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 14, 2021
Emergency Meeting
Meeting conducted via Zoom
MINUTES

Members Present: Rick Petrie (Chair), Tammy LaChance (CMMC), Pret Bjorn (NL-EMMC), Dr. Julie Ontengco (MMC), J. Sam Hurley (MEMS), Anna Moses (NL-EMMC), Dr. Richard King (CMMC), Dr. Matthew Sholl (MEMS), Dr. Pete Tilney (CMMC), Dr. Amy Fenwick (NL-EMMC), Dr. Joe Rappold (MMC), Joanne LeBrun (Tri-County EMS), Thomas Judge (LifeFlight), Chris Paré (Wells EMS), Leslie Anderson (Cary), Dr. Christopher Bowe (Mid Coast), Chris Costello (Mount Desert Island)

Guests: Phillip MacCallum, Dr. Norm Dinerman, Dr. Bryan Morse, Chip Getchell, Dr. Seth Ritter, Tiffany Tscherne, Dr. Alfred Riel, Dr. John Alexander, Brent Libby, Aiden Koplovsky, Anita Chadbourne, Dr. Jason Krupp, Robert Ecker, Dr. Michael Baumann, Dr. Tim Pieh, Keith Friedrich, William Montejo, Mal Meyer, Emily Boder, Chase Labbe, Paul Marcolini, Ann Marie Lattanzi, Tim Hall, Jim MacDonnell, Sheldon Stevenson, Dwight Corning, Rob Sharkey, Shawn Cordwell, Dakota Turnbull, David Guildford, Joe LaHood, Ann Kim, Sally Taylor, Ryan Haskell, Alice Gervasini, Vanessa Paolella, Terry Stackhouse, Stephanie O'Brien, Dawn Kowalski, Patty Wright, Rebecca Koerting, Anand Rughani, Dan Maselli, Susan Clough, Unidentified individuals: WGME, News Center ME, Mike S, 3 phone numbers ending in 86, 06, and 62.

Staff Present: Dr. Kate Zimmerman (Trauma Systems Manager), Marc Minkler, Darren Davis, Melissa Adams, Shannon Moss (DPS-PIO), Ron Guay, (AAG)

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 (also referred to as Trauma Center in the discussions)
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
AMS – altered mental status
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.
OLMC – online medical consult
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

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.

This meeting was conducted virtually on Zoom.
Meeting called to order by Mr. Petrie at 13:04
A quorum was present (17 of 24).
(Bold indicates decisions, normal font is discussion)

The goal for the meeting today is for the TAC (Committee) to determine how we will move forward to support our patients, our EMS providers, and our trauma institutions.

Public comments will not be taken. Meeting was recorded. Media was given permission to record.

Previous Minutes

- Tabled until next regular meeting

Dr. Jason Krupp, chief physician executive of Central Maine Health Care (CMHC) and president of Central Maine Medical Group (CMMG) was invited to speak on changes at Central Maine Medical Center regarding trauma services. Dr. Krupp stated that for the next 60 days, CMMC will have sporadic neurosurgical coverage. There will be no coverage for the remainder of December and they will only have coverage for seven days in January. After the 60 days, CMMC will no longer offer neurosurgical services for trauma. However, they will continue to be a tertiary care referral center. They will continue to offer the same surgical specialties to the community and state, with the exception of neurosurgery. CMMC will continue to have 24/7 coverage by their trauma group and orthopedic surgeons. Dr. Krupp stated that they will continue to be able to handle complex multisystem trauma patients. They will continue to follow their trauma protocols. If the patient requires neurosurgical services, CMMC will stabilize and prepare the patient for transport to a system that has neurosurgical services.

Dr. Krupp stated that they are committed to play any role that they can in supporting EMS and this Committee in caring for the patients of this state as CMMC's neurosurgical capabilities change.

A discussion on the impact and options based on the changes outlined by CMMC ensued.

