



Northern Virginia EMS Council  
**EMS Hospital Diversion Workgroup**  
Via ZOOM

October 6, 2021 Meeting Minutes

Those present were:

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Todd Lupton, [chief.lupton@gmail.com](mailto:chief.lupton@gmail.com)

**Call to order:**

Brian Hricik, Alexandria Fire Department Deputy Chief called the EMS Hospital Diversion Workgroup meeting to order.

**Introductions:**

As this is a new meeting, DC Hricik asked that all participants introduce themselves, where they are from and their interest in the program.

**Goals of this process:**

- Defining diversion
- Update the Regional Hospital Diversion Plan which was last updated in 2010.
- Perspectives
  - Hospital group discussion on their perspectives
  - EMS group discussion regarding their perspective
- Data Discussion
  - Number of transports, from which jurisdiction
  - Average time from arrival to patient hand-off
- Goals of this process
  - Must-haves
- Medium of document development
- Group composition
  - Do we have the right players – anyone not represented?
  - Frequency and lengths of meetings

**Perspectives from Hospital and EMS Systems**

Hospitals

Keith Morrison, Reston Hospital Center advised their main reason for diversion lately is capacity.

- Staffing issues like most hospitals
- Increase in sick patients, COVID related or not
- The influx of patients from the Afghan Repatriation Project through Dulles Airport.
- When the units or floors are at capacity it flows to the other area of the hospital
  - When the units/floors are full, ED patients to be admitted are boarding in the ED which creates an overflow and not enough ED staffing
  - Because the units and floors are at capacity they don't have extra staff to send to the ED to assist with caring for the patients boarding in the ED
- This all turns into a patient safety issue in the end

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- The hospital CEO, CMO, etc., are all in the discussions when it comes to diverting incoming patients
  - Keith also notifies all EMS partners of the upcoming diversion status when the decision is made

Eric Reist from Inova Health System said Keith did a great job of summing up the current issues and this isn't just a Northern VA issue, this is statewide and nationwide. It is important to understand the VHHA's definition of diversion because they are updating their indicators into VHASS so aligning the Northern VA Regional plan with the Commonwealth's definitions are important first steps because those are the initial indicators that the hospitals are reporting on.

Mary Laurel Castle from NVHA/RHCC reported that because VHASS is a statewide system, we are unable to change the definitions at the regional level. However, NVHA is always happy to advocate for changes the region feels are necessary. She also provided the following definitions per VHASS:

- **OPEN:** Unrestricted access to all EMS agencies
- **SPECIAL DIVERSION:** Indicates that specific services are unavailable or are currently being utilized to maximum capacity. EMS units are advised to transport to another healthcare facility if possible for patients needing those services.
- **FULL:** Indicates that patient load is utilizing all current emergency department/hospital resources. EMS units are advised to transport to another healthcare facility if possible.
- **DISASTER ALERT:** Current event has exceeded hospital's capability to manage event, outside resources or aid anticipated or needed.

#### EMS Agencies

Chief Ed Mills from DC Fire & EMS advised they're seeing overcrowding in every hospital, staffing shortages. They have created a hospital load distribution plan with their Emergency Liaisons at their Office of Unified Communications and they have the authority to bypass certain hospitals if too many units are there unless it's a critical patient, then they go to the appropriate designated hospital (STEMI, Stroke, Trauma) regardless of capacity. They see little relief from that due to call volume, averaging 600-625 calls per day which is back to or surpassing 2019 call volumes. They're seeing hospital drop-off times as high as three hours on occasion, but routinely 65 minutes. DC does monitor Maryland's CHATS system but he is unsure about VHASS. DC hospitals by law do not "close" and any diversion has to be done by the DC Medical Director. They will often "load balance" with a hospital to divert to other hospitals for four hours so they can reduce their load, but again, any specialty hospital must take an appropriate critical patient.

Chief Terrell Buckson from Prince Georges County echoed the same as DC where they are seeing their hospitals often on red or yellow alert status. They also have a similar plan where they put a hospital on re-route if there are a lot of units at a certain hospital but they're getting reports that have sat at a hospital for upwards of 8 hours waiting on a bed and it's becoming

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routine, unfortunately. Even if they place a hospital on re-route, it's not easing the situation because it flows into the surrounding hospitals. They do not monitor VHASS, but they use a system in Maryland called CHATS (County/Hospital Alert Tracking System - <https://www.miemssalert.com/chats/>)

Mary Laurel Castle advised they have been working with the DC Health Coalition and NEMS to try to have VHASS visibility National Capital Region-wide but it doesn't appear it's getting to the appropriate people. Please email her at [marylaurel.castle@novaha.org](mailto:marylaurel.castle@novaha.org) and she can get people set up with appropriate access to VHASS to see Northern VA diversions.

