STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
152 STATE HOUSE STATION
AUGUSTA, MAINE

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISSIONER

J. SAM HURLEY
DIRECTOR

TRAUMA ADVISORY COMMITTEE
December 28, 2021
Meeting conducted via Zoom
MINUTES

Members Present: Rick Petrie (Chair), Dr. Amy Fenwick (NL-EMMC), Dr. Richard King (CMMC), Dr. Joseph Rappold (MMC), Dr. Pete Tilney (CMMC/LFOM), Director Sam Hurley (MEMS), Anna Moses (NL-EMMC), Dr. Cynthia Richards (CMMC), Joanne Lebrun, (Tri-County), Thomas Judge (LFOM), Christopher Paré (Wells EMS), Ben Zetterman (Van Buren Ambulance), Leslie Anderson (Carey Medical Center), Chris Costello (MDI Hospital), Dr. Matthew Sholl (MEMS), Tammy Lachance (CMMC), Pret Bjorn NL-EMMC), Dr. Julie Ontengco (MMC), Dr. Ian Neilson (MMC)

Guests: Dr. John Alexander, Devore Culver, Steve Littleson, Michael Tayler, Ann Kim, Jason Cooney, Dr. Alfred Riel, Sally Taylor, Brent Libby, G. Pineau, Chip Getchell, J. Hamilton, Paul Marcolini, Phil MacCallum, Hugh Jones, Jackie Mundry, Keith Fredrich, Jesse Thompson, Terry Stackhouse, Tom Moses, James Corrigan, Shawn Cordwell, Chief MacDonnell, Vanessa Paolella, Dr. Bruce Chung, Dr. Seth Ritter

Staff Present: Dr. Kate Zimmerman (Trauma Systems Manager), Darren Davis

NOTE: Although not part of the meeting, we have added information that may be helpful to the reader as there are a variety of abbreviations used in these minutes that may be unfamiliar – these abbreviations include:
RTC – Regional Trauma Center, currently defined at Maine Medical Center, Northern Light-Eastern Maine Medical Center and Central Maine Medical Center
TSH – Trauma System Hospital – All hospitals in Maine with a 24/7 Emergency Department, that are not a RTC and support the transfer of patients needed trauma services
IFT – Interfacility Transport, typically from a smaller hospital to a larger hospital for more advanced care
MEMS – Maine EMS
ACS – American College of Surgeons, which verifies trauma centers at various levels, with level 1 being the most comprehensive. Currently Maine Medical Center is a Level 1, while Northern Light-Eastern Maine Medical Center and Central Maine Medical Center are both Level 2.
LFOM – LifeFlight of Maine

The current Maine EMS Trauma System Operations Manual (Trauma Plan) can be found on the Maine EMS website under the Trauma Advisory Committee Resources page: https://www.maine.gov/ems/boards-committees/trauma-advisory/resources

This meeting was conducted virtually on Zoom.
Meeting called to order by Mr. Petrie at 13:02

Mr. Petrie reads the Maine EMS mission statement

The mission of Maine EMS is to promote and provide for a comprehensive and effective Emergency Medical Services system to ensure optimum patient care with standards for all providers. All members of this board/committee should strive to promote the core values of excellence, support, collaboration, and integrity. In serving on this Board/Committee, we commit to serve the respective providers, communities, and residents of the jurisdictions that we represent.

Mr. Petrie read a roll call for TAC member attendance.

Motion #1 by Tom Judge to approve the December 14, 2021 TAC minutes. Seconded by Pret Bjorn.
Discussion
None

Roll call vote, unanimously in favor, motion passed.

Motion #2 by Pret Bjorn to approve the December 20, 2021 TAC Subcommittee minutes. Seconded by Dr. Julie Ontengco.
Discussion
None

Roll call vote of those present at the Subcommittee meeting, 8 in favor, 1 abstention, motion passed

Mr. Petrie would like to add to the Agenda a discussion regarding IFT in response to the MDPB guidance and the TAC subcommittee that met on 12/20/21.
There was a consensus to add this topic to the Agenda.

