



Northern Virginia EMS Council  
**Regional Time-Sensitive Coalition (ReTSCo) Meeting**  
Meeting held virtually via Zoom  
September 8, 2021 Meeting Minutes

Those present were (All attendees were present via Zoom):

Beth Adams, Fairfax County Fire & Rescue, [beth.adamsroemmelt@fairfaxcounty.gov](mailto:beth.adamsroemmelt@fairfaxcounty.gov)  
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Northern Virginia EMS Council  
**Regional Time-Sensitive Coalition (ReTSCo) Meeting**  
September 8, 2021 Meeting Minutes

The Regional Time-Sensitive Coalition (ReTSCo) meeting was called to order at 9:05 a.m. by Dr. John Morgan.

**Meeting Information for new attendees:** This is a combined multi-discipline meeting to compare, collaborate and share lessons learned across time-sensitive medical care in the region.

**Topic:** Transfer processes for trauma, large-vessel occlusion stroke, and STEMI cases.

- Presentation and review of case studies in each specialty with the rapid transfer of critical and emergent patients

**Approval of Minutes:**

Meeting minutes from June 9, 2021, meeting were distributed via email before this meeting and unanimously approved with no changes.

**Presentations:**

- Cases were chosen to show the flow of how cases arrived at the original hospital, the decision to transfer to a higher level of care, care and transfer times, similarities across multiple disciplines, advances, changes to be made, and how we can move care forward in each discipline

**Case 1** – STEMI Transfer, Nancy Morrissey Inova Alexandria Hospital  
See slides starting on next page

# EMS (PTS) Activation to arrival at sending facility





# Transportation to PCI Center

- PTS ETA to Patient = 15' (If ETA > 20' call 911)

PTS from Blast to at patient = 10"

PTS scene time = 5'      PTS transport time = 9'

**PTS from Blast to arrival at hospital = 24'**

- Handoff paperwork and EKG to PTS
- SPHP MD conferenced with IAH ED MD by Cardiac Access for handoff
- SPHP MD calls IAH Attending MD and enters bed request in EPIC
- SPHP RN calls IAH ED RN for handoff
- **ED Dwell = 34'**
- After departs SPHP ED, Cardiac Access schedules the case in EPIC using the "STEMI button"

# EMS (PTS) Arrives at PCI Center





# Arrival at PCI Center

- Quick pit stop in IAH ED; triaged patient
- Cath lab Team calls Cardiac Access when arrives and “**ready” for patient = 30’**”
- Cardiac Access calls ED and asks to have patient sent to the lab
- ED MD and ED RN escorts patient to Cath Lab
- ED MD handoff to IOC/ED RN handoff to Cath Lab staff
- **Procedure = 23’**

Patient arrival to Access = 6”      Access to Balloon inflation = 17”

**Transfer Door to Balloon = 83”** (NCDR Registry benchmark is  $\leq 120$ ”)

PTCA and drug-eluting stent placement of the proximal LAD

# STEMI Standard Work





# Standard STEMI Workflows

## IAH developed 4 STEMI workflows

- Transfers (SPHP); D/C readmits (IMVH, Lorton); EMS arrivals and POV
- Includes patient flows, EPIC functional flows, and communication/staff flows and documentation
- EPIC consulted to verify steps and impact on downstream events on the cath lab
- Involved all stakeholders
- Standardized use of STEMI button and EPIC flow across Inova
- Detailed document from patient presentation to arrival on inpatient unit
- Each STEMI is monitored for each workflow step and feedback given to staff
- All four STEMI work flows are updated annually
- Set benchmarks for buckets of time to identify where delay occurred

# Buckets of Time (Benchmarks)

<i>Time Line</i>		<i>Benchmark</i>	<i>Roll Up</i>
EMS at Patient to IAH Arrival		<30"	
At Patient to EKG (5") =	Alert to Door (20") =		
ED Dwell time for IAH		<30"	
Door to EKG (5") =	Dr. to Blast (5") = <i>Field</i>	Door to Blast (10") = <i>Field</i>	
Blast to Team Arrival (30") =	Blast To Physician Arrival (30") =		
Team Arrival to CL Door Arrival (5") =			
Procedure		<30	
CL Door Arrival to Access (10") =	Access to Balloon Inflation (20") =		