Reed Smith, MD, from Arlington County Fire Department advised we need a clear understanding because all EMS systems are seeing the same issues. Hospital diversion is not a guaranteed status and hospitals need to understand that this must be a coordinated, collaborative conversation with the leadership of the fire departments because they're also being held accountable for the safety of their patients. He has talked to several hospitals and finding they say they are on diversion but that's actually just a request on their end, actual diversion is based on a transport destination policy under the purview of the OMD for that agency. Not that the request won't be granted, but it has to go through the appropriate chain and across multiple agencies; Hospitals can't do it on their own. And even if a hospital is on diversion for non-critical patients, stroke, STEMI, and trauma centers are never on diversion for these specific types of cases. If it's unsafe to take patients to a specific hospital, the Fire Department makes that decision, not the hospital.

Scott Weir, MD, from Fairfax County Fire & Rescue echoed Dr. Smith's statement that a hospital may request a diversion with exceptions for individual cases. He also stated that the hospital systems could enter their status on VHASS but EMS systems either lost their ability or never had it to begin with. It places EMS systems in a disadvantaged position to take the proactive step to notify units to 'load share' but this could be a definite positive step forward to establish the keys to that system for an EMS representative to be able to enter that info into VHASS as well.

Kari Scantlebury, MD, from Fairfax County Police echoed what Dr. Smith and Weir discussed and acknowledged that this is a nationwide problem and our priority is patient safety. Beginning the conversation here to have all stakeholders knowing they have a voice, creating a line of open communication, the ability to have an open forum in this setting, and possibly identify trigger points from an EMS and hospital perspective is important. For example, if a hospital has a two-hour ED wait time, they know they need to initiate a plan to reduce the load, and if EMS is finding it's taking two hours to offload a patient at certain hospitals, they need to be able to initiate the plan. We are all responsible for safe patients so all the stakeholders need to be equal and have the ability to recognize there are issues and decide what can be done as one system, EMS and hospital together, to address them so we all stop running into a brick wall.

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## Data Discussion

Chief Hricik advised that over the last 3-4 years he has been running monthly transport data and sharing it with Virginia Hospital Center, Inova Alexandria Hospital, and GWU Hospital upon their request. In August, they were actually below 90% of transports being taken to Inova Alexandria and that's the first time in his time here that they've ever seen it that low. He shared his data with the group.

Captain Daniel Acosta from Prince William Fire & Rescue advised they also keep track of their transport locations and also experienced some diversion of some lower acuity patients over the last year and they called around to the other facilities and checked volumes of their other facilities.

Jonathan Arnburg from Inova asked why so many transports were to Alexandria Hospital and so few to Springfield Healthplex. Chief Hricik advised that primarily it's because from anywhere in the City of Alexandria, Inova Alexandria is the closest facility and for a while, their OMD did not want them transporting to the HealthPlex in case there was a need for admission, as they can't be admitted there.

Michael Homeyer from Inova stated that the free-standing EDs are full-service EDs and bypassing them does create clogs at the hospital-based EDs and if a patient needed to be admitted, they are a direct admit and do not start over through the ED at that hospital. He highly encourages not bypassing the free-standing EDs with Inova because it helps reduce the clogs at the main hospitals. He asked if there was a coordinated effort for distributing ambulances to various EDs and not just the closest facility. They don't have great visibility of the ambulances and EMS doesn't have great visibility at any given time of the hospital systems, has there been any thought on EMS distributing patients based on the ED volume as a centralized system versus just choosing the closest hospital?

- Chief Hricik advised that for Alexandria Fire Department specifically, in the past they always went to Inova Alexandria Hospital because of proximity. Now, because of the higher ED volumes and wait times for crews to get a patient handed over, they are going to Springfield HealthPlex, Mount Vernon, VHC, etc.
  - They only cover 15 square miles and Inova Alexandria Hospital is the only hospital inside their jurisdiction. They're not bypassing it, they're choosing other facilities because Inova Alexandria is stretched thin
- Reed Smith reiterated that this needs to be a coordinated effort. EMS is good at making transport decisions, but when one hospital is overwhelmed, EMS can divert to another but that can, in turn, bog that hospital down. There needs to be a conversation from the hospitals to say they need a break and have EMS reduce the volume of incoming transports. Additionally, keep in mind that EMS has a large volume of calls and limited resources for transporting patients, so in addition to a long transport and turnaround, they may also have to go to another hospital to restock supplies and meds, taking them

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out of service for longer than normal, which also filters down to other units and other departments to pick up the slack when a unit is gone for a long time.

