weekday working hours. They may treat and transport or elect to transfer hyper-acute strokes. Implementation of telemedicine/teleradiology, transfer agreements and pre-planned transfer routes/service will be most useful in integrating this type of institution within a regional stroke system.

PSC certification by The Joint Commission: http://www.jointcommission.org/CertificationPrograms/PrimaryStrokeCenters
PSC certification by DNV Healthcare, Inc.: http://www.dnvaccreditation.com/pr/dnv/primary-stroke-center-certification.aspx
BAC recommendations: http://stroke.ahajournals.org/cgi/content/full/36/7/1597
Virginia Stroke Systems: http://www.virginiastrokesystems.org

Joint Commission Definitions of Acute Stroke Ready Hospital (ASRH)/Primary Stroke Center (PSC)/Comprehensive Stroke Center (CSC)

ASRH	PSC	CSC
• Collaborate with local emergency management systems (EMS) to encourage communication with the hospital prior to bringing a stroke patient to the emergency department • Have access to stroke expertise 24/7 (in person or via telemedicine) and transfer agreements with facilities that provide primary or comprehensive stroke services • Administer intravenous (IV) thrombolytics, if needed, prior to transferring the patient to a facility that provides primary or comprehensive stroke services • Demonstrate the application of and compliance with recommendations for acute stroke ready hospitals published by the AHA/ASA or equivalent evidence based guidelines • Core stroke team members receive at least four hours of annual stroke education • Educate 67 percent of emergency department practitioners on acute stroke protocols • Address processes for transferring patients • Define four performance measures; collect, analyze and use these data in the performance improvement process	• Designate a stroke unit for continuous patient monitoring • Demonstrate application of and compliance with clinical practice guidelines for primary stroke centers published by the AHA/ASA or equivalent evidence-based guidelines • Core stroke team members receive at least eight hours of annual stroke education • Educate 80 percent of emergency department practitioners on acute stroke protocols • Address processes for receiving transferred and/or for transferring patients • Provide at least two stroke public education activities per year • Collect, analyze and use standardized performance measure data to continually improve treatment plans; eight measures required	• Have significant resources in infrastructure, staff, and training to provide state-of-the-art care to all stroke patients • Have dedicated neuro-intensive care unit beds for complex stroke patients available 24/7 • Use advanced imaging capabilities • Meet minimum requirements for: providing care to patients with a diagnosis of subarachnoid hemorrhage; performing endovascular coiling or surgical clipping procedures for aneurysm; and administering IV-tPA • Coordinate post-hospital care for patients • Use a peer-review process to evaluate and monitor the care provided to patients with ischemic or hemorrhagic stroke • Participate in stroke research • Core stroke team members receive at least eight hours of annual stroke education, and other disciplines have education requirements • Educate 80 percent of emergency department practitioners on acute stroke protocols • Protocols address circumstances for not receiving transferred patients for neurosurgical and cerebrovascular surgery • Licensed independent practitioners and staff members prepare and present two or more education activities to internal staff and/or individuals external to the CSC • Collect, analyze and use standardized performance measure data from the eight stroke (STK) measures and eight comprehensive stroke (CSTK) measures to continually improve treatment plans

Note: A current list of The Joint Commission Acute Stroke Ready/Primary/Comprehensive Stroke Centers that meet the definition of Virginia Certified Stroke Centers is available at http://virginiastrokesystems.org/ or by entering the state of interest at http://www.qualitycheck.org/consumer/searchQCR.aspx

Presently the list includes the following area Hospitals:

Northern Virginia

Hospital Name	Location	Designation	24/7 Thrombectomy Capable?
Inova Alexandria Hospital	Alexandria	Primary	Yes
Inova Ashburn	Ashburn	Acute Stroke Ready	
Inova Fairfax Hospital	Falls Church	Primary	Yes
Inova Fair Oaks Hospital	Fairfax	Primary	
Inova Lorton HealthPlex	Lorton		
Inova Loudoun Hospital - Lansdowne	Leesburg	Primary	
Inova Loudoun Hospital - Cornwall	Leesburg	Acute Stroke Ready	
Inova Mt. Vernon Hospital	Alexandria	Primary	
Inova Springfield	Alexandria		
Mary Washington Hospital	Fredericksburg	Primary	
Novant Health Haymarket Medical Center	Haymarket	Acute Stroke Ready	
Novant Health Prince William Medical Center	Manassas	Acute Stroke Ready	
Reston Hospital Center	Reston	Primary	Yes
StoneSprings Hospital	Dulles	Primary	
Sentara Northern Virginia Medical Center	Woodbridge	Primary	
Virginia Hospital Center	Arlington	Primary	Yes
George Washington University Hospital	Washington, DC	Comprehensive	Yes
Georgetown Hospital	Washington, DC	Primary	
Washington Hospital Center	Washington, DC	Comprehensive	

