Regional Performance Improvement and Trauma Committee
Northern Virginia EMS Council
March 1, 2017
Minutes

Those present were:
Craig Beavers, Prince William County Fire and Rescue, cbeavers@pwcgov.org
Stephanie Boese, Inova Loudoun, stephanie.boese@inova.org
Jon Brantley, City of Fairfax Fire Department, Jonithan.brantley@fairfaxva.gov
Kristen Eimer, Inova Fairfax Hospital, Kristen.Eimer@inova.org
Jordan Estroff, Inova Loudoun Hospital, Jordan.estroff@inova.org
Maggie Griffen, Inova Fairfax Hospital, Committee Co-Chair, margaret.griffen@inova.org
Kate Kramer, Arlington County Fire Department, kkramer@arlingtonva.us
Lisa McAllister, PHI Air Medical, lmcallister@phihelico.com
John Morgan, Loudoun County Fire and Rescue, john.morgan@loudoun.gov
Keith Morrison, Reston Hospital Center, keith.morrison@hcahealthcare.com
Michelle Ludeman, Northern Virginia EMS Council, michelle@vaems.org
Kristen Ray, Inova Fairfax Hospital, kristen.ray@inova.org
Erik Rhodes, Physician's Transport Services, erhodes@ptsems.com
Chris Wanka, Metropolitan Washington Airports Authority, Christopher.wanka@mwaa.com
Scott Weir, Fairfax County Fire and Rescue OMD, Committee Co-Chair, weirsd@comcast.net
Ray Whatley, Alexandria Fire Department, ray.whatley@alexandriava.gov
Jamie Wolfin, StoneSprings Hospital, jaime.wolfin@hcahealthcare.com

The PI & Trauma Committee meeting was called to order at 9:00 am by Dr. Scott Weir at the City of Fairfax Fire Department Station 403.

The December 7, 2016 meeting minutes were distributed prior to today's meeting. A motion was made and unanimously approved to accept the minutes from the December 7, 2016 meeting. Introductions were made around the room.

The guest speaker from Union Memorial was unable to attend to speak about amputations and re-implantation with hand injuries. This will be addressed at the June 7 meeting and will be postponed until next session.

Dr. Weir thanked Kristen Eimer with Inova Hospital's Cardiac Services for being available to come speak to the group on short notice. Kirsten is the Interim Director Inova Heart and Vascular Center, Cardiac Outcomes Specialist and she also works volunteering for the Northern Virginia Heart Attack Coalition as the Northern Region Steering Committee leader for that group. They meet quarterly to discuss STEMI care as a region and report back to the state. February was heart month. Her presentation included 2016 Q3 data from the state. Heart disease is the number one killer in the United States and also a killer among women.

Kristen shared that there is a need for more community education. It starts as soon as EMS arrive. People need to be aware to call 911 instead of driving to the hospital. There is a hospital in Tennessee that transfers their patients to Virginia so they are also listed in the numbers for Virginia. A typical patient is a middle-aged white male. The median age for patients is sixty. Of those who are seeking treatment for STEMI, 73% are male and 27% are female.

Dr. Weir asked if the data includes post cardiac arrest patients. Kristen says the data do include those patients and there are two registries that track the data. Her data registry is Mission Life Line for STEMI and non-STEMI. Mission Life Line doesn't include data from when STEMI patients arrest in the pre-hospital settings.

EMS on the Hill Day is on April 25 and EMS is encouraged to continue to participate. Despite the Commonwealth being so close to the District, Virginia still remains one of the states with the least participation.

When STEMI patients arrive at the hospitals via EMS, the average time was 29 minutes from door to balloon. If a patient comes by car the average is 48 minutes. There is registration, ECG and other steps for self-transports that delay treatment. The more direct route is by EMS and they can do pre-activation. There is also ED bypass which Virginia Hospital Center is doing now. Dr. Peter O'Brien has a presentation that Kristen will try to get to share on ED bypass protocols.

The Viginia State Median Goal of First Medical Contact (FMC) to device time of 75 minutes.