Review the MDPB guidance provided to EMS clinicians regarding destination decision-making for the transport of trauma patients
This is a clinical bulletin that can be found on the MEMS website.

Dr. Sholl discussed the guidance that was published by the MDPB on December 16, 2021.
In brief, MEMS sent out an Operational Bulletin on December 10, 2021(#2021-12-10-01) after they were made aware of the situation with loss of neurosurgical coverage at CMMC for the remainder of the month. The TAC, at the December 14, 2021 emergency meeting requested that the MDPB "provide clear direction to the EMS providers on their decision-making for the transport of trauma patients". The MDPB, at their regular meeting on December 15, 2021 drafted and approved a Clinical Bulletin (#2021-12-16-01) which was published on the following day. In brief, EMS services should continue to follow the Trauma Triage Protocol (Green 3-5) and the EMS Head Injury Protocol (Green 11-14) when determining the most appropriate destination facility. When the total transport time from the scene is less that 45 minutes, trauma patients should preferentially be transported to an RTC with neurosurgical services (MMC, EMMC). Patients with known or highly suspected neurologic injuries should preferentially be transported to an RTC with neurosurgical services when total transport time is less that 45 minutes. Air ambulance field traumas should preferentially be transported to an RTC with neurosurgical services. If the patient requires immediate stabilization or transport time to one of the two RTCs with neurosurgical services is greater than 45 minutes, the patient should be transported to the nearest hospital for stabilization.

Dr. King asked if there was any discussion regarding the different capabilities of the Trauma System Hospitals (TSH) and destination. i.e. CMMC vs. St. Mary's, where CMMC has been an RTC in the past and retains its Trauma Service.
Dr. Sholl noted that the language, "the most appropriate hospital" used in the Clinical Bulletin should reflect CMMC's stature and continued importance in the system.

Director Hurley provided an update with discussions with DHHS regarding IFTs.
The guidance of the TAC was that Trauma System Hospitals or ACS-verified Level 3 Trauma Centers should not accept trauma patients from other hospitals. There were risks identified with this including:

1. The risk to the hospital that denies the patient that they have the capability and capacity to treat, which would be an EMTALA violation, and
2. If the hospital accepts a patient that they cannot care for could be in violation of EMTALA.

With that, it Mr. Hurley noted that it could be the will of this committee to *discourage* non-ACS-verified Level 1 or 2 Trauma Centers from accepting IFT trauma patients. MEMS would need input from the federal government regarding the authority to bar this practice.

Dr. Dinerman noted that the statute is silent in the case of accepting a patient in error, i.e. accepting a patient they thought they had capability/capacity to accept only to find that they need a higher level of care. He noted that EMTALA is preemptive of state law and permissive relative to the discussion between the sending and accepting physicians – if the decision was made that it was appropriate to transfer, it would not create an EMTALA violation.

Mr. Bjorn asked Dr. Dinerman for clarification. It was his understanding that EMTALA speaks to the receiving hospital. Is there something that tells the sending physician who they transfer to? Would a state plan supersede this?

Dr. Dinerman noted that a state trauma plan could be integrated with a hospital-owned ambulance e.g. that ambulance could bypass the hospitals that it owns and operates based on the statewide trauma plan. There is a Safe Harbor feature as well. Dr. Dinerman noted that a federal judge has the final decision.

Dr. King asked if there were any precedent with any Level 3 Trauma Center as having a violation in accepting patients that they could not take care of?

Mr. Hurley cautioned the group that we are not lawyers. We would also caution non-ACS-verified Level 1 and 2 Trauma centers from accepting patients that they do not have the capability of caring for. Looking at the data that was provided by CMMC, there were noted to be a lot of IFTs that required neurosurgical consultation.