Inter-facility Triage Criteria

It is recommended that hospitals, including non-certified stroke centers have transfer guidelines and agreements in place for the expeditious and appropriate management of acute strokes when the care required exceeds their capabilities. This is especially critical for transfer of patients following thrombolysis.

The enclosed tPA transfer sheet is an example of a tool that could be used to monitor tPA en route. This is jurisdictionally dependent and we encourage discussions between jurisdictions and their receiving hospitals to reach an agreement as to how situations where a private company is unavailable to transfer an urgent stroke patient receiving tPA.

Stroke Triage Quality Monitoring

It is strongly suggested that each jurisdiction form a relationship with their primary receiving facility involving the exchange of information with the intent of quality improvement and identification of potential delays in the timely care of patients with acute strokes.

The Northern Virginia EMS Council's Performance Improvement Committee will report aggregate acute stroke triage findings biannually. A de-identified version of the report will be available and will include, minimally, as defined in the statewide plan, the frequency of:

Agency Specific Performance Measures	Hospital Specific Performance Measures
Number of field activations of Code Strokes	Number of times tPA given
Percentage of instances where 100% of treatment bundle is performed (glucose and stroke scale)	Average time between documented arrival and registration time
Percentage of time first medical contact (FMC) to stroke scale is less than 5 minutes	Average door to needle time
Percentage of time FMC to notification of receiving facility is less than 10 minutes	Number of transfers to Comprehensive Stroke Centers
Percentage of time last known normal is documented	Average door to groin times (for interventional candidates)
Percentage of time glucose is checked and documented	Number of acute interventional stroke cases
Average FMC to transport initiated	
Average FMC to arrival at destination	

The program reports shall be used as a guide and resource.

Stroke Related Resources

Virginia Stroke System Web page: http://www.vdh.virginia.gov/stroke/virginia-stroke-systems-task-force/

Virginia Office of EMS Stroke Web page: http://www.vdh.virginia.gov/OEMS/Trauma/Stroke.htm

Joint Commission: http://www.jointcommission.org/CertificationPrograms/PrimaryStrokeCenters/

VDH Heart Disease and Stroke Prevention Project

Target Stroke – Resources and Best Practices

American Stroke Association (AHA/ASA)

National Institute of Neurological Disorders & Stroke (NINDS)

NIH/NINDS Know Stroke Website

Northern Virginia Region

EMS system coordination is central to the development and implementation of an efficient and effective regional emergency medical services delivery system. EMS regions are designated by the Virginia Board of Health. The Code of Virginia, §32.1-111.11, charges regional EMS councils with the development and implementation of an efficient and effective regional emergency medical services delivery system. The Northern Virginia Emergency Medical Services Council (the Council) provides coordination and oversight to a very large and complex EMS system. Since 1980, the Council has coordinated working relationships with local fire/EMS agencies, hospitals, physicians, nurses, healthcare facilities, police, medevac agencies, training institutions, emergency planners, health departments, military installations, federal agencies, and fixed wing agencies.

The Northern Virginia region includes the counties of Arlington, Fairfax, Loudoun, and Prince William; the cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park; and the Metro Washington Airports Authority (Reagan National and Washington Dulles International Airports).

The Northern Virginia region has a population of over 2.6 million, two major airports, two large municipal airports, the Pentagon and other Federal and state agencies, numerous corporate headquarters, and endless highways and commuter routes. One out of three Virginians live in the Northern Virginia region.