Mr. Petrie stated there he saw two options in light of the current State Trauma Plan and the operations of the Committee today, as a committee of the MEMS Board:

1. Defer to the language in the state operations plan and request that the MEMS Board appoint a subcommittee
2. We will move forward as a full committee to discuss these issues and make a recommendation to the MEMS Board

Members identified the need to take up this discussion today to provide guidance and clarity to our physician and EMS colleagues. It was acknowledged that the TAC will need to consider the impact on IFT system as well as primary EMS coverage response.

Two populations that needed to be addressed were identified as:

1. Patients with clear neurosurgical emergencies and when to bypass CMMC as the priority for a clear neurosurgical case is to get them to a Trauma Center.

2. Trauma patients that do not have clear neurosurgical injuries.
    a. Is there a role for a non-Level 1 and 2 centers to screen these patients?
    b. Could we be promoting more secondary transfers?

Dr. Rappold expressed concern that making a "pitstop" at CMMC for a neurosurgical issue does not serve the patient well, puts CMMC at risk and ultimately results in bad outcomes.

It was acknowledged by Mr. Bjorn that CMMC has a role to maintain the primary stabilization like a Trauma Systems Hospital. The IFT issue should be considered and should be maintained as it is in the current Trauma System Plan.

Mr. Judge acknowledged that clarity is important, however, most of the EMS providers are common-sense driven. They know when they need to go direct to a Trauma Center vs. going to the closest hospital for management.

Dr. King emphasized that CMMC continues to provide trauma services to their community and beyond. He agreed that clarity is important, but advocated for looking at the broader impact on the system going forward as it will be quite influential to the whole care of the trauma patient in Maine, wherever that patient may be.

Mr. Petrie asked Ms. Lachance if she was ready to present the data so that the Committee can see what the impact will be. Ms. LaChance deferred to Dr. Krupp. Dr. Krupp stated in general, the number of neurosurgical cases makes up 10% or less of their trauma cases. In terms of the full scope, they are finalizing the information and will share in the short term but are not ready to do that today.

Motion #1: To discuss the CMMC announcement as the full Committee and then develop a recommendation for the MEMS Board moving forward. Motion made by Dr. Rappold. Seconded by Mr. Paré.

Discussion

Discussion ensued re: importance of beginning the discussion today, noting that there may be interim guidance and then a final recommendation once there is more data. As there is no current neurosurgical coverage, a decision should be made today for clarity for our EMS clinicians in how they behave in this situation while enacting our Trauma Plan as written.

Dr. King noted that we also need to consider context of COVID and staffing/resource shortages in the state.

Director Hurley raised a Point of Order. He notes that the discussion at this point should be limited to the motion on the floor which is whether or not we are going to have the discussion today as a full Committee.

Motion #1 Vote: Motion to discuss the CMMC announcement as the full Committee and then develop a recommendation for the MEMS Board moving forward as motioned by Dr. Rappold and seconded by Mr. Paré. 17 Yes, 0 No, 0 abstentions; motion carried.

Mr. Petrie asked the Committee to address the following question:

1. How does the loss of neurosurgical coverage affect CMMC's role as an RTC? The current Trauma Plan notes that without neurosurgical coverage, a hospital cannot function as a Level 2 Trauma Center. This would functionally place CMMC as a Level 3 Trauma Center. This would imply that CMMC cannot

receive any IFTs. It would also imply that CMMC cannot receive trauma scene calls from LFOM, depending on the distance from other RTCs, thereby affecting 911/scene-call transport.

a. Can CMMC continue to receive Trauma IFTs?
b. Can LFOM continue to transport field traumas directly to CMMC?

Mr. Judge shared his view to this question and its subparts.