- Michael agreed that this needs to be two-way communication on how to make this work for all and developing a system where everyone has better eyes is very important. He's not suggesting taking someone from Alexandria to Loudoun but a short drive to Mount Vernon may be a good alternative when Alexandria is busy.
- Mark Kordalski from Fairfax County Fire & Rescue advised that when they send a message to their field personnel, they don't know if they've read it or not. It would be more helpful when they push the button on CAD to say they're transporting to Alexandria Hospital, that something pops up to say it's on diversion except for OB, Trauma, etc., and they know not to go there. This would ultimately be the best way to communicate that.
- Kari Scantlebury stated it all circles back to increasing communication between the local EDs and EMS agencies and units on the street. Having that communication is also key for keeping them aware of what's going on in the ED such as walk-ins because with the recent increase in volumes, they're seeing an increase in walk-ins and EMS traffic.
- Mary Laurel Castle also advised they're working under the VHHA and VDH definition under the Code of Virginia 12VAC5-31-10, "'Diversion' means a change in the normal or established pattern of patient transport at the direction of a medical care facility." But the definition of full diversion ends with the phrase "if possible" so EMS units have the final say on where the patient goes.
- Eric Reist reiterated the use of VHASS as a resource to see what hospitals are needing a break from incoming EMS transports because their communication room nurses update that frequently. He also reiterated the use of alternate transportation destinations to be added to the mix
- Reed Smith said his one pushback is that if a patient is transported to Urgent Care, they can't bill for that unless it's under ET3 and Arlington only has one currently, so there is a cost-recovery issue there as well. Additionally, why can't an incoming patient at the ED have a medical screening exam and be determined they don't need an ED and they're sent to Urgent Care by secondary transport?
- Rick Cohen from PHI Aircare stated he has worked in two cities in the past where they made this all happen. One fire department but multiple hospitals but the fire department was able to divert ambulances in multiple directions. How easy is it this information getting distributed to help make those decisions?
- Reed Smith advised it's not getting out and that's the issue. They broadcast it on the radio or MDCs because although VHASS works, they don't have someone monitoring it all day. Often crews find out a hospital isn't available when they call to give report and then it's not widely distributed to other units in the same jurisdiction, let alone others.
- Chief Hricik advised that they also understand that when a hospital goes on diversion, it's because they're past all the scenarios that Eric Reist explained (incoming EMS, incoming walk-ins, etc.) and they don't know that until it's too late unless an EMS provider sees that and notifies him or someone else and then, in the past, they would

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call their PSAP and broadcast it on the radio and PSAP would call the surrounding jurisdictions to let them know. VHASS is not integrated into their CAD.

- Chris Cook from NVHA advised Fairfax County Fire & Rescue is currently the only locality where VHASS is integrated into their CAD
- Keith Morrison added that Reston Hospital Center as they're making the determination for a diversion a text is simultaneously going out to the primary contact of the EMS agencies, PTS, AMR, LifeCare, etc., to let them know that they have an issue (staffing, capacity, etc.) to give them a heads up that they're going on diversion except for STEMI, stroke, and OB. In the past, that has generated phone calls to bring everyone together ahead of time and that way, no one is blindsided when the final call is made. That seems to be working for them overall. If it's overnight, then typically he'll call the 911 center instead of calling everyone at that hour.
- Kari Scantlebury stated that for those who have this integrated, it's helpful to know when a hospital goes on diversion. Would it be more helpful if they integrated more pre-cursor information before they go on full diversion? Can they add ED wait times, volume of sick patients, etc.? Would it be a useful conduit to use more preemptive indicators rather than going on full diversion? How do we get ahead of it so EMS can better balance the load from a prehospital standpoint? We need to make it as easy and seamless as possible for providers to get diversion information. It needs to be readily available at a glance and not require the providers who are attempting to care for a patient have to go to a website to see diversion status.
- Scott Weir also advised this is a good idea because at times patients request a destination and that may be a helpful tool to let them know what to expect at their requested destination
- Kristin Nickerson from NVERS, as a stop-gap measure, the PSAPs do have logins to VHASS. There had been some changes by VDH as to the access they had but they can work through those issues. In the near term, this may be something that can help.
- Mary Laurel advised they have a tab that captures ED waiting and boarding times, among other ED Indicators. Currently, EMS cannot view but she has messaged VHHA during this meeting to ask for that change
- Chris Cook also advised there is an opportunity for EMS to sign up for VHASS accounts and diversions will pop up on that automatically when you sign up for the agency. Chris can help with that if anyone is interested.