Reviewed & discussed recommendations of the TAC data review subcommittee whose recommendations are noted below:
This subcommittee makes the following recommendation to be presented to the TAC at the December 28,2021 meeting:

1. *Continue to follow the current state Trauma Plan as written,*
2. *LifeFlight field trauma transports will go to a verified Level 1 or 2 RTC,*
3. *CMMC cannot accept trauma IFTs, even from Bridgton and Rumford,*
4. *TAC should immediately reconvene the Trauma Plan subcommittee to revisit the destination designations and any needed revisions.*

Mr. Hurley reminded the TAC that we were here to represent the *people* that we serve in Maine and need to be very cautious to not represent the affiliations (e.g. with hospitals or transport services) that we may hold.

Mr. Bjorn was in favor of amending #3 until the IFT/EMTALA issues can be clarified.

Mr. Judge, who was part of writing the original trauma plan noted that it was their aim to create a system that did not have mandatory rules. Rather, they emphasized having a system that was voluntary and inclusive. He did not see that in the subcommittee recommendations. He noted that this does not look to align with the MDPB guidance either. He noted that we could not afford to lose the capacity to care for our trauma patients and that in many states ACS-verified Level 3 Trauma Centers accept trauma transfers.

Mr. Hurly urged caution in rushing to re-do the trauma plan. We should take time in looking how to integrate Level 3 centers.

Mr. Bjorn acknowledged that since the trauma system was conceived, that that shape of the system has changed dramatically.

Ms. Costello emphasized that there was a capacity issue. The Trauma System Hospitals are having to care for patients that they would be able to transfer readily in the past for as long as days now.

Dr. Sholl believed that if we orchestrated this conversation the right way, that we could help our capacity – by being inclusive of Level 3 centers. He noted that this committee has historically not embraced Level 3 centers in the past. He cautioned the committee to not rush to a decision today but rather to go back and look at and thoughtfully revise our plan.

Dr. King felt that there was an immediacy in what was to be decided today. He noted that there is a crisis and that CMMC needed to continue to accept the patients that they have the capability and capacity to care for.

Motion by Dr. King – The TAC continues to allow the interfacility transport of [trauma] patents that have the capability to care for those patients.
Second by Dr. Tilney
Discussion

Mr. Paré noted the way that the motion read opens up the ability for any hospital to do the same thing that CMMC is suggesting. Mr. Petrie felt that this was correct.

Director Hurley discouraged this motion, would want a more inclusive motion rather than piecemealing multiple motions and create one inclusive motion that states this is our pathway forward. He cautioned the TAC on how we word motions on IFTs. We can caution hospitals from accepting transports that they may not be able to care for. It is not our lane to tell hospitals what they can and cannot do re: IFTs, until we have further clarification from the federal government.

Dr. King amended the motion for CMMC to be named here exclusively. Under the setting with limited capacity, hospitals are taking care of patients that they cannot take care of.
Dr. Tilney is ok with seconding this amendment. He notes that EMTALA still governs this piece.

Mr. Bjorn stated that motion suspends the trauma system as how we had defined it. He noted that when they built the system, it was to define the hospital that you could always send a major trauma to. They would be able to receive them and take good care of them – it took all the decision-making out of it. He feels that creating

another level of a trauma center is workable, but cautioned that we should not abruptly change our recommendations. He noted that we needed to think very carefully about suddenly changing the rules because one of our Regional Trauma Systems has a big hole in it now. He noted concern of the precedent that this sets.

Dr. Rappold just joined, would like to hear the motion on the floor (joined at 14:08)
CMMC continues to be allowed to accept those trauma patients for which they have the ability to care for.

Dr. Rappold noted that he agrees with Mr. Bjorn. Concerned that we are now trying to rewrite the state trauma plan midstream and it was neither wise nor prudent.

Mr. Bjorn noted that the other thing here we needed to discuss was capacity. He noted that neither MMC or EMMC have had an issue with capacity right now that they have discussed this at their meetings. EMMC and MMC can absorb this and this is the safest approach in the near term while we figure this out.