<i>Time Line</i>		<i>Benchmark</i>	<i>Roll Up</i>
ED Door in and Door Out (Transfers)		>30"	
Door to EKG (5") =	Dr. to Blast (5") =	Door to Blast (10") =	
Blast to PTS Arrival to IAH for Transfers (40") =	PTS Actual Travel Time =		
Blast to PTS at Patient =	PTS scene time =		
Blast to Team Arrival (30") =	Blast To Physician Arrival (30") =		
Team Arrival to CL Door Arrival (5") =			
Procedure		<30	
CL Door Arrival to Access (10") =	Access to Balloon Inflation (20") =		

# Lessons learned and opportunities





# Lessons learned and opportunities

- Develop detailed STEMI Standard Workflows
- Do not assume the Standard work is disseminated and well known
- Changes take a long time to hard wire
- Drill down each STEMI case and determine reason for variances
- EPIC issue vs People issue
- EPIC flow is critical to limit downstream impact on the Cath Lab
- Discuss STEMI cases at monthly AMI meetings (physicians) and discuss fallouts
- Educate and update Standard work ongoing
- Feedback, Feedback, Feedback



# Transport Times

0716 EMS Transport

0725 - Arrival at Alexandria Hospital

Cath Lab notified enroute

TIME	BLOOD PRESSURE	PULSE	RESP	GLASGOW COMA SCALE				EKG	SPO2
				E	V	M	TOTAL		
07:16	141 / 88 (106)	91	18	4	5	6	15	NORMAL SINUS RHYTHM	98%
07:24	142 / 88 (106)	87	18	4	5	6	15		98%

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Case 1 Discussion:

- Is the Cardiac Access line run by PTS/GMR?
  - Yes, it is a call center run by PTS and is available to Inova and HCA hospitals in the region
- Why do some patients show discharge and re-admit and others are transfer?
  - This is driven by CMS Licensure numbers and type of facility
    - Mount Vernon Hospital and Lorton HealthPlex have to be discharged and re-admitted to the new facility, other's do not, even though they are still within the Inova system
  - Dr. Dan Avstreich also advised this is a "button flow" in the Epic HER
    - There is a "STEMI Button" in Epic but could this do more for the flows in other units? Is this a build or shortcut by Epic? Is this hospital system-specific?
      - Nancy Morrissey advised this was a very long build by Epic
      - Jean Snyder advised they are working on a "PTS Button" for non-emergent transfers
    - Craig Evans asked to clarify what the "button" does
      - When you hit the "button" created in Epic, it creates a workflow and two accounts (for STEMI it creates one for the ED and one for the cath lab) so both areas can be in the account simultaneously
        - Later registration will merge the two accounts into one, just as they do with a discharge and re-admit

**Case 2 – Stroke Transfer, Jean Snyder, Inova Fair Oaks Hospital**  
See slides starting on next page

# Stroke Transfer

## July 2, 2021

Inova Fair Oaks Hospital to Inova Fairfax  
Hospital via Physicians Transport Service