### **Goals of this process**

Chief Hricik suggested that perhaps we do not need every stakeholder at each meeting but a core group that can meet regularly and reports back to the larger group at designated timeframes.

The group agrees that we have the correct representatives in this meeting and nothing is underrepresented.

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What are the goals of the group? VHASS works as intended, but what indicators can be shared by the hospitals before they request diversion that EMS can help facilitate sharing or reducing the load on those particular hospitals? What do we need to include or change in VHASS to communicate that properly to the agencies?

- Eric Reist said he learned today that while they're updating the ED indicator tabs daily or every few hours, most of the EMS agencies can't even see that and they were not aware of that. Additionally, diversion has a lot of financial implications not just on the hospital but also the EMS agencies depending on where they transport to. Focusing on getting our regional policy in line with what the state's definitions are and updating that. Updating the ED tabs on their website is also important because they also drive patient decisions on where to go for care when they see wait times for various hospitals. There are some things that hospitals can do to include their health system and he'll be presenting those to the Inova management in the next week or two. As non-profit hospitals such as Inova, they do have the ability to lobby for change with NVERS and NVHA and they need to lobby for those strategic changes in the future
  - ED boarders and ED wait times are captured in VHASS already
  - Mary Laurel advised that ED indicators in VHASS are Number of patients in ED, Number of patients in ED waiting room, Number of boarders in the ED, Average ED boarding time, and Average ED Wait Time
  - Dr. Weir suggested that perhaps percentages rather than raw numbers would be more relevant
    - Percentage of capacity
- What are the EMS indicators to consider diversion?
  - Drop times over 45 minutes

Chief Hricik advised that we are approaching the time allotted for the meeting and a few people have had to drop off. He suggested that the meeting end now and reconvene next month unless there is a topic that needs to be handled.

Mark Kordalski asked if we can work toward a short-term stopgap for opening lines of communication sooner than 6-9 months down the road?

- Chief Hricik advised that the best process now is that when one agency finds that their local facility is having issues to notify their counterparts at the other agencies or notify the PSAP and request they notify the neighboring jurisdictions.
- Chief Mills from DC advised that they use FirstWatch and was curious if anyone here uses it and if it can interface with VHASS. They use FirstWatch now and they can see what units are at what hospitals but it doesn't show what hospitals are on diversion. If it could be built into FirstWatch that could interface with VHASS they could likely bring it to the COG partners for use region-wide.

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- Chief Hricik stated that it was a regional COG initiative but there were a lot of undelivered promises so most of the regional chiefs have moved away from using it, but it could be a consideration if someone has access to it.
  - Arlington County & Fairfax City do not use it because it didn't serve a purpose for most.

Do we as EMS agencies track wall times? There was a request from COG to look into that.

- Chief Marsh from Arlington County advised that most of the agencies didn't see a large effect on their operations and didn't track them but Prince George's County was having an issue with their wall times. Unfortunately, not everyone measures the same data points. For example, everyone agrees that arriving at the hospital and returning to service are important points but there is no consistent patient transfer data point so times were not accurate across agencies. Additionally, some doing it by voice activation, others did it on radio, others have a button on their MDC, but because they don't all have the same data points, it's gone to the side. She'll recommend it be discussed again at the next COG meeting.

**Medium of document development**

Inova and Fairfax County Fire & Rescue can't access Google docs on their main workstations but both can get through it on a backend workaround and that will work at this time.

Please look for an invite in the future for this meeting probably early or mid-November. If you have suggestions, questions for future meetings, etc., to Chief Hricik at [brian.hricik@alexandriava.gov](mailto:brian.hricik@alexandriava.gov)

The meeting was adjourned at 3:28 pm.

**CERTIFICATION OF the EMS HOSPITAL DIVERSION WORKGROUP**

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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 EMS Hospital Diversion Workgroup of the Northern Virginia EMS Council on October 6, 2021. The minutes were officially approved on the \_\_\_\_\_, 2021, meeting of the Workgroup.

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Craig Evans  
Northern Virginia EMS Council

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Date

DRAFT

Meeting ID	Topic
89547374232	EMS/Hospital Diversion Workgroup

Start Time	End Time
10/6/2021 13:45	10/6/2021 15:27

Duration (Minutes)	Participants
103	46

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