Inova Fairfax Hospital does not have the availability to accept ECGs. Instead they accept patients based on three criteria: clinical systems of ACS, ECG reads active STEMI, medic reads ST elevation. Currently they have a pilot program with the City of Fairfax where they use Tiger Text to transmit the ECG image to the hospital communications desk. She still doesn't have any meaningful data.

She would love to discuss how we can build on each other's practices. We are all working to strive for better practices to help our patient's outcome. Most of the guidelines that everyone is using requires placement of an ECG on the patient within 5 minutes of touching the patient. Then vital signs are taken. She said the ECG can be thought of as the first vital sign being taken of a stable patient. Scene time should also be under 10 minutes. Once the provider reads the ECG and suspects a STEMI, they call the hospital to report a Code STEMI. There are also agency protocols that have a specific regimen to follow. With regards to multiple readings of the EKG: the Paramedics read it, the machine reads it as an Acute MI suspected or Acute MI and then, if available, the ECG transmission is read by the receiving physician or medical control. Pre-arrival activation may be accomplished on the way to the hospital. The sooner the hospital can be alerted to a STEMI patient the sooner the CATH Lab can be notified and everything can be set into motion.

City of Fairfax: Jon reported that they borrowed this from Fairfax County. They use the 5,5,10,2 rule. Put on ECG in 5 minutes if they have anything cardiac. Then within 5 minutes of that determine if it's a STEMI or not. They transmit ECG via Tiger text. A confirmed STEMI patient they take two providers in the back place pads on the patient and transport. They notify ED through the hospital Communications desk that they have a confirmed STEMI patient or Code STEMI. Their scene time from diagnosis is not supposed to be more than 10 minutes. They encourage the provider to notify immediately that they know it's a STEMI patient whether it's beside the patient or in the back of the medic unit.

For the Mission Life Line report Q3, metrics now are reporting a percentage how many times EMS are notifying the Cath lab in the field. There are time stamped STEMI notifications to the hospital with Image Trend Elite version 3. It is now a NEMSIS data requirement. Some you can change your program to capture the times. For the Lifepak with 12 leads, in the summary, you can hit a button to stamp the time then later you can use that to figure out when you called the hospital. Kate said the hospitals do not receive the stamped EMS incident report. This can be changed if you go in to Image Trend and have it as a required field for the hospital report. There are other things that can be added such as collection times, and fields such as "at patient." But providers have to remember to go in and click them for the report. She also said that scene times were also added in Mission Life Line Report Q3. They only look at data that were from confirmed STEMI patients and not patients that you thought were STEMI and then turned out not to be a STEMI patient. Also they are looking at MI patients with chest pains that got ECGs.

There was discussion on the possible need to get with stakeholders to figure out their time that they have for our EMS units' arrival at ramp or when the report was given to the hospital. Our arrival to hospital could be 5 minutes where they could have transport time eight minutes. There are nine PCI hospitals in our region. We only have one hospital not on the action registry. The report is a state-wide report it's hard to get a

regional report.

Dr. Weir sent an article to share with the committee. It is from our EMS LLSA 2016 reading list. This is on ED by-pass to Cath Lab. http://circ.ahajournals.org/content/128/4/352.full

Both Arlington Fire and Fairfax Fire and Rescue have a policy that when a medic unit is not on scene but an ALS Engine is, the Engine can call hospital and give report for STEMI Alert activation.

Arlington Fire is using bypass. ECG is first vital. Engines can also do ECG if medic units are not on scene. Next they call the hospital with STEMI alert. No further info is given. The hospital is updated enroute.

Some providers are having issues when calling Inova Fairfax Communications desk with a STEMI Alert. Instead of just taking STEMI Alert the Comms. nurses want to ask a lot of questions about the patient. Jamie says it's frustrating she's trying to work with them. Kristen said she will handle this. This is a culture change for EMS calling STEMI Alerts.

Dr. Weir said that they have been tracking on-scene and at-patient times. Both numbers can be very different. These numbers can come into play when you are looking at what floor of a high-rise your patient is at. Also affected may be unit positioning, staffing and other things. Their fire chief is closely monitoring these numbers.