1. For patients with a clear neurological injury, EMS should go to closest RTC, the fastest way needed.
2. For multi-trauma patients with Altered Mental Status (AMS), they should go the RTC.
3. If an immediate life-saving intervention is necessary, then that patient should go to closest hospital for stabilization and then allow the facility/physician to decide if IFT is needed.
4. IFT: this is a smaller group of patients. This is a physician-physician/hospital-hospital function using EMS services for transport. The IFT piece will require more data to discuss and is a secondary piece of the conversation today.

Dr. Rappold agreed with Mr. Judge and emphasized to Dr. Krupp that this is why the data is so important. He felt that the interfacility transfers to CMMC, according to the current Trauma Plan, should stop until they can be further addressed by the TAC. Mr. Bjorn agreed that trauma IFTs to CMMC should be suspended.

Dr. Sholl reminded the TAC that the presence of a neurosurgical injury could be more opaque early on and that our system has valued rapidity of transport over an extensive workup at the Trauma System Hospital. When discussing IFT transfers to CMMC in the future, we will need to have the information/data to help us make an informed decision. Recommended no IFT transfers to CMMC.

Dr. Krupp expressed his concern about the size of the group meeting today as there are subtleties in presenting/interpreting the data and he is not prepared to answer questions which address the subtleties in the data at this time. He recognizes its importance. Dr. Krupp reiterated that what we are describing today is their interruption in neurosurgical serves and that they are still certified as a Level 2 Trauma Center. They do have a gap in services and they understand where that puts CMMC in the recertification process [with ACS]. The topic today should be what we do with neurosurgical patients with an interim plan given that CMMC has not abdicated all of its trauma services.

Dr. Ontengco noted that the TAC is here to help and support CMMC and for that reason proposes that a small group convene, with input from their neurosurgeons, to dig into the data deeply.

Dr. Sholl acknowledged the desire to have CMMC maintain a footprint in the trauma system. He noted that the difficulty lays in our current Trauma Plan where we define an RTC and its role. Dr. Sholl also noted that the ACS requires neurosurgical services for Level 2 verification. Our rules state that neurosurgical services is an *essential* service to be considered an RTC. Our rules go on to further state that only an RTC can receive IFTs.

Dr. Tilney noted that he met with Ms. LeBrun and the Tri-County EMS chiefs last week. He reiterated that CMMC is able to provide trauma care. When CMMC first identified neurosurgical gap, Dr. Tilney informed the LFOM staff and identified that if there is a scene call for trauma, that would best go to EMMC/MMC. Local trauma taken to CMMC falls on the physician to decide if it will need transfer out.

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Ms. Costello asked if we have data on EMS services that bypass one hospital to go to an RTC. She noted that in Bar Harbor, they are stabilizing patients prior to transfer. Limiting who can accept transfers is really scary to her hospital. The TAC really needs to talk this out a little more. The Trauma Plan, when written, did not take into consideration the environment (pandemic) we are in. Using OLMC to help EMS decide which facility is appropriate would be helpful.

Dr. Tilney noted that CMMC can manage their local area and that should not change. CMMC has trauma surgeons who are able to manage cases. He does not see that changing. If we have to transfer out for neurosurgical coverage, then that is appropriate. The questions also revolves around the transfers coming to us from other facilities. LFOM still has a base here at CMMC and it will remain here. We need to figure out that part as well.

Dr. King acknowledged Ms. Costello's concerns. He stated that the rules were not written with a pandemic in mind, and though we still have rules to follow, we still have a crisis in this state regarding capacity. This discussion also borders on capability. We have 2 questions that we need to address:

1. Do we (CMMC) continue to accept and support the trauma mission of the state that is non-neurosurgical? Dr. Krupp noted that they do plan on treating and admitting non-neurosurgical trauma patients that arrive by 911 services.
2. What do we (CMMC) do for clarity for neurosurgical cases that are obvious for the EMS system?

Director Hurley felt that at this point, we need to discontinue IFTs to CMMC. 911 transports should still go there if they reside in the trauma catchment area, but if EMS clinicians suspect brain/spinal involvement, they should be diverted to the RTC if within 45 minutes. There may be a conversation regarding the transport time-window here. How do we capitalize on the resources of CMMC but not put the patient as risk by going to the wrong facility based on their potential injuries? We want them to be able to take field traumas, and support their mission to their community.