In this region there are:

- Over 50 EMS agencies (government, volunteer, federal, non-profit, commercial, and industrial)
- 237,000 EMS calls per year
- More than 4,700 EMS providers
- 500 licensed EMS vehicles
- 5 medevac helicopter agencies serving our region
- One fixed wing agency
- 12 hospitals and one psychiatric institution
- 3 freestanding ED's

Hospital Catchment Area:

- HCA Reston Hospital
- INOVA Alexandria Hospital
- INOVA Emergency Care Centers
    - Fairfax
    - Reston/Herndon
    - Springfield Healthplex
    - Lorton Healthplex
- INOVA Fair Oaks Hospital
- INOVA Fairfax Hospital
    - INOVA Fairfax Hospital for Children
    - INOVA Heart & Vascular Institute
    - INOVA Women's Hospital
- INOVA Loudoun Hospital

    - Lansdowne Campus
    - Cornwall Campus (freestanding ED)
    - Ashburn Campus (freestanding ED)
- INOVA Mount Vernon Hospital
- Novant Health Haymarket Medical Center
- Sentara Northern Virginia Medical Center
- HCA Stone Springs Hospital Center
- Novant Health Prince William Hospital
- Novant Health Haymarket Campus
- Virginia Hospital Center Arlington
- Some patients are transported to Washington, DC hospitals

Helicopter Agencies:

- Fairfax County Police Helicopter Division
- MedSTAR Transport
- PHI Air Medical – Virginia
- STAT MedEvac
- U.S. Park Police

For a more comprehensive listing of the region's resources, see the ***Northern Virginia EMS Resource Directory*** on the front page of the Council's website: http://www.northern.vaems.org/

Code of Virginia References

Code of Virginia

§ 32.1-111.3. Statewide Emergency Medical Care System

C. The Board of Health shall also develop and maintain as a component of the Emergency Medical Services Plan a statewide prehospital and inter-hospital 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 formal regional stroke triage plans that incorporate each region's geographic variations and stroke care capabilities and resources, including hospitals Certified as "primary stroke centers" through certification by the Joint Commission or a comparable process consistent with the recommendations of the Brain Attack Coalition. The regional stroke triage plans shall be reviewed triennially.

2. A uniform set of proposed criteria for prehospital and inter-hospital triage and transport of stroke patients developed by the Emergency Medical Services 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 of Health 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.

§ **32.1-116.1:1**. Disclosure of medical records.

Any licensed physician, licensed health care provider, or licensed health care facility may disclose to an emergency medical services provider, emergency medical services physician, or their licensed parent agency the medical records of a sick or injured person to whom such emergency medical services provider or emergency medical services physician is providing or has rendered emergency medical care for the purpose of promoting the medical education of the specific person who provided such care or for quality improvement initiatives of their agency or of the EMS system as a whole. Any emergency medical services provider or emergency medical services physician to whom such confidential records are disclosed shall not further disclose such information to any persons not entitled to receive that information in accordance with the provisions of this section.

§ 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 preformed as required by this article unless such act or omission was the result of gross negligence or willful misconduct.

§ 8.01-581.19 Civil Immunity for physicians, psychologists, podiatrists, optometrists, veterinarians, nursing home administrators and Certified emergency services personnel while members of certain committees.

A. Any physician, chiropractor, psychologist, podiatrist, veterinarian, or optometrist licensed to practice in the Commonwealth shall be immune from civil liability for any communication, finding, opinion, or conclusion made in performance of his duties while serving as a member of any committee, board, group, commission, or other entity that is responsible for resolving questions concerning the admission of any physician, psychologist, podiatrist, veterinarian, or optometrist to, or the taking of disciplinary action against any member of, any medical society, academy, or association affiliated with the American Medical Association, the Virginia Academy of Clinical Psychologists, the American Psychological Association, the Virginia Applied Psychology Academy, the Virginia Academy of School Psychologists, the American Podiatric Medical Association, the American Veterinary Medical Association, the International Chiropractic Association, the American Chiropractic Association, the Virginia Chiropractic Association, or the American Optometric Association, provided that such communication, finding, opinion, or conclusion is not made in bad faith or with malicious intent.

B. Any nursing home administrator licensed under the laws of the Commonwealth shall be immune from civil liability for any communication, finding, opinion, decision, or conclusion made in performance of his duties while serving as a member of any committee, board, group, commission, or other entity that is responsible for resolving questions concerning the admission of any health care facility to, or the taking of disciplinary action against any member of, the Virginia Health Care Association, provided that such communication, finding, opinion, decision, or conclusion is not made in bad faith or with malicious intent.

C. Any emergency medical services provider who holds a valid certificate issued by the Commissioner of Health shall be immune from civil liability for any communication, finding, opinion, decision, or conclusion made in performance of his duties while serving as a member of any regional council, committee, board, group, commission, or other entity that is responsible for resolving questions concerning the quality of care, including triage, inter-facility transfer, and other components of emergency medical services care, unless such communication, finding, opinion, decision, or conclusion is made in bad faith or with malicious intent.