StoneSprings: Jaime reported that they just have changed their protocol. If EMS brings the patient in then they pre-alert AirCare and notify Reston Hospital. They have the Doctor look at the ECG confirm STEMI and notify Reston STEMI Alert. They can't receive transmitted ECGs.

Kristen shared some dates of interest:

- The last week of April, AHA is hosting a quality conference in Raleigh, NC that will focus on CHF, ACS, A-Fib and CVA. Reach out to John Dugan if you did not receive a discount code to attend. EMS will get a better discount.
- The state VHAC/ Mission: Lifeline Annual Meeting will be in Lynchburg on May 19.

Kirsten then shared Dr. O'Brien's presentation on ED bypass. ED bypass is normally done during working hours and they have seen no adverse effects.

Fairfax City: Train for BLS 12-lead placement. BLS can activate code STEMI if the ECG reads STEMI but since they are ALS heavy they come in with BLS and are always close behind them. They promote team concept and objectives.

MWAA: BLS providers train, also ALS heavy, medic on scene quickly may cut down on tasks, helps to get 12-lead on faster for 5 min. BLS do 12-leads on chest pains. They have not found any actual STEMIs. It does help cut down on scene times. When you only have one ALS resource it helps having the BLS provider help with 12-leads and makes the team work better as a whole.

Arlington: BLS also taught how to put on 12-lead and they are also ALS heavy. There is never an opportunity for BLS to be without an ALS provider.

PTS: BLS is taught how to place 12-lead on patients but they don't have the monitors on their BLS units. That is on their ALS or critical care units.

Alexandria: Eventually they would like to have ALS engines but they don't have the equipment to do so. They are missing the Lifepak 15's. BLS are getting the training but just don't have the equipment to do the skills on the units.

Fairfax County: Train BLS providers to place 12-lead but not to interpret and they are not transmitting yet. They continue to work towards transmission but haven't made progress. Not allowed to use Bluetooth because of the IT rules and with the port-of-entry rules for the county server.

MWAA: They have gotten around their IT issues using bluetooth on their Tough Books. They did a work-around with NVERS patient tracking where they clarified to their IT folks that the hardware and software is not theirs to administer.

Prince William: In January 2017, BLS were taught to place ECG and began transmission. There were 12 12-leads placed since January 2017 but no transmissions have occurred. They also now have BLS drug boxes that include aspirin and nitro that BLS providers can now give for cardiac patients. Question was asked if other BLS providers can interpret a STEMI and if it can be billed at an ALS rate or BLS rate for transmission of ECG? There is no expectation for BLS providers to interpret; they can read off the monitor. It was also clarified that transport units must have an ALS provider on the unit to bill at an ALS rate per CMS.

Trauma: Dr. Griffen reported on April 18, Loudoun Inova Hospital is having their site visit to be a Level 3 Trauma Center.

Dr. Griffin reported that OEMS is still working on their Trauma Systems Plan still working and have been for the last 15 months. The state meetings are public meetings that are open to the public. They meet quarterly and there are 6 groups that meet monthly. They must physically meet in person, they can't meet by video and must also have a quorum. These groups have put in a lot of hard work. Hopefully in the next month we will find out if the Trauma Systems Plan is getting approval from across the state. Then once the powers at be approve the plan there will be a formal implementation date for the plan. There will be a period for final approval and then a time in which implementation will take place. All the different groups are on the OEMS website if you would like to attend the meetings and dates. Critical Care another big topic at the state level.

When agency data is input into Image Trend and then the State Trauma Registry where does this information go? It just seems like it goes into a void.
This concludes the discussion on STEMI care.

The group shared information for their respective agencies on re-implantation destinations for patients with amputations.

PTS: From 2016 until now only transported eight to Union Memorial.

PHI Aircare: They always check first but they have been using Washington Hospital Center. They must get all types of permissions to go to Union. They must have a prior evaluation before Union would consider seeing a patient. Reston Hospital will start taking hand injuries soon.

Alexandria: In 2015 they only had one case that was flown to Union.

Hand On-Call Team: on a limited basis, some agencies have used images from the field to assist with decision making.