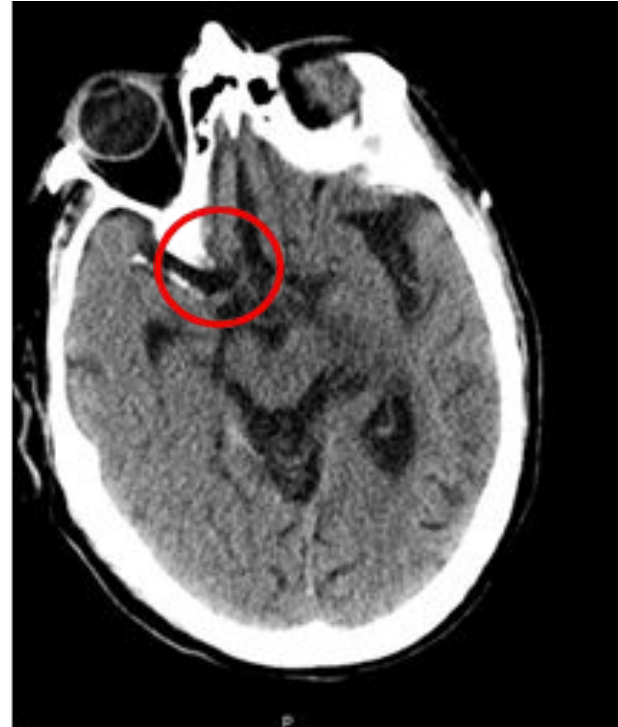
# Decision for PTS Transfer Activation





## 76 year old male arrived at IFOH ED via EMS at 10:08

On 7/2/21 M417 pre-alerted and transported a 76 y.o. male for possible stroke. Symptoms included intermittent slurred speech, facial droop and not consistently following commands. On arrival to IFOH, the NIHSS was 17 with the following findings: left facial droop, slurred speech and left sided weakness arm greater than leg. LKW was 22:00 which is out of the Alteplase time window. PMH includes hypertension, diabetes, stroke and alcoholism. CT with findings suspicious for abnormal hyperdensity within the right M1-M2 segments of the MCA. CT Angiogram and CT Perfusion study was obtained while activating intra-facility transport.

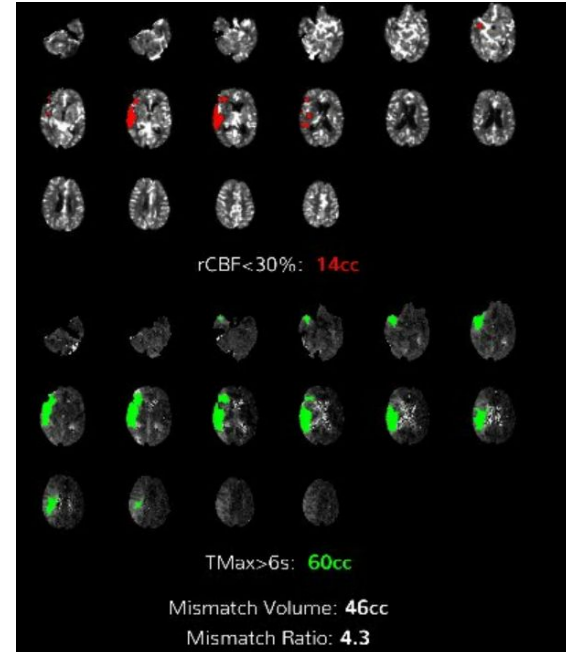


**Door to CT: 5 minutes (10:08-10:13)**

**Door to CTA/Perfusion Start: 52 minutes (10:08-11:00)**

**The patient was en route to IFH at the time when CTA/P urgent results were called to ED Provider**

Results of the CTA imaging showed an occlusion of the right MCA including its M1 and M2 segments. Also a perfusion abnormality which showed a small infarct with large penumbra within the right MCA distribution.



Mismatch:  
Core infarct  
with large  
penumbra

# Door to Transfer Times





# Inova Fair Oaks Hospital

Patient Arrival to ED: 1008

Door to CT: 1013 (5 minutes)

Door to CT: 1028 (20 minutes)

Preload PTS: 1035 (27 minutes)

PTS Arrival in ED: 1050 (Patient awaiting completion of CTA/P)

Door to CTA/P: 1100 (52 minutes)

Door to Transfer: 1112 (64 minutes) **Fastest DIDO for LVO!**

# PTS Activation to arrival at sending facility





# PTS Response Times

Call Received: 1037

Dispatched: 1037

En Route: 1038

At Scene: 1045

At Patient Side: 1104

Transport: 1107

Arrival: 1124

Care Transferred: 1128

# PTS Arrival at sending facility to Departure





## PTS Findings

Upon PTS's arrival, patient was receiving a CTA. Report was received from nurse stating patient was found at home by his wife after having an episode of incontinence at some point in the evening. Patient's last known normal was the night before, just before going to sleep. After his wife found him, he was not making complete sentences and had left-sided weakness with facial droop and slurred speech. Upon return to ED from CTA, patient was immediately placed on PTS's stretcher and secured and placed on cardiac monitor. Patient found to be hypertensive with left-sided weakness and facial droop. Patient intermittently followed commands but was able to protect his own airway. Patient packaged for transfer to Inova Fairfax ED.

