Northern Virginia EMS Council
Performance Improvement and Trauma Committee
Fairfax County Fire Station 40
4621 Legato Road, Fairfax, VA 22030
December 6, 2017 Meeting Minutes

Those present were:

Beth Adams, Fairfax County Fire & Rescue Dept, beth.adams@fairfaxcounty.gov
John Barbachano, Prince William County FRD, jbarbachano@pwcgov.org
Stephanie Boese, Inova Loudoun Hospital, Stephanie.boese@inova.org
Jonithan Brantley, City of Fairfax Fire Dept, jbrantley@Fairfaxva.gov
Mindy Carter, Reston Hospital Center, Melinda.carter@hcahealthcare.com
David Coullahan, Physicians Transport Service, dcoullahan@ptsems.com
Valentina Daly, Fairfax County Fire & Rescue Dept, valentina.daly@fairfaxcounty.gov
Craig Evans, Northern Virginia EMS Council, Craig@vaems.org
Tiffany Fischer, Novant Prince William Medical Center, tdfischer@novanthealth.com
Elizabeth Franco, Inova Fairfax Hospital, Elizabeth.franco@inova.org
Kate Kramer, Arlington County Fire Dept, kkramer@arlingtonva.us
Tracy Lane, Loudoun County Fire & Rescue, tracy.lane@loudoun.gov
Michelle Ludeman, Northern Virginia EMS Council, Michelle@vaems.org
Anne Marsh, Arlington County Fire Department, AMarsh1@arlingtonva.us
Keith Morrison, HCA Reston Hospital Center, Keith.Morrison@hcahealthcare.com
Melinda Myers, Inova Fairfax Hospital, Melinda.myers@inova.org
Brian Orndoff, City of Fairfax Fire Dept, brian.orndoff@fairfaxva.gov
Erik Rhodes, Physicians Transport Service, ERhodes@ptsems.com
E. Reed Smith, MD, Arlington County Fire Dept/VHC,
Jennifer Svites, Fairfax County Fire & Rescue Dept, Jennifer.svites@fairfaxcounty.gov
Laura Vandegrift, Northern Virginia EMS Council, laura@vaems.org
Chris Wanka, Metropolitan Washington Airports Authority, Christopher.Wanka@mwaa.com
Scott Weir, MD, Fairfax County Fire & Rescue Dept, scott.weir@fairfaxcountygov.org
Jaime Wolfin, StoneSprings Hospital, Jaime.wolfin@hcahealthcare.com

The PI and Trauma Committee meeting was called to order at 9:03 a.m. by Dr. Scott Weir and introductions were made around the room.

Meeting minutes from September 6, 2017, meeting were distributed and unanimously approved with no changes.

Trauma Discussion
Guest Speaker Presentation

Dr. E. Reed Smith, Emergency Physician from Virginia Hospital Center and Arlington County Fire Department OMD, presented an active shooter and unified command incident presentation. He advised that in response to the recent active shooter attacks such as the Pulse Nightclub and Las Vegas, the NFPA3000 Standard for Preparedness and Response to Active Shooter and/or Hostile Events will be followed by both police and fire once it is completed and published despite NFPA being a set of fire standards. The presentation detailed the use of Rescue Task Force and a multi-faceted approach with law enforcement and fire & rescue each having components. The main priority is to stop the killing with

police deploying into the scene to immobilize and stop the shooter(s), the second is to stop the dying by working with police to deploy into areas cleared but not secured to treat and rescue patients.

The pattern of an active shooter:

- Typically a single male without warning inside the building/gathering area
- Well-populated building in daylight hours
- May have significant pre-plans and tactical skills
- Often prepared for first responders
- More than one firearm, possibly IED(s)
- Initially targets specific people, then random
- Injures 0-5, kills 0-5
- Over in less than 10 minutes
- Likely dies by force or suicide

Following the presentation, Dr. Weir asked that the participants go around the room and describe how their organizations/agencies handles these types of situations. They are as follows:

- Physicians Transport Service
    - Contracted with RHCC
    - As non-911, they participate like the general public
    - Often back-fill/standby at hospitals for transfer needs
- Novant/UVA Prince William and Haymarket Medical Centers
    - Drill with Prince William County, Cities of Manassas and Manassas Park quarterly
    - October 2016 drill was an MCI with an active shooter at the same time
    - Only the first floor has gear for this type of incident, not every floor
- Inova Fairfax Hospital
    - Currently revamping their disaster plan
    - Drill regularly
        - Have not practiced MCI with active shooter at the same time but will recommend to disaster team
- Prince William County Fire & Rescue
    - In the “toddler” phase currently with policies, training, and equipment
        - Policies currently with senior management for approval
        - Training basics are complete
            - Command level training with police and fire in the works
        - Tactical equipment is available for personnel
    - Currently writing an active shooter/high-threat response drill for March 2018
- Reston Hospital
    - Recently completed a “Las Vegas copycat” drill
    - Have not done MCI with an active shooter
    - Will be doing a drill with police and a walk-through scenario at a local school
    - There will be a tabletop active shooter drill in Richmond with their Disaster Manager in January 2018
- StoneSprings Hospital
    - They are doing a 6-month rollout currently