City of Fairfax is using Tiger Text with the Fairfax ED. It is an app that is HIPPA compliant. There is no video though. Everyone in the region has NVERS i-Pad.

Dr. Weir continued with the yearly task of determining topics for future meetings in this calendar year. For Quarter 4, fiscal year 2017 (the next meeting), for the Trauma portion of the meeting, we will look at amputations, mangled amputations and re-implantations. Topics to be covered include: triaging, Union

Memorial Hospital (hopefully Dr. Sarani can arrange the guest speaker), scene flights and whether they can go to Union or not, and who else can handle re-implantations and amputations in the region. Dr. Sarini has a contact there and will try to arrange as a speaker. Dr. Griffen will also try to find out a name through some of her specialty physicians and they will work together to find the right person to attend our June meeting. Historically, Union Memorial does not accept scene flights, but they recently celebrated a call that originated at a scene and was transported from that scene to Union. Keith Morrison is going to get in contact with Dr. Freedman to see if he can attend.

For the Medical portion of the meetings, topics that the group want to consider include the following:

- Opioid Abuse, prescription abuse, use of Narcan. DOH training. Some agencies are embracing the use of Narcan and we need to look at administration of Narcan prior to arrival of EMS. Also look at positive responses to Narcan administration. This could be a medical and system topic. Current mandates re: state agencies, police, agencies, and some are embracing it, mostly the rural agencies.
- Opioid Abuse – ED representatives to attend. Magistrate. How to keep patients there, medical TBO. Has the increased incidence of this epidemic changed practice pattern in the EDs? Define "at risk" populations. 3rd party prescriptions for Narcan. Loudoun sheriffs carrying Narcan. OEMS is interested in Narcan administration with a positive response.
- Mass casualty – DC DOH. NV Regional Disaster Plan. Dr. Sarani.
- Sleep deprivation. Worker fatigue in decision making. EMS and hospital staffers. Long duty assignments and prolonged Ops calls. This is a Trauma, Medical and System issue. NAEMSP, issue has been oversimplified in the past. Dual jobs on off-days. Intervention team, CIT training. How long are employees allowed to work? Hospital, fire, EMS? Policies, DOT. How is it really happening vs. studies? What is out there in the way of literature? Cognitive functions. NIH just did a study. Dr. Weir knows a sleep physician at NIH. He will check to see if he can attend at a later date. A 24-hour shift is different in a busy station vs. a station that sees one call during the 24-hours. There are also providers who leave their fire department jobs and go to their second and third jobs. How does that affect their cognitive functioning for patient care? How long are employees allowed to work? Fire vs. EMS. This is an across the board issue to investigate. Covers medical, trauma and system. Opportunity to look at studies and look at how actions are based on current literature/data that may be flawed. NIH just did a big study/presentation on this. Reality vs. studies.

This will be a good full day of info to add sleep deprivation to the opioid abuse. Maybe do this for June. We will make a decision about the topic and get that out as soon as possible.

The next meeting will be Wednesday June 7, 2017. The meeting will be held at the **Fairfax County Fire Department Fire Station 440. That station is located at 4621 Legato Road, Fairfax, VA 22030.** We will begin at 9 am and the group will complete the discussions by noon.

Please bring pertinent data from your agency and if you are

unable to attend, please have your back-up representative attend.

Without further, the meeting was adjourned at 11:10 am.

CERTIFICATION OF BOARD OF PERFORMANCE IMPROVEMENT AND TRAUMA MEETINGS

NV EMS Council
7250 Heritage Village Plaza, Ste. 102
Gainesville, VA 20155

I, Marcia Pescitani, Interim Executive Director of the Northern Virginia EMS Council certify that the above minutes are a true and correct transcript of the minutes of a meeting of the Performance Improvement and Trauma Meetings of the Northern Virginia EMS Council on ~~(date of meeting)~~ 3/1/2017. The minutes were officially approved at the ~~(date of approval)~~ 6/7/2017 meeting of the Committees.

Marcia Pescitani　　　　6.8.2017

Marcia Pescitani
NV EMS Council

Date