**PTS Departure from  
sending to PTS  
Arrival at receiving**





# Vital Signs

EKG: Normal Sinus Rhythm

SPO2: 99%

**Time - BP - Pulse - Resp - GCS**

1106 - 172/81 - 93 - 16 - GCS 9

1110 - 158/78 - 83 - 16 - GCS 9

1115 - 157/79 - 83 - 16 - GCS 9

1120 - 152/81 - 82 - 16 - GCS 9

# Transfer from PTS to receiving hospital





# Transfer to Fairfax ED, EVT and Discharge

Patient transported to Inova Fairfax ED as a Code Stroke where he was transferred to a stroke bed in the ED. Report given to the Stroke nurse and care transferred.

Patient arrived in IR at 11:50. Groin puncture at 12:00. Time to revascularization was 12:36 with TICl Score 2B (CSTK-08)

MRI next day confirmed right MCA infarct. Patient was discharged to Acute Rehabilitation facility and discharge NIHSS was 9.

Specifications Manual for Joint Commission National Quality Measures (v2021A)

Posted: 7/29/2020

[Home](#) » [Comprehensive Stroke \(CSTK\)](#) » CSTK-08

[Print this page](#)

**Release Notes:**  
Measure Information Form  
Version 2021A

## Measure Information Form

**Measure Set:** Comprehensive Stroke (CSTK)

**Set Measure ID:** CSTK-08

**Performance Measure Name:** Thrombolysis in Cerebral Infarction (TICI Post-Treatment Reperfusion Grade)

**Description:** Ischemic stroke patients with a post-treatment reperfusion grade of TICI 2B or higher in the vascular territory beyond the target arterial occlusion at the end of mechanical endovascular reperfusion therapy

**Rationale:** The Thrombolysis in Cerebral Infarction (TICI) Reperfusion Grade is used to measure cerebral reperfusion. Four results are possible with this scoring system: 0 (no perfusion); 1 (perfusion past the initial occlusion, but no distal branch filling); 2 (perfusion with incomplete or slow distal branch filling); and , 3 (full perfusion with filling of all distal branches). Reperfusion past the target arterial occlusion and into the distal arterial bed and terminal branches, in conjunction with recanalization of the target arterial occlusion, demonstrates flow restoration or revascularization.

<https://manual.jointcommission.org/releases/TJC2021A/MIF0295.html>

# **Inova Fair Oaks Hospital Stroke Pilot Program**





# Why and Stakeholder Areas

System approach to provide stroke expert 24/7

## Stakeholders:

ED

Neurology (stroke, Critical Care, NIR and possibly Neurosurgery)

eICU Transfer Center (Capacity)

