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 WORK GROUP
January 21, 2022
Meeting conducted via Zoom
MINUTES

Members Present: Rick Petrie (Chair), Sam Hurley (MEMS), Thomas Judge (LFOM), Dr. Matthew Sholl (MEMS), Tammy Lachance (CMMC), Pret Bjorn (NL-EMMC), Dr. Julie Ontengco (MMC), Dr. Richard King (CMMC)

Guests: Phil MacCallum, Dr. Norm Dinerman, Dwight Corning

Staff Present: Dr. Kate Zimmerman (Trauma Systems Manager), Marc Minkler

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 workgroup was conducted virtually on Zoom.
Workgroup called to order by Mr. Petrie at 12:06pm

Mr. Petrie asks if all workgroup members have received the working draft for this project discussed last meeting for modifications to the Maine EMS State Trauma Plan. Dr. Sholl and Dr. Dinerman worked on this draft document to build off the last meetings work and the efforts of Mr. Bjorn and the workgroup discussion.

Drs. Sholl & Dinerman express important aspects in the development of the document as:

- Not all users of the document may not know all the verbiage and details of the levels of trauma care that TAC members are used to, and to make a user-friendly document with guidance and the