Dr. Sholl continued to affirm the role that CMMC has in trauma, especially ground-based 911 transports. He recommended that the TAC lean into the current Trauma Plan. He noted the need to recognize CMMC's historic stature in the Trauma System and their current capabilities and the need to maintain the current Trauma Triage Guideline (Maine EMS Protocols) and follow the remainder of the Trauma Plan as written.

Discussion re: Maine General being able to accept transfers from their Waterville campus.
Discussion re: possibility of accepting single-system ortho trauma.
Discussion re: capacity of the system and how CMMC could contribute if EMMC or MMC were unable to accept trauma patients due to capacity.

Mr. Bjorn noted that RTCs do not refuse trauma patients. They can negotiate for single system injuries e.g. – delay transfer, defer or talk about having them go to another hospital. The system has worked well for generations. It is important that those neuro patients do not get missed and that they do not present to a facility that cannot treat them. The need to move them secondarily to an RTC would take an EMS agency from primary response area and potentially leave a community uncovered.

Director Hurley stated Level 1 and 2 Trauma Centers should be the receiving facilities for all IFTs. If the receiving physician feels that the patient could go somewhere else, they can offer that option, but the RTC should be the first to triage and help make that decision.

Dr. Bowe noted that the key question is at the original point of transfer. If the patient is undifferentiated, then that patient needs to go to a Trauma Center vs. a patient who had trauma but was seen at the local ED who has ruled out a neurosurgical injury. That patient may still require transfer, but not for neurosurgical care. Now the Trauma System Hospital needs to find an accepting facility who can manage the specific injury(ies). There may be other hospitals with capability and available beds that should be able to take that patient with known specific injury vs unknown/potential/undetermined injuries.

Dr. Sholl noted that Dr. Bowe's question makes intuitive sense but that this group has argued against this rationale, historically favoring rapidity of transport vs. the workup. In some cases, there can be partial or incomplete workups, even in case that Dr. Bowe described. That is what drove the group to move away from other hospitals taking trauma IFTs. We should, though, look at this question. We likely cannot come up with a definitive answer today regarding this but may have value in an interim decision today then we will have a detailed dive into this as we go forward to develop a more definitive plan that is more completely informed. Dr. Sholl recognized that parts of the plan may not apply anymore, but would recommend that we follow it now, with a plan to revisit in the future.

Motion #2: Rappold motions that we convene a small subcommittee determined by Dr. Zimmerman and Mr. Petrie to meet with CMMC group to look at data, followed by another emergency meeting of the TAC.

Dr. Sholl stated he would second the motion if we affirm the position of Trauma Plan to halt IFT until this Committee can make a recommendation to the TAC and EMS Board to make sure that patients are having a timely arrival at the most appropriate place. Dr Rappold agreed to this friendly amendment.

Motion #2 with amendment: To convene a small group to review the data with Dr. Krupp / CMMC and then with follow up with the full TAC at an emergency meeting to discuss the data and a plan moving forward. In the interim to immediately implement the Trauma Plan as it stands right now in terms of IFT by Dr. Rappold, 2nd by Dr. Sholl.

Discussion
Dr. Fenwick is concerned regarding IFT and what this will do to the system. There are some things CMMC should be able to cover. She does not agree that CMMC could not take some IFTs.

Mr. Judge would like to see us make these decisions with data. He stated that he remains in favor of his prior recommendations. He added that he would like to hold on other discussions as we may undo these decisions a week from now. It is clear that neurosurgical patients should not go to CMMC but not so clear on other patients.

Ms. LaChance felt we need data regarding who should come for IFT especially where beds are limited and trying to keep patients near their families. Another thing to consider is how hard it is to turn off these messages once we turn them on. She agreed that we need good data for this decision.