Medical Access Line which includes PTS

Telecommunications

EMAR/IT – capture of documentation (narrator/navigator) and reporting

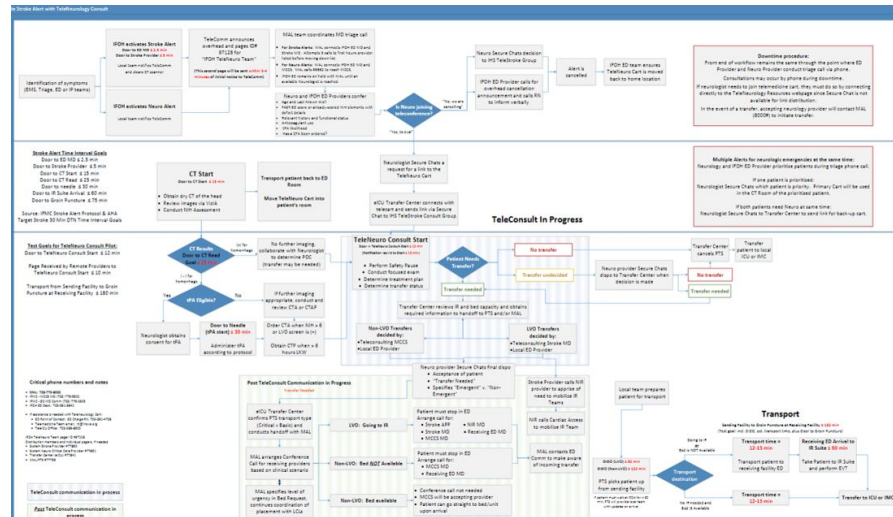
Telemedicine technology infrastructure



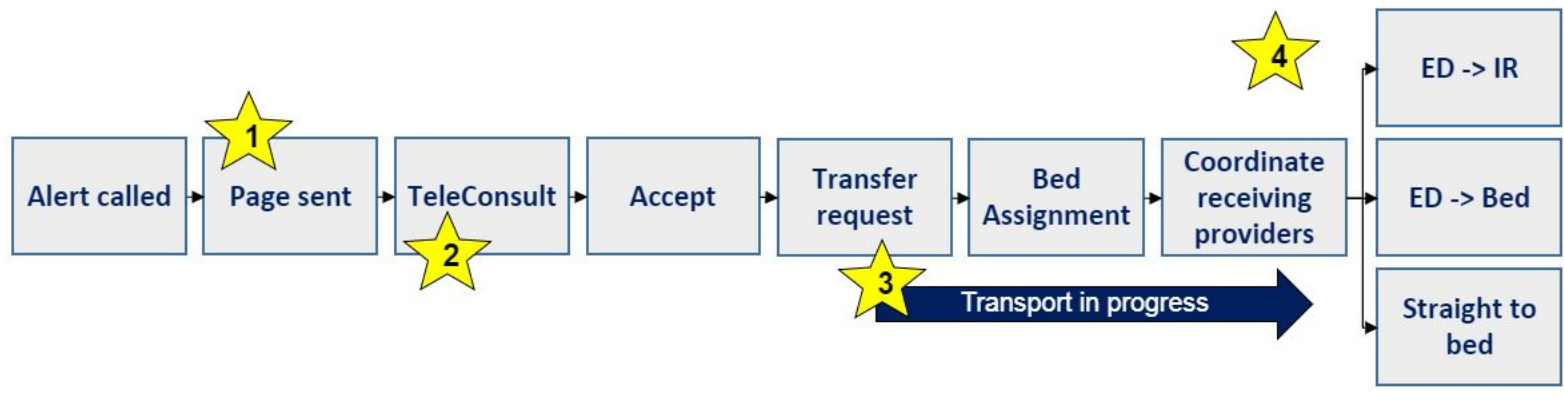
# Go-live

Go-live was March 16

Many rapid-cycle improvements (18) since March 16



# Current Process



Pit stop in ED at designated area (Provider, Nurse, Tech, Charge and Pharmacy)

FAST ED – if >2 add CTA

Telecomm page included Medical Access Line – calling to connect ED Provider with Stroke MD

Pre-alert from EMS – quicker to pit stop and quicker to CT – still the most efficient use of time



# Optimization and Future Plans

Streamline paging process (currently 2 pages)

Reduce steps to telemedicine camera connect

Documentation opportunities – to capture data elements

Deploy to 2<sup>nd</sup> Inova site with future 3<sup>rd</sup> and 4<sup>th</sup> sites

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Case 2 Discussion:

- Could EMS have chosen a better destination with identification of LVO in the field than transport to IFOH?

**Case 3** – Trauma Transfer, Elizabeth Franco, Inova Fairfax Hospital  
See slides starting on next page

DRAFT

# Trauma Transfer

Haymarket Medical Center to Inova Fairfax

*This presentation is a privileged document for PI  
under VA Code Ann.8.01-581.17*

# Decision to EMS Activation





# 6/2/2021

63M presented to Haymarket Medical Center via **POV** at approx. **22:10**

- HPI: Scooter (up to 18MPH) crash; unhelmeted; walked home and his son brought him to ED
- PMH: Diabetes
- Haymarket ED MD Physical Exam:
  - Significant facial trauma including avulsion injury to tip of nose, laceration through the lower lip, instability of lower mandible, forehead laceration
  - Vitals: BP 144/97, HR 96, RR 19, spO2 97%; GCS 15, alert and following commands, able to ambulate without assistance
  - Imaging:
    - Head CT: SAH without MLS
    - Facial Bones CT: L frontal bone fx, L posterior orbital wall fx, comminuted fracture of nasal bone, maxillary sinus fxs, bilateral pterygoid fxs, mandibular fx
- Significant Event: Tonic-clonic seizure at approx. **23:11**; arrested (asystole)
  - Difficult intubation; significant blood in airway complicated by facial fractures; 3 attempts required
  - Obtained ROSC after CPR/ACLS (2 doses of Epinephrine and 2 doses of Sodium Bicarb)
  - IFMC accepted patient for trauma transfer at approx. **23:18**

