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 WORKGROUP
December 20, 2021
Special Workgroup 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. Amy Fenwick (NL-EMMC), Dr. Joe Rappold (MMC), Chris Paré (Wells EMS)

Guests: Phillip MacCallum, Dr. Seth Ritter, Tiffany Tscherne, Dr. John Alexander, Dr. Jason Krupp, Emily Bader, Paul Marcolini, Ann Kim, Dr. Elbert White, Jason Cooney, Michael Tayler

Staff Present: Dr. Kate Zimmerman (Trauma Systems Manager), Marc Minkler, Darren Davis, Jason Oko

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 13:07

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.

This was a work group meeting only. No other business was conducted.

The goal of the meeting was for the TAC subcommittee workgroup to learn more about the trauma data from Central Maine Medical Center as directed by the full TAC committee on 12/14/21 and to provide a recommendation to the TAC for the 12/28/21 meeting and Maine EMS Board of how we will move forward to support our patients, our EMS providers, and our trauma institutions.

Public comments were not taken. Meeting was recorded.

Dr. Richard King and Tammy LaChance (CMMC Trauma Program Manager) presented data on their neurosurgical volume for CMMC based on a 5-year. This data was emailed to TAC members and shared on screen for the discussion (*copy of data attached as a one-page pdf to these minutes*). Dr. King spoke on the data and noted that the volume of the neurosurgical trauma is relatively low, especially when compared to other Level 2 Trauma Centers, and noted that this was the impetus behind the decision not to continue with their neurosurgical trauma service.

Mr. Petrie stated that it appears that 25% of total trauma call volume involve neurosurgical consult (15% from IFTs and 10% of scene trauma calls).

Mr. Bjorn noted that looking at the numbers the volume that would be lost to CMMC due to de-verification, would be 25% overall and that it appeared like the majority 108/180 would be neurosurgical consults.

Ms. LaChance noted that the overall volume loss would be at least the 180 IFTs and 58 LFOM scene calls. She noted that as it were now, many EMS services transporting from a scene bypass other hospitals, if they are within the 45-minute radius of CMMC as an RTC. The 45-minute radius would go away if CMMC were not a Regional Trauma Center, and some of those patients would go to the closest hospital that were previously bypassed, as they would be outside the 45-minute radius to MMC or EMMC. CMMC does not have the exact number of these and would have to dig into EMS patient care reports to see where the scene was and if another hospital would have been closer and thus not have been transported to CMMC – this would potentially change the "From Scene By Ground" number.

Dr. King voiced that one of his concerns is that other hospitals do not have the trauma experience that CMMC does and those hospitals may not want to have those patients at their facility, yet CMMC would be considered the same level of trauma system hospital as St. Mary's or Stephens Memorial Hospital.

Director Hurley noted that in January of 2020, the TAC spoke against Level 3 hospitals being a destination for trauma transfers, and now that CMMC is functionally a Level 3, is it time to revisit this? Maine General had previously submitted their application as a Level 3 and it was not approved as an RTC. Can the system absorb this volume of patients (previously seen at CMMC) into the 2 remaining RTCs?

Dr. Rappold asked Dr. King and Ms Lachance, of the numbers presented, if she had a sense for how many might go to MMC vs EMMC so that he could better understand impact and potential workload on those RTCs.

Ms. LaChance stated that she thinks the majority would go to MMC, as most are pretty far from the EMMC catchment area, both by ground and air.

Dr. Rappold calculated that there would be approximately 250 to 300 additional polytrauma patients coming to MMC, and of those approximately 25% will need a neurosurgical consult. He would like to have Dr. White contribute to this discussion with the Chair's approval.

Mr. Petrie recognized Dr. White, neurosurgeon at Maine Medical Center.

Dr. White felt that this seems to be about a 15 consults per month increase, and that MMC could handle this, with probably 20% being surgical. The challenge would be beds and OR space which is at a premium with the effects of the COVID pandemic.

Dr. Rappold felt that MMC would be able to handle this increase in patients.

Dr. Ontengco noted thus far in this period of time without neurosurgical capabilities at CMMC, that they (MMC) have handled the increase of incoming patients well.

Dr. Zimmerman asked Ms. Lachance if she had a sense of the volume of neurosurgical consults transferred out?