Dr. King noted that there are two separate issues. 1. Obvious multi-system trauma that needs to go to an RTC, 2. Issue of capacity of the hospitals. We know that the small hospitals are desperate, and capacity is a major factor.

Dr. Bowe noted that if current rules say no IFT now, it seems as though we should follow our current rules and only adjust if there is data supporting this which I think is the intent of the motion.

Dr. Rappold agreed that we need data to look at the implications and our intent is not to just keep changing our decision, but can we put it on hold until we get the data? For all discussions?

Mr. Petrie asked Dr. Rappold if he was changing his motion to put any changes on hold until the data is looked at and the subcommittee reviews and presents to the TAC?

Dr. Rappold stated that he was.

Mr. Petrie addressed Dr. Sholl who had seconded the original motion. Dr. Sholl noted that there is a sense of urgency and acknowledged the messaging and the complexities of this, but that we have a current plan that clearly lays out the steps of this. He noted that he was fine with taking steps to deliberate with data and have more conversation, but that the statement should come out of current plan. He does not want to alter the motion.

Mr. Petrie acknowledged that Dr. Sholl did not wish to alter the motion and asked if there was anyone willing to 2nd Dr. Rappold's changes.

Director Hurley called for a Point of Order noting that the motion on the floor needed to be voted on as is. At that point, Mr. Petrie raised concern that there may be information from the State Hospital Licensing Board that would be relevant to the discussion on the floor. Would not allowing CMMC to accept transfers that they are capable of treating put them at risk of EMTALA violations?

Director Hurley recommended that the Chair invite Mr. Bill Montejo (DHHS) to speak to this concern.

Mr. Petrie asked Dr. Rappold if he would be willing to withdraw his motion so that Mr. Montejo could speak.

Motion #2 withdrawn: Dr. Rappold withdraws his motion so that Montejo can speak. Dr. Sholl withdraws his second.

Mr. Bill Montejo (Director, Division of Licensing & Certification, DHHS) was recognized by the Chair. Mr. Montejo wanted to make the Committee aware of the federal regulations of EMTALA. He places the regulation in the chat:

- §489.24(f) Recipient Hospital Responsibilities: A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at §412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual

He noted that the regulations do not specify designations when it comes to trauma facilities, but they do indicate that when there is need for a transfer, a receiving hospital that has specialty capabilities and the capacity must accept a patient that needs those capabilities and capacity from a sending facility that does not (i.e. a rural hospital that does not have ortho and has a patient with fractured hip). CMMC would not be able to refuse that transfer if they have capability and capacity. You could be inadvertently opening that hospital up to EMTALA violations.

Dr. Ontengco asked CMMC when the data would be available.

Dr. Krupp noted that it would be available in the next couple of days however he would like to look at this in a smaller group of TAC members than what is convened today.

Director Hurley noted that the TAC could have a subcommittee look at the data, but it will have to be a public meeting as this is a statutorily defined committee and work.

Dr. King noted that the data needs to be regarding the neurosurgical patient. He also noted that the discussion needs to be what it means to be a Level 2 vs. Level 3 Trauma Center. The data becomes important when

looking at the capacity of MMC/EMMC accommodate the other hospitals, and do if need a Level 3 designation to make this work.

Dr. Sholl noted that what is challenging is that we have a significant change in our system in that one of our Level 2 Trauma Centers is now effectively working as a Level 3. Our plan does not currently acknowledge Level 3 Trauma Centers. He noted that he is appreciative of the options and potential reliance on a Level 3 Trauma Center, but we have a binary plan right now with the defined RTCs and TSHs. He reminded the TAC that in their prior conversations re: potential Level 3 Trauma Centers that the TAC has fallen back to and re-affirmed the current Trauma Plan as is.