        - Most recently completed active shooter training
        - They are performing a tabletop of an active shooter in the hospital without an MCI first
        - MCI Surge to start with slow drills
    - TECC kits are at 4 main entrances of the hospital
    - Loudoun County is doing a month-long active shooter drill and StoneSprings is participating (MDs, RNs, techs, etc.)
- Loudoun County Fire & Rescue
    - Did their first active shooter drill approximately 2 years ago
    - March 2018 they will be performing unified command drills
- City of Fairfax Fire Department
    - Currently using the Rescue Task Force concept
        - They have 2 vests per suppression unit and 4 per battalion
    - Training is done yearly using the TECC refresher and they re-familiarize themselves with the supplies
    - They use a flexible posture that is dynamic to their system needs.
        - 2-4 person Rescue Task Force or police team
    - Their current challenge is getting a drill scheduled with the police department
- MWAA
    - They have largely adopted the Arlington County Fire Department model with Rescue Task Force
        - Medics all have TECC kits
    - Their current issues are with law enforcement and night shift staffing of patrol officers to train together
    - They have FBI/DHS agents assigned to the airports but they aren't involved with training.
    - Other challenges are that anything at the airport requires an airport badge or master key so they have to have airport personnel with non-airport personnel for access so bringing an RTF from one agency
    - Police has been doing Surge days and will bring in Loudoun County Police and Virginia State Police
    - They recently got a grant for a Complex Coordinated Attack Coordinator on-site for a 2-3 year position to do full-scale drills
- Arlington County Fire Department
    - The presentation by Dr. Smith summed up their plan. They are still planning and working to move forward with it
    - Similar training issues with outside agencies and access
- Fairfax County Fire & Rescue
    - Rescue Task Force model
    - Unknown date of last drill
    - Warm corridor and escorted warm zone model depending on resources
- Inova Loudoun and Cornwall
    - Recently completed an active shooter drill with full decon procedure
        - Had hospitalists discharge patients to have room for those in need, as in a real-life situation

        - Moved "patients" to the OR and floor beds to simulate what happens when they are moved from the ED
    - Many changes currently due to construction at main campus
    - Drills being performed monthly for each component of their active shooter drill to fine-tune those parts instead of as a whole
    - Using EPIC for armbands
    - Loudoun Hospital is now a trauma center

Jon Brantley asked about an article he saw about the recent Las Vegas shootings and what happens with similar events in our area, such as during election time and other large-scale outdoor events. There is discussion about personnel and self-dispatch/self-presenting to the local hospitals. Dr. Smith stated in a major event, we should be sending an EMS Task Force unit to the scene and another to the closest hospital for those who self-transport. In Las Vegas, for example, there were 500 patients but only 150 went by ambulance; the remainder went by personal vehicle, cab, Uber, etc. The thought that RHCC will be able to handle the situation in a real-life situation is not likely. During a drill, it's a good plan, but citizens are not going to call RHCC to find out where to go to be seen. This way, if a patient arrives by personal vehicle to Virginia Hospital Center, for example, and has a minor injury that requires treatment but is not urgent, they can be sent by ambulance to a further out facility for appropriate treatment. One problem is the EMTALA law and they are currently working to get approval to scrap EMTALA in a MCI/Active-shooter situation so the closest hospitals are triaging and treating the most serious patients and the outlying hospitals can take the overflow with less critical patients. Jaime from StoneSprings Hospital stated that the hospital in the Las Vegas event is also an HCA hospital so they received some insight into that event. They determined that most of the ER staff doesn't have certain skill-sets to perform interventions such as IO, so off-duty paramedics were self-presenting to the hospital to assist with those skills. Per Dr. Smith, this is definitely not how we want it handled and hopefully by having the EMS task forces outside the hospitals, they can handle those tasks. During a recently call regarding the EMTALA issues, it was suggested that EMS Task Force units sit off the hospital property and triage because this takes the EMTALA violation out of the equation by the patient not being seen on property.

Medical – Pain Management, Narcan and Opioid Protocols

Craig Evans provided some regional data numbers regarding medication administration.

- Last quarter drug administrations:
    - Narcan was administered approximately 300 times not including the numbers for Prince William because they did not come up
        - John Barbachano from Prince William Fire and Rescue will get those numbers and provide them to Craig
        - Even without the Prince William numbers, this is about 3-3.5 times per day
        - Some administrations may be repeat doses during one call
        - Last month alone, it was given 116 times
    - Morphine Sulfate was administered 100 times
    - Fentanyl was administered 1982 times
        - Some agencies find repeat dosages of Fentanyl during transport as well
    - Ketamine was administered 259 times
    - Toradol was administered 42 times

Dr. Weir asked that the group go around the room again and discuss their policies, procedures, issues, etc., with the group.