Ms. Lebrun quoted from page 3 of the current Trauma System Operations Manual. She asked where in her plan where CMMC could not continue what they were doing, caring for patients that they have the capability & capacity to care for, while still making sure that severe/complex patients that need to get to a trauma center get there. She reflected upon with Mr. Judge said – we have a lot of need in our state to take care of patients. She noted Central Maine's area/need and its effect on the citizens who live and recreate there.

Mr. Paré noted on p. 4 of the plan, bullet 1re: the commitments of the Trauma Centers, that current Level 1 or 2 include neurosurgical services. Recalled the approach of a prior center looking to be included in the system as a Level 3 and being told no that there was not a place in the system to be a Level 3 center. Cautioned not to upend/piecemeal the system.

Dr. King noted that we should vote on our conscience and what is right for our patients. We are not asking to re-write the trauma plan but rather adapt in these times to decompress MMC, EMMC. He noted that it is not in preserving CMMC, but in preserving our trauma surgeons who are here to care for the patients. Notes that it is about the immediacy of the issues that we face.

Mr. Bjorn responded to Ms. Lebrun's question – all we can do is *recommend* as a voluntary system. The best way to articulate this was via ACS Verification Level 1 and Level 2. There is a place for Level 3 but it may not be in accepting multi-traumas. We need to admit to this – there has been a big hole blown in the western part of the state and we need to protect those patients and the system that serves them.

Mr. Judge proposes that we look at this in a more comprehensive manner and not as a standalone.

Dr. King withdraws the motion to be included in a more comprehensive motion. Dr. Tilney agrees.

Motion #3 by Tom Judge and seconded by Dr. King:

1. **TAC reaffirms its commitment to a voluntary and inclusive trauma system**
2. **TAC should immediately reconvene the Trauma Plan subcommittee to revisit the destination designations and any needed revisions.**
3. **In the interim, CMMC continues to accept differentiated trauma IFTs and continues to participate in CQI (continuous quality improvement), including TQIP, re: the transfers**
4. **Follow the guidelines as issued by the MDPB.**

Differentiated: i.e. no identifiable neurosurgical needs/the decision of the sending clinician on best place for patient and receiving physician agrees that they can manage that patient.

Discussion

Mr. Judge notes that the recommendations that we make may have significant impacts in the future.

Dr. Rappold expressed his concern that we are ignoring our current trauma plan.

Dr. Sholl commented on the concept of differentiated vs. undifferentiated patient and that it is difficult to determine. We have historically valued brevity in a work-up for haste in transport of the patient to a Trauma Center. Many times that workup is in process and not complete at the time of transfer. To differentiate a patient might require a significant amount of imaging. Differentiated to him means that we have ruled out neurosurgical emergencies- which requires significant imaging (and time).

Ms. Lachance recommends phrasing it as patients that CMMC has "capability and capacity to care for". That would leave the clinical decision-making up to the clinicians.

Mr. Judge noted that this is a conversation between the referring clinician and the receiving physician.

Dr. King noted that they are in the process of going to a Level 3. We are a Level 2 Trauma Center without neurosurgery. We should be able to accept the patients we are capable of caring for.

Dr. Rappold discussed the terms of differentiated and undifferentiated. We accept incomplete workups all the time and err on the side of rapid transit. Should we be scanning all patients prior to transfer to go to CMMC to look for occult injuries?

Dr. Ontengco notes that we are all committed to prompt evaluation and revision of the trauma plan but feels committed to the plan that we already have. There is a way for the recommendations that the subcommittee came up with and soften things to address the concerns that Dr. King brought up that does not compromise our current plan, giving us time to work on the plan and address the concerns.

Mr. Judge noted that a patient with an incomplete workup = undifferentiated trauma patient.

Dr. King noted that we are trying to define something you know when you see it.

Dr. Sholl noted that he felt we were getting closer to where we needed to be. He stated that he would feel more comfortable with more time/dialogue about this. He noted that the TAC has had a history of providing guidance to hospitals and clinicians in the workup and the transfer process around trauma. He noted that our practice has not always valued the robustness of the workup that would be needed for the undifferentiated patient to differentiate them and make sure they end up at the right place. He felt we needed to be more deliberate in what this means to be differentiated. He would offer – no matter what we do today – we need to find a way to gauge the impacts of these changes. Both positively and negatively to continually assess what the impact of the changes we make today.