Ms. LaChance noted that she did not, but could find that if needed. She noted that a lot of the transfers out were pediatric, facial traumas, and burns and that the majority of any neuro transfers would be due to spinal injuries as their locums neurosurgeons did not always cover spine.

Dr. Ontengco noted that she and Ms. Lachance have collaborated over the years and that in the past year MMC has received 44 trauma patients from CMMC This closely matches the number of transfers out from the data presented.

Mr. Petrie clarified that this data did not include fractured hips from standing height falls in patients over 65 (as noted at the bottom of the table),

Ms. LaChance noted that was correct, and with a recent change in trauma registry, these will be included in future data. The data does vary year to year based on trauma registry requirements, so hence the average presented better picture overall.

Director Hurley asked what the trauma volume trend has been over the past five years e.g. is it rising?

Ms. LaChance noted that it seems to be in the middle right now. COVID did not really affect trauma for them over the past 2 years. It was a bit lower for the years before COVID.

Dr. Zimmerman raised a question about the denominator used in the calculation for percentage of neurosurgical consults (both transfers in and scene). She noted that the total number of trauma patients was used instead of the total of each type of transport. As an example, the data listed neurosurgical consults for IFTs as 15% (108/720) when it was actually 60% (108/180) of IFTs had neurosurgical consults.

Ms. LaChance noted that it was easier by using the total numbers for everything to compare, but yes, that would be correct. She noted that there were many of ways to present the data, but the percentage of the whole seemed best. There is also some overlap of these patients due to multisystem trauma.

Mr. Petrie opened the floor for TAC subcommittee members to work on a recommendation for the TAC meeting next week of how to move forward given the changes at CMMC.

Mr. Bjorn noted that CMMC cannot be a Level 2 Trauma Center anymore, and they need to be de-designated as an RTC. However, the TAC needs to preserve their volume and access to their surgeons and will need to rewrite our statewide Trauma Plan to accommodate this. EMMC has been working with hospitals to carefully select appropriate destinations, and although he was not sure that a Level 3 Trauma Center was the answer for RTCs, we need to look at less acute injuries that may be suitable for smaller hospitals.

Dr. Rappold agreed with Mr. Bjorn that need to rewrite the Trauma Plan, but in the short term we need to follow the existing Plan.

Dr. King agreed in principle with Mr. Bjorn, but he notes that (1) the wider question is that we ensure that patients get to the right place with the right capability and capacity and that (2) We need to expect a surge in COVID in the coming months and plan to preserve capacity and how CMMC can help with this.

Dr. Rappold felt that we need a multiprong approach and a multifactorial recommendation for the TAC starting with a declarative statement of what CMMC is currently capable of, followed by an intermediate plan for undesignated trauma IFTs and LFOM patients followed by a revision of the state Trauma Plan.

Mr. Petrie summarized the discussion into the following recommendation:

1. Continue to follow the current Maine State Trauma Plan as written,
    a. Following guidance from MDPB regarding field transports to a Trauma Center,
2. CMMC will not be able to accept IFTs of trauma patients,
3. LifeFlight of Maine will not be able to transport undifferentiated trauma patients to CMMC,
4. Local ground EMS services outside of the 45-minute radius to an RTC (MMC and EMMC) can still transport to CMMC for initial management and stabilization.

Director Hurley enters the recommendation into chat:
The sub-committee recommends to the Maine TAC the following:
-- Immediate enforcement of the Trauma Plan that is currently adopted and in force;
-- Discontinue all trauma-related interfacility transfers inbound to CMMC
-- Ensure that all LFOM transfers are discontinued to CMMC
-- Direct the plan sub-committee to immediately begin work on revising the trauma plan

Ms. LaChance asked about options to accept IFTs from Bridgton and Rumford Hospitals and clarity on this. Mr. Bjorn asks if they are part of CMHC. Ms. LaChance states they are but they are different hospitals unlike Maine General which is all one hospital with different campuses.

Director Hurley cannot address that question but noted that the would like to make sure that the Trauma Plan revision is a top priority to see what options there may be to improve the plan and address these changes. We need to use the current Trauma Plan, but also then take a step back in developing improvements in the State Trauma Plan. Mr. Bjorn agreed.

Dr. Ontengco offered that with the capabilities that CMMC will still have, we can explore repatriation of patients back to CMMC once the acute phase of the trauma management is over to help with capacity and CMMC's role .

Dr. Zimmerman agreed with Mr. Bjorn and Director Hurley, and noted that once these meetings are done, they will to start working on the Trauma Plan revisions.