- Physicians Transport Service
  - They maintain their own pharmacy so they do not restock from the hospitals
  - Currently, there are no shortages
  - Currently using Fentanyl, morphine, and ketamine.
  - Narcan was used on only 4 incidents last year
- Novant/UVA Prince William and Haymarket Medical Centers
  - They have become a "Dilaudid-free ER" so they have a higher usage of Fentanyl now
  - They have seen an increase in overdoses coming into the ED, hospital parking lot, etc.
  - ER providers have requested the use of Ketamine for pain management but it has been opposed by Corporate except in pediatrics
  - IV Toradol and Acetaminophen are used
  - There is signage in each ER room with their pain policy stating no refills for chronic pain medications
  - Prince William Health Department has a local Task Force for reducing the opioid crisis and requires all patients given a prescription for narcotics be given a prescription for Narcan as well
- Inova Fairfax
  - Trauma surgeons are pushing for the use of IV Tylenol but they are receiving significant pushback from the pharmacy
- Prince William County Fire and Rescue
  - Increased use of Fentanyl for pain management
  - Have moved away from the use of morphine
  - Increased use of Narcan as well
    - Seeing more in the west end, more affluent neighborhoods
    - Police department now carries for use on citizens also, previously only carried for officers
      - Administration training happening now should have 700 officers trained by January or February 2018
    - Police will carry two doses per officer
      - If they administer, the patient still has to go to the hospital and patient refusal is not an option in case they have a drug on-board that outlasts the Narcan
- Reston Hospital and StoneSprings Hospital
  - Both seeing the same shortages as every other facility
- Loudoun County Fire and Rescue
  - Carries Fentanyl, morphine, Ketamine
  - Ketamine is used for RSI
  - Narcan usage over the last 10 months was 190 incidents
    - Narcan is now out on BLS units and on suppression units
- City of Fairfax Fire Department
  - Carries Ketamine, Toradol, morphine, Fentanyl which is used approximately 75% of the time

        - Protocols changed to increase the use of Ketamine and use drip versus push
        - Narcan used in approximately 20 patients, some diagnostically
        - City of Fairfax Police does not carry Narcan but GMU Police will be carrying soon
- Arlington County Fire Department
    - Multi-modal pain management
        - Low dose Ketamine (10mg) with 50mcg Fentanyl
    - Toradol is being used with decreased doses
    - Oral Celebrex being looked into because there is no inhibition to platelets with its use and it's ideal for surgical patients
    - Police want Narcan training but doesn't want to stock the drug
    - Working on a peer-to-peer program for people taken to the ED with an overdose/usage problem, they can be met with someone in recovery to discuss and guide them.
    - Working on a community Narcan program with PD, FD, and schools in line with the REVIVE program but the program doesn't provide Narcan
- Fairfax County Fire & Rescue
    - Using Fentanyl, Ketamine, and morphine
    - Biggest issue is the pain management protocol with ages over 65 and 50% initial dosages
    - Minimal change in Narcan use noted
    - Increased usage of Narcan prior to arrival (self/bystander administration)

Topics for December Meeting

Dr. Smith suggested the blood products on scene and how much each hospital is carrying. Does anyone do whole blood resuscitation? Are their policies in place for this? Secondly, he suggested the topic of patient tracking and that it should not be the primary responsibility of EMS in an MCI and should be the hospitals. Jaime Wolfin mentioned that she recently had a meeting with Virginia 211 and they require three specific data points for reporting and these are not data points that are routinely collected, so it is reasonably 24-48 hours before VA211 has valuable patient tracking information anyway. She also advised they there are often staffing deficits at the switchboard at the hospitals and during this type of incident, the switchboards are even more inundated with calls for information they cannot reasonably provide. The group agreed on the topic of blood products on scene and will ask the participants from the Loudoun incident (hospital, Fire/EMS, and medevac) to present the case to the group on how it worked, the challenges they faced on the incident and how to improve on it in the future.

The system topic will be a discussion on the use of video/audio body cameras by providers.

The next Regional PI/Trauma Committee meeting will be on March 7, 2018, at 9:00 a.m. and the location will be announced once confirmed. A reminder will be sent out before the meeting.

The meeting was adjourned at 11:50 am.

CERTIFICATION OF BOARD OF PERFORMANCE IMPROVEMENT AND TRAUMA MEETING

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

I, Craig Evans, Executive Director of the Northern Virginia EMS Council certify that the above minutes are a true and correct transcript of the minutes of the Performance Improvement and Trauma Meetings of the Northern Virginia EMS Council on December 6, 2017. The minutes were officially approved on March 7, 2018, meeting of the Committee.

__________________________________ __________________________

Craig Evans Date
NV EMS Council