# EMS Activation to Arrival at Sending Facility





## Haymarket Medical Center Request for EMS

ROSC obtained; patient intubated and IFMC had accepted transfer

- 23:18: Haymarket Medical Center attempted to request helicopter transport; not flying due to weather
- 23:19: Physicians Transport Service received request for STAT ground transport

Primary Unit Dispatched: 23:19      Assist Unit Dispatched: 23:21

Primary Unit Enroute: 23:20      Assist Unit Enroute: 23:26

Primary Unit On Scene: 23:35      Assist Unit On Scene: 23:52

# EMS Arrival at Sending Facility to EMS Departure





# PTS On Scene at Haymarket Medical Center

- 23:35: PTS unit arrived at Haymarket Medical Center
- 23:43: PTS at patient bedside
  - Vitals: BP 131/83, HR 129, RR 20 (on vent); SpO2 97%; GCS 3T
- Activities during transfer of care:
  - Obtained paperwork and report
  - Transfer patient from ED bed to stretcher
  - Nicardipine drip prepped on PTS pump for potential hypertension (medication NOT administered en route)
  - Switch from ED to PTS monitor and ventilator - Vent Settings: Mode: AC RR: 20 Tidal Vol:550 PEEP:8 FIO2%: 100
- 00:14: PTS departed from Haymarket Medical Center
  - Transported Priority 1 – Lights and Siren

# EMS Departure From Sending to EMS Arrival at Receiving





# PTS Transport

- 00:14: PTS departed from Haymarket Medical Center
  - Transported Priority 1 – Lights and Siren
- Care provided during transport:

TIME	BLOOD PRESSURE	PULSE	RESP	GLASGOW COMA SCALE				EKG	SPO2	ETCO2
				E	V	M	TOTAL			
00:07	157 / 100 (119)	138	20	1	1	1	3		97%	
00:13	153 / 98 (116)	135	20	1	1	1	3		96%	45
00:17								SINUS TACHYCARDIA		
00:20	145 / 96 (112)	133	21	1	1	1	3		96%	44
00:25	155 / 103 (120)	134	21	1	1	1	3		96%	42
00:31	151 / 107 (122)	125	21	1	1	1	3		96%	41
00:39	170 / 128 (142)	65	20	1	1	1	3		95%	38
00:41	135 / 107 (116)	77	21	1	1	1	3		93%	36

- Pt began moving and appeared uncomfortable
  - 00:33 Versed 5 mg
  - 00:34 Fentanyl 75 mcg



## PTS Transport

- 00:43: Arrival at IFMC
  - 27.2 mile transport
  - Transferred to ED Bed in Trauma Room 1
  - Transfer without incident
- Time from presentation at OSH to arrival at IFMC = **2h 39m**

# Transfer From EMS to Receiving





## Care at Inova Fairfax Trauma Center

- Full Activation on arrival
  - BP 142/85, HR 95, SpO2 95%; GCS 4T; Temp 96 (none documented at OSH/EMS)
  - Vent settings: Rate 20, PEEP 8, Tidal Volume 500mL
  - Admitted to TICU
- NSGY consulted; ICP monitor inserted; opening pressure 2
  - TBI Protocol used to manage brain injury. ICPs were controlled and bolt was removed the following day.
  - EEG for seizure monitoring; no seizures identified; results suggestive of mild to moderate encephalopathy
- Chest tube inserted for post central line placement pneumothorax
  - Unplanned removal on 6/4; CXR showed lung re-inflated; did not require replacement tube



