



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

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

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The Regional Time-Sensitive Coalition (ReTSCo) meeting was called to order at 9:02 a.m. by Dr. John Morgan.

Approval of Minutes:

Meeting minutes from September 7, 2021, meeting were distributed via email before this meeting and unanimously approved with no changes.

Craig is hoping to have a chairperson and co-chair for each service line for the next year. If there are any EMS leaders interested in pairing with a physician for a specific service, please email Craig directly at craig@vaems.org or northern@vaems.org

Topic: Hospital Diversion

- We will discuss this as a collaborative group and each service line will discuss them individually

Dr. Morgan stated he was reading up on diversion yesterday including the definitions, papers published on this topic, etc. There is great material online for this, which is a good read for good models in existence from other areas that have tackled this in a more overt way than northern Virginia has in the past years. We are lucky to have little requests for diversion, low load, and wait times but it has gotten worse over the last few months with changes with the pandemic, staffing, etc. We should perpetuate it beyond what is discussed and/or decided today.

Group discussion on diversion

- Dr. Morgan, reading from notes from yesterday was reviewing the concept of diversion and how much impact it has on the real-time problem, which is volume overload in ED. What was thought provoking for him is that the relative minority of volume to the EDs is EMS, most are walk-ins. By denying EMS arrival, how impactful is that if EMS is the lower volume. The acuity of EMS patients is typically higher than walk-ins, so are we doing a disservice by limiting the lower volume and higher acuity

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rather than the other way around. We are sending EMS to outlying areas or freestanding EDs where a hospital is a better option for longer-term definitive care.

- Dr. Avstreich stated there needs to be a way to communicate that something is physically closed and we need to be sure that EMS and the hospital reserve that communication for such instances only. There needs to be specific language to communicate that so we don't go there regardless of "diversion" status because they actually can't treat that patient because of actual maintenance, equipment out of service, or another emergency like fire/flood.
 - Can we get everyone is on the same page regionally for what it means to say something like "the cath lab is out of service" and we don't use that language any other way
 - Secondly, think about what would be a reasonable expectation for diversion of one of the big three because something downstream isn't available except for treat and ship out
- Dr. Glenn Druckenbrod from Inova Fairfax ED stated diversion allows them to catch their breath for the 2-4 hours they are on diversion so it does help them to make a difference clinically in treating patients
- Dr. Babak Sarani stated treat and ship out is wrong. With the number of trauma centers in the region, there is no reason to go down that road, as it becomes logistically an issue. The bigger issue is a patient too unstable to transport; this becomes a malpractice and liability issue when transferring. Other hospitals are also not willing to accept these types of patients so we are better to transport an extra 15 minutes to get them to a place they can stay instead of treat and ship which ends up being an hours-long issue.
 - Dr. Avstreich stated in trauma that is an easier issue. If you can't take care of a STEMI after the STEMI, do you transfer or do you just drive further to be able to take care of the STEMI after the STEMI?
 - Dr. Steven Day stated that for Inova it all goes thru cardiac access so if there is a large MI with shock, they go to Fairfax first for Impella support. If not, they pop open the LAD and put in a balloon pump, and then move the patient
 - Dr. Druckenbrod advised they try to keep reroute to a short time to get things under control. He says it's in single numbers per year that the ICU does it. He thinks it is a small number for EMS incoming and they can control that but then you cannot send the patient out after that to the ICU. It's more if ED is overwhelmed, they just need to get to catch their breath sometimes
 - Dr. Sarani agreed
 - Dr. Franco advised trauma has gone on re-route twice in the last 5 years due to a facility issue, not a capacity issue
 - She agrees it's a better idea to transport further initially rather than treat and ship
- Dr. Morgan advised Reston has had several trauma diverts recently due to lack of IR. So if you have that knowledge, can you take others there that do not need that service and

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function as a lower-tier trauma center? How do you communicate that? Loudoun's Level 3 trauma center goes on divert sometimes