Dr. Tilney reiterated that it is his responsibility, as an EM physician, to make the diagnoses/decision and for the receiving facility to determine that they are going to the right place. It is the discussion between the clinicians that is the important part re: IFTs.

Mr. Judge acknowledges Dr. Sholl's point and that part of the requirement is that CMMC maintains their quality improvement program.

Dr. King reiterates that they will and that it would be part of the requirement for Level 3 verification.

Mr. Judge added to the chat:
"Level III

A Level III Trauma Center has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations.

Elements of Level III Trauma Centers Include:

24-hour immediate coverage by emergency medicine physicians and the prompt availability of general surgeons and anesthesiologists.
Incorporates a comprehensive quality assessment program.
Has developed transfer agreements for patients requiring more comprehensive care at a Level I or Level II Trauma Center.
Provides back-up care for rural and community hospitals.
Offers continued education of the nursing and allied health personnel or the trauma team.
Involved with prevention efforts and must have an active outreach program for its referring communities."

Ms. Lebrun also noted that the trauma centers provide feedback to the transferring hospitals in our plan and this would not change.

Chairman Libby expressed a concern with the CQI/TQIP, he was under the impression that not all of the information had been received or submitted/was not available for release. He would hope that CMMC is up-to-date on all of their information. He also expressed a concern re: MEMS Board conflict of interest and noting a CMMC camp vs. others and wants to make sure that this is acknowledged.

Dr. King noted that it was not a problem with having the quality data ready and available, it was that the leadership wanted to review the data prior to its release. I am not self-interested and am thinking about the whole trauma system and how it benefits the people of Maine. We are all here to think about what is best for the state and its people.

Mr. Petrie conducts a roll call vote on Motion #3 10 Yes, 9 No, motion carries

Mr. Petrie noted that he would reconvene the trauma plan subcommittee as directed by the motion.

Mr. Bjorn thanked the group for the thoughtfulness of the conversation today.

Mr. Judge motioned to adjourn, 2nd by Mr. Bjorn.
Meeting ended at 1502h

Next TAC Meeting – January 25, 2022 at 1230h

Action summary

Member	Attendance	Motion #1	Motion #2	Motion #3
MEMS Board	---	---	---	---
Dr. Fenwick	Y	Y	*Y	N
System User	---	---	---	---
Dr. King	Y	Y	*Y	Y
Dr. Rappold	*Joined at 1400h*	*Not present*	**Not present*	N
Dr. Tilney	Y	*Dropped off call*	*Dropped off call*	Y
Dr. Nuki	*(absent)*	---	---	---
Sam Hurley	Y	Y	*Y	N
Lyndsy Gardner	*(absent)*	---	---	---
Anna Moses	Y	Y	*Y	N
Dr. Richards	Y	Y	---	Y
Joanne Lebrun	Y	Y	---	Y
Thomas Judge	Y	Y	---	Y
Chris Paré	Y	Y	**Abstained*	N
Ben Zetterman	Y	Y	---	Y
Leslie Anderson	Y	Y	---	Y
Dr. Bowe	*(absent)*	---	---	---
Mindy Gammon	*(absent)*	---	---	---
Chris Costello	Y	Y	---	Y
Dr. Sholl	Y	Y	---	N
Tammy Lachance	Y	Y	*Y	Y
Julie Ontengco	Y	Y	*Y	N
Pret Bjorn	Y	Y	*Y	N
Dr. Neilson	Y	Y	---	N
Rick Petrie	Y	Y	*Y	Y
Total	**19/23 Y**	**17/23 Y**	**8/10 Y, 1A**	**10 Y, 9 N**

*Present at December 20, 2021 Subcommittee meeting

Draft minutes submitted by Dr. Zimmerman (via notes, audio recording, and transcription) on December 31, 2021
Minutes accepted on January 25, 2022