## Care at Inova Fairfax Trauma Center

- Additional consults: Ophthalmology, OMFS, and Plastics
  - Required multiple Plastics OR visits for reconstruction and repair of multiple facial injuries/fractures
  - Received Trach and PEG on 6/8 and OMFS performed ORIF mandible and repair of Le Fort fractures
- Hospitalization complicated by development of fever while on the vent; BAL resulted in GNR and he was treated with IV abx
- Mental status improved and he was weaned from the vent
- Diet advanced per SLP recommendations
- Decannulated on 6/16
- Discharged home with supervision on 6/23; GCS 15; on mechanical soft diet with thin liquids
- LOS at IFMC = **20 days**

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Case 3 Discussion:

- Inova Fairfax has a transfer agreement with Haymarket Medical Center in place already
- Good decision to transfer by ground as helicopter transport was grounded due to weather
- Good opportunity for feedback and discussion on how to shorten transfer times from the ED to the trauma center
  - PTS arrival at hospital to transport time was 40 minutes
- Beth Adams advised this is a good opportunity for public education for the number of patients arriving by POV
  - Many are of the belief “If you can walk to the house, you can ride in the car to the hospital” and do not call EMS.
  - We need to change the view of EMS as an extension or start of your hospital visit
- Dr. Morgan advised this was a good case to recognize the need for early transfer
- Kim Klein from Inova Loudoun Hospital advised if they see an obvious transfer patient, they call PTS immediately to get the process started
- Julie Montasser from Inova Loudoun Hospital advised that EMS transfers for stroke are low for them, but we need to consider “out of the box” ways to encouraged people to call EMS first
  - Fliers in backpacks of kids in schools
  - Other public education opportunities

**Discussion:**

What have we learned and how do we improve on these processes?

- Continuous feedback to sending facilities and EMS providers from receiving facility
  - Several hospitals have one person who looks at all transfer cases then follows up with a group of doctors to discuss and review the cases and provide opportunities for feedback
- Time Matters!
  - How can we find the opportunity to shorten times to definitive care?
    - Registration?
    - Hand-off processes?
    - Equipment or medication needs?
- Inova Fairfax Trauma has a good relationship with all in-transferring hospitals and Jamie in the Quality Department sends feedback to their EMS partners and sending facilities
- HCA Reston receives feedback from other hospitals and this goes to peer review with a group of doctors for opportunities for improvement/review

**Future Meetings and Topics**

The original topic for this December 8, 2021 meeting was in-field blood transfusion. Do we want to continue with that or defer to a later date? Northern VA has only been doing in-field blood for a year now.

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Discussion:

- Too soon, should defer
- Group agrees it's too soon, defer to 2022 at some point

Topic suggestion and discussion:

- Hospital diversion, volume overload
  - Beth Adams
    - Transfer of care is a high-risk situation
    - Diversion/re-route
    - Wall time
    - Transfer of care
  - Neha Sullivan
    - Alternate destination transports
    - Criteria for EMS routing to alternate destinations
    - Capabilities of those sites
    - Transfer agreements and if they avoid EMS use
    - Transfer method from free-standing ED to hospital (EMS or private transport)
    - How does a hospital diversion stress and over-run other EDs and facilities in the area

As a reminder, the meetings for the committee will take place on the second Wednesday of the first month of each quarter but this may change next year. The ReTSCo meeting dates are as follows for the remainder of 2021:

- Wednesday, December 8, 2021

The meeting was adjourned at 10:29 am

CERTIFICATION OF REGIONAL TIME-SENSITIVE COALITION 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 Regional Time-Sensitive Coalition Meeting of the Northern Virginia EMS Council on September 8, 2021. The minutes were officially approved on December 8, 2021, at the meeting of the Committee.

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Craig Evans  
Northern Virginia EMS Council

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Date

Meeting ID	Topic	Start Time	End Time
83441629743	NOVA ReTSCo	9/8/2021 8:49	9/8/2021 10:37