- Dr. Dennis Wang from Reston Hospital stated the challenge from a trauma standpoint is that it is hard to know initially whether they need embolization or other specialty care that is time-sensitive. It's rare, less than 1-2 per month that need immediate embolization but it's hard to determine that in the prehospital setting, so this is their challenge
 - Dr. Sarani agrees. They had a patient that fell out of a window and initially looked great but turned out to have an open book pelvic fracture.
 - A second patient they had, EMS was convinced he had a head injury but had a major liver laceration. It's too hard for EMS to determine that in the field
- Beth Adams stated they also have an issue with prolonged wait times. There is a perception that some facilities prioritize people in some uniforms over others. This contributes to the dismay of the diversion, wait times, and impacts transfer of care and how that plays downstream.
 - Dr. Morgan added that no one system oversees all over this for the region so this is a difficult part for us in northern Virginia
 - Dr. Scantlebury added that when Fairfax goes on diversion, they are aware of what is going on in the region because of the RHCC. They check theirs and others, but she is not sure if EMS does so often hospital has better insight than EMS does or EMS perception is if they are not looking at RHCC for status.
 - Dr. Sullivan stated the RHCC system is not adequate for EMS utilization. Each hospital can put in that they want to go on diversion but there is no good comparison of the hospital to hospital load, etc. For her, if they are all busy, no one goes on diversion. It feeds on insufficient data and needs to be more real-time and sophisticated. Maybe color-coding as Maryland has would be better.
 - Diversion for 2 hours when working in the ED can decompress and help with the load reduction but that transfers to another hospital in the region and bogs them down. How do we get daily active on-going traffic management before we get to the point of putting them on diversion? We have been using VHASS for years but it is insufficient. We have the tech ability to see EMS units at EDs through FirstWatch, can we get an auto-feed that shows how many EMS waiting, how many walk-ins are waiting in the waiting room, how many beds are available in ED, awaiting transfer out/to the floor, etc.?
 - Jamie Cooper stated this is a spot-on point for this discussion. VHASS is only as good as they put it in the computer by each hospital. Patient tracking is used for MCI currently, but looking to put that out for all transports for more real-time patient tracking and a hospital census scenario which would be more beneficial
 - Craig Evans advised there is a patient tracking committee through

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the Northern Virginia Fire Chiefs group that we use for MCI events. We use that for patient tracking software for MCIs but they are looking for software that is more comprehensive for all EMS patients in the region at all times that can rack surge, MCIs, biological events, medical/infection events. Hospitals can see their loads and that of others, they can see what EMS is doing, where they are going, etc., and will allow them to send text messages to EMS to create voice communication but this is still at least 18 months until this happens.

- Dr. Scantlebury asked if this captures waiting room and walk-ins
- Craig advised they are trying to see what data points they can capture to share that info. That is a question, hopefully in phase 2 to see in real-time. This will be auto-feed, not user-specific input, and is to be used daily, not just during a surge.
- Chris Cook agrees about VHASS. It is a statewide system, so to develop that is a better option than VHASS because that would require statewide change and would take much longer.

Breakout room summaries

STEMI –

They had a good conversion. STEMI is an obvious life threat and all involved in the care of this patient recognize this is a sick patient. In the rare instances when the cath lab is fully out of service, the benefit of transport to the next closest within one hour outweighs the facility for alternative therapy like thrombolytics. Alternative methods of transport are considerations (helicopters, etc) for outlying areas for extenuating circumstances. Another insight was “serious as a heart attack” is how we should approach other patients such as shock, peri-arrest, etc., regardless of status as some of these patients should still come to the closest facility for the best interest of the acute patient.

Stroke –

As they discussed in the STEMI group, some patients need to go to the closest facility due to the acuity of the illness. Interventional Radiology has to be available and rarely does diversion happen specifically to stroke unless it is for scheduled maintenance, an IR upgrade, the scanner is down, etc. However, how do they share that info with everyone involved? They do not see a historical use of diversion for stroke care only and primarily see it as “X hospital is on diversion except for trauma, STEMI, stroke”, or essentially all non-acute things. The definition of diversion is to take all non-acute patients elsewhere. For those receiving, when an ED is on

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diversion, it does not affect them and their care. They also discussed, if there is a diversion request for strokes, knowing the last known well is a good indicator for destination (therapeutic window means go to the best available facility) if the window is closing they should go to closest regardless.

Craig Evans stated we decided this is a non-acute issue unless it is an equipment issue. If it is not an immediate issue (i.e. the diversion is taking place tomorrow because of maintenance), this communication can be sent through EMS Council to distribute on Social media and the listserv.

Trauma – The ACS trauma committee for every level trauma center states that when they go on diversion it has to be reported to the ACS by minutes and the number of times. They also must notify other centers of diversion and filters down to EMS. They discussed downgrading a trauma center from diversion, but from an ACS standpoint is not acceptable. You are either a Level 1 trauma center or you aren't; you can't decide to be a Level 2 today and a Level 1 tomorrow. The other major discussion point was that the document we are working off (NVEMS Diversion Plan) is 10 years old and needs an update. The difficulty is what kind of diversion a hospital is on and can EMS still take a patient there regardless? If you have a critical patient in your unit, you can't be calling multiple hospitals to see who can take the patient. There is also a difference in a full diversion of the hospital vs. specialty diversion for one service (STEMI, stroke, etc).

Comments/Discussion

Craig Evans advised the document is being updated. Diversion should not be for acute issues, it's for non-acute problems due to staffing shortages, equipment failures, or maintenance. Communication is our largest barrier shared among all service lines and we will ensure we make this language clear in the new document.

Stephanie Boese asked when going on diversion is there a way for specific selections vs. manual entry. Is there a pathway that when they choose trauma it takes them down the appropriate path?

- Dr. Morgan advised VHASS is a statewide process so we can look into that for the northern Virginia specific regional solution but it's not in the current setup

Beth Adams stated when this information is sent out by email, it may or may not go out by CAD message, and the more simple the message, the better they receive. Frequent, repetitive, or long messages are often overlooked.

Craig French advised that daily at 3:30 pm Inova does a capacity coordination call for all hospitals and freestanding EDs. He provided a copy of yesterday's data showing the northern region has zero, but central (Richmond) had 11 partial or special diversions.

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- Beth Adams added that the hospitals in the central region are working hard to reach this level of info sharing and transparency and it has been well received but their info is correct that they have this many. Not sure if it's embellished. A recent issue identified in our region was with people using Inova ED wait times showing on the Inova websites and finding that the times were not accurate. She would appreciate a better picture as it would help better manage the expectations of others

Dr. Morgan advised that some places in the country have 8-hour transport off-load times and we do not want that here and do not want to normalize that process here. Culturally there is a posture where they know diversion is not a positive thing and it is driven from the ED side but it's not just an ED issue with things like too many elective surgeries, staffing, full units, etc., and it starts with ED as they can't move people forward and this leads to excess transfer time or wall time.

Chris Cook advised he spoke with the RHCC manager for the central region. They have consistently had 5+ hospitals on diversion daily for over a year. Their RHCC is responsible for telling units where to go for their patient needs. They are more casual with diversion than we are which is why they have more. We are just as full as they are so we would see as many if we followed the same guidelines; they are using to put on diversion but how is that beneficial if we are on all the time as they are? Providers can get diversion messages via text for specific hospitals, services, etc.; they can sign up for alerts for anyone in the state if they want to. We need better communication on when hospitals go on diversion based on ED indicators but it is based on hospital inputting that info. Chris put in a suggestion for automated systems for items like registration status, ED wait times, bed status, etc., with VHASS multiple times to get IT to work on that project. However, due to money and the personnel needed on that project, it is a heavy lift because these changes would be for the whole state.

- Stephanie asked if special diversion says why it is special or it is only based on the comments they input.
 - Chris Cook stated if there is no comment put in, he will call the hospital to find out and enter the reason

The take-away message is that we need to clean up communications.

Next steps

- Beth Adams will help draft edits to the current NVEMS Diversion Policy.
- Beth Adams also added that there are still many other patients that EMS provides care to that this model does not look at like CHF, COPD, respiratory, pediatrics, etc., that we used to look at how we provided care. Since we still have unique protocols in the region, those conversations have been helpful. Maybe one meeting for those special cases to do a PI/QA opportunity for those that don't meet stroke, STEMI, and trauma would be helpful in the future

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- The ReTSCo is still a new meeting but there is a benefit of collaboration with multiple service lines.
 - How many topics we delve into on a regional level require all services lines to be present.
 - How do we want to have a regional meeting that brings them all together?
 - Do we want to do condition-specific meetings a few times a year?
 - Being more focused on the individual services lines, we could continue with the ReTSCo but with only two meetings per year
 - The recommendation was to go back to individual stroke, STEMI and trauma meetings and bring our findings/discussions and any overlapping issues we can improve together back to a ReTSCo meeting twice a year

Craig Evans stated we will return to stroke, STEMI, and trauma meetings quarterly and plan to do ReTSCo only twice per year and bring back overlapping issues we can improve together and use ReTSCo as a steering committee model.

The meeting was adjourned at 10:48 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 December 8, 2021. The minutes were officially approved on _____, at the meeting of the Committee.

Craig Evans
Northern Virginia EMS Council

Date

Meeting ID	Topic
83441629743	NOVA ReTSCo

Start Time	End Time
12/8/2021 8:44	12/8/2021 11:01

User Email	Duration (Minutes)	Participants
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