Dr. King asked a question about the immediate catchment area of CMMC and St. Mary's Hospital and local EMS. Is CMMC still the preferred center for trauma in the Lewiston area?

Dr. Zimmerman - The MDPB made recommendation on this and discussed destinations for EMS with multi-trauma and produced a bulletin for guidance (https://www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/2021121601-Clinical-Bulletin-Trauma-Care-at-CMMC.pdf). Director Hurley places link in chat as well.

Discussion regarding the fact that Maine General has the option to transport patients from the Thayer campus (a free-standing ED under the same hospital license as ME Gen Med Augusta) to the Maine General Augusta campus, if within their capability. Does this apply to CMMC with Bridgton and Rumford? Dr. Ontengco believed that because Maine General has two campuses licensed as one hospital that it is not the same with CMMC and their affiliate hospitals.

Mr. Bjorn stated that he believes that CMMC is capable of deciding who should be transferred from their community hospitals to them vs. an RTC.

Dr. King stated that he strongly supports their ability to accept patients within their own healthcare system. He reiterates that they have the capability to decide what can safely come to CMMC from their own hospitals. Notes they share the same EM Physicians and EMR.

Ms. LaChance noted that of the IFTs coming in to CMMC, about 75% of those are from Bridgton and Rumford.

Mr. Paré noted that the in-system IFTs model is also replicated in the York hospital system with their free-standing ED in Wells and SMHC with their free-standing ED in Sanford– it shouldn't need to be any different for CMHC

Dr. Fenwick asked if CMMC considered Level 3 ACS verification.

Dr. King responded that leadership has supported CMMC in seeking ACS Level 3 verification and they are committed to being a Trauma Center minus neurosurgery and maintain a role within the state Trauma Plan

Mr. Bjorn noted that even if CMMC became a Level 3 Trauma Center, it wouldn't change the state Trauma Plan which only uses Level 1 and 2 as RTCs. It does show a commitment to the system and it may be a factor in future changes to the Plan for CMMC and other hospitals seeking to be Level 3 Trauma Centers.

Motion #1 by Dr. Rappold 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, and
4. TAC should immediately reconvene the Trauma Plan subcommittee to revisit the destination designations and any needed revisions.
2nd by Mr. Bjorn

Discussion

Dr. King respectfully disagreed and stated that CMMC should be able to accept patients from their own hospital system. He requested that we expedite this decision in the Plan revisions.

For clarification, it was noted that today's decisions are recommendations that will be brought forth to the TAC at next week's meeting. Until then, CMMC will continue to operate as per the decision of the TAC at the 12/14/2021 meeting including accepting trauma IFTs without the need for neurosurgical consult.

Mr. Petrie conducts a roll call vote on Motion #1 8 Yes, 1 No, 1 Abstention, motion carries for recommendation to TAC

Mr. Petrie will forward the recommendation to the TAC for the meeting on 12/28/21

There was no motion to adjourn
Meeting ended at 14:12
Next TAC Meeting – December 28, 2021 at 1300

Action summary

Member	Attendance	Motion #1
Dr. Sholl	*(absent)*	---
Dr. Fenwick	X	Y
Stephanie Joyce	*(absent)*	---
Dr. King	X	N
Dr. Rappold	X	Y
Dr. Tilney	*(absent)*	---
Dr. Nuki	*(absent)*	---
Sam Hurley	X	Y
Lyndsy Gardner	*(absent)*	---
Anna Moses	X	Y
Dr. Richards	*(absent)*	---
Joanne LeBrun	*(absent)*	---
Thomas Judge	*(absent)*	---
Chris Paré	X	Abstain
Ben Zetterman	*(absent)*	---
Leslie Anderson	*(absent)*	---
Dr. Bowe	*(absent)*	---
Mindy Gammon	*(absent)*	---
Chris Costello	*(absent)*	---
Tammy Lachance	X	Y
Dr. Ontengco	X	Y
Pret Bjorn	X	Y
Rick Petrie	X	Y
Dr. Neilson	*(absent)*	---
Vacant (Maine EMS Board)	---	---
Attendance / Vote	**10/24**	**8 Yes / 1 No / 1 Abstention**

Draft minutes submitted by Minkler (via notes, audio recording, and transcription) on December 21, 2021
Minutes accepted on December 28, 2021