Motion #3: Motion by Mr. Judge

1. **MDPB to issue clear direction to the EMS system regarding single-system neuro and multi-system trauma with AMS, and those needing life-saving immediate intervention.**
2. **No neurosurgical trauma should arrive at CMMC on an IFT basis**
3. **The three trauma centers will work together on data and come up with a collaborative recommendation to the TAC and then we can look at this recommendation and discuss.**

Second by Dr. Fenwick.

Discussion

Mr. Bjorn asked the Chair to repeat the motion.

Mr. Petrie repeated the motion as:

Motion #3: Motion by Judge that

1. **MDPB will provide clear direction to the EMS providers on their decision-making for the transport of trauma patients; and**
2. **CMMC will continue to receive inter-facility transfers unless there is a neurological/neurosurgical piece to it; and**
3. **The three trauma centers to come together to develop a longer-term plan for interfacility transfers that will bring back to this committee in two weeks.**

Mr. Judge confirmed the repeated motion.

Dr. Bowe asked for clarification regarding the second part of the motion. It stated that rather than follow the current Trauma Plan in place, we would send trauma IFT to CMMC, and break from the plan without data in advance?

Mr. Petrie confirmed.

Motion #3 Vote: 10 Yes, 7 No, 0 abstentions; motion carried.

Mr. Petrie noted that there will be a TAC meeting 2 weeks from today and prior to this meeting, the Trauma Centers will need to meet to review data and make recommendations to the TAC.

Ms. LeBrun noted that the MDPB is meeting tomorrow and asked to get the first part of the motion on the Agenda. Dr. Sholl confirmed that he has discretion and can add it to the Agenda.

Motion to adjourn – Mr. Bjorn, 2nd by Ms. LeBrun

Meeting adjourned at 15:11

Next TAC Meeting – December 28, 2021 at 1300

Judge - sends his language in email/chat to Mr. Petrie for the motion #3 (above)

Motion Language from #3 (above):

1. **MDPB issue guidance to EMS clinicians for transport decisions to closest Regional Trauma Center with neurosurgical services:**
   a. **Trauma patients needing immediate life-saving interventions and stabilization.**
   b. **Single system neuro trauma patients.**
   c. **Undifferentiated trauma with altered mental status**
2. **Neurosurgical trauma will not be transferred to CMMC**
3. **TAC will request small committee to review data from CMMC and encourage the TC's to review data and convene a secondary meeting no later than 2 weeks to make recommendation to Board regarding interfacility transfer.**

Votes on motion summary

Member	Attendance	Motion 1	Motion 2	Motion 3
Dr. Sholl	X	Y	---	N
Dr. Fenwick	X	Y	---	Y
Stephanie Joyce	*(absent)*	---	---	---
Dr. King	X	Y	---	Y
Dr. Rappold	X	Y	---	Y
Dr. Tilney	X	Y	---	Y
Dr. Nuki	*(absent)*	---	---	---
Sam Hurley	X	Y	---	N
Lyndsy Gardner	*(absent)*	---	---	---
Anna Moses	X	Y	---	N
Dr. Richards	*(absent)*	---	---	---
Joanne LeBrun	X	Y	---	Y
Thomas Judge	X	Y	---	Y
Chris Paré	X	Y	---	N
Ben Zetterman	*(absent)*	---	---	---
Leslie Anderson	X	Y	---	Y
Dr. Bowe	X	Y	---	N
Mindy Gammon	*(absent)*	---	---	---
Chris Costello	X	Y	---	Y
Tammy Lachance	X	Y	---	Y
Dr. Ontengco	X	Y	---	N
Pret Bjorn	X	Y	---	N
Rick Petrie	X	Y	---	Y
Dr. Neilson	*(absent)*	---	---	---
Vacant (Maine EMS Board)	---	---	---	---
Attendance / Vote	**17/24**	**17 Yes / 0 No**	**Withdrawn**	**10 Yes / 7 No**

Minutes submitted by Minkler (via notes, audio recording, and transcription) on December 20, 2021
Minutes accepted on December 28, 2021

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