Duration (Minutes)	Participants
108	37

Name	User Email	Join Time	Leave Time	Duration (Minutes)	Recording Consent
Alex Stephenson	astephenson@pwcgov.org	9/8/2021 9:00	9/8/2021 10:30	91	Y
Anne Marsh	amarsh1@arlingtonva.us	9/8/2021 9:01	9/8/2021 10:37	97	Y
Babak Sarani	bsarani@mfa.gwu.edu	9/8/2021 9:50	9/8/2021 10:29	40	Y
beth adams Fx Co	beth.adams@fairfaxcounty.gov	9/8/2021 8:55	9/8/2021 10:29	95	Y
Brian Orndoff	brian.orndoff@fairfaxva.gov	9/8/2021 8:55	9/8/2021 10:23	88	Y
Carl Morrison	cmorrison@pwcgov.org	9/8/2021 9:02	9/8/2021 10:30	88	Y
Craig Evans	craig@vaems.org	9/8/2021 8:49	9/8/2021 10:37	108	
Craig French	craig.french@inova.org	9/8/2021 8:59	9/8/2021 9:20	22	Y
Craig French	craig.french@inova.org	9/8/2021 9:20	9/8/2021 10:29	70	Y
Dan Avstreich	dan.avstreich@fairfaxcounty.gov	9/8/2021 9:52	9/8/2021 10:29	38	Y
Doris Warner-SNVMC	djwarner@sentara.com	9/8/2021 8:57	9/8/2021 10:29	93	Y
Dr. Dan (FCFRD) (Dan Avstreich)	dan.avstreich@fairfaxcounty.gov	9/8/2021 9:00	9/8/2021 9:52	52	Y
elizabeth Franco	elizabfranco@hotmail.com	9/8/2021 9:06	9/8/2021 10:30	84	Y
Frances Hughes	frances.hughes2@hcahealthcare.com	9/8/2021 9:11	9/8/2021 10:29	79	Y
Jean Snyder	regina.snyder@inova.org	9/8/2021 9:02	9/8/2021 10:29	88	Y
john bowers	jbowers@manassasva.gov	9/8/2021 9:06	9/8/2021 10:30	84	Y
John Morgan	john.morgan@loudoun.gov	9/8/2021 9:01	9/8/2021 10:37	96	Y
Julie Montasser	julie.montasser@inova.org	9/8/2021 9:09	9/8/2021 10:29	81	Y
Justin Nelson	jnelson@virginiahospitalcenter.com	9/8/2021 9:03	9/8/2021 10:37	94	Y
Karen Kovach	karen.kovach@fairfaxcounty.gov	9/8/2021 8:57	9/8/2021 10:29	93	Y
Kari Scantlebury- Fairfax County Police	karibury@gmail.com	9/8/2021 8:53	9/8/2021 10:00	68	Y
Kate Kramer- ACFD	kkramer@arlingtonva.us	9/8/2021 8:57	9/8/2021 10:30	93	Y
keith morrison Reston Hospital RHC	keith.morrison@hcahealthcare.com	9/8/2021 8:58	9/8/2021 10:19	82	Y
Kim Klein Inova Loudoun	kim.klein@inova.org	9/8/2021 8:58	9/8/2021 10:29	92	Y
Laura Vandegrift	laura@vaems.org	9/8/2021 8:58	9/8/2021 10:37	99	Y
Lindsay Jacobs- LCFR	lindsay.jacobs@loudoun.gov	9/8/2021 9:59	9/8/2021 10:37	39	
Lindsay Jacobs- LCFR	lindsay.jacobs@loudoun.gov	9/8/2021 8:58	9/8/2021 9:58	61	Y
Lisa McAllister	lisa.mcallister@inova.org	9/8/2021 9:06	9/8/2021 10:37	91	Y
Michelle Ludeman	michelle@vaems.org	9/8/2021 9:00	9/8/2021 10:37	98	Y
Nancy Morrissey	nancy.morrissey@inova.org	9/8/2021 8:58	9/8/2021 10:35	98	Y
Nathan Kee# ILH	nathan.kee@inova.org	9/8/2021 9:19	9/8/2021 10:30	71	Y
Neha Sullivan	nsullivan@pwcgov.org	9/8/2021 9:04	9/8/2021 10:37	93	Y
Stephanie Boese	stephanie.boese@gwu-hospital.com	9/8/2021 9:51	9/8/2021 10:21	30	Y
Stephen Gerber	stephenherber@gmail.com	9/8/2021 9:02	9/8/2021 9:42	40	Y
Topper Crame	tcramer@phiairmedical.com	9/8/2021 9:27	9/8/2021 10:29	63	Y
Zachary Baxter	zachary.baxter@gmr.net	9/8/2021 9:00	9/8/2021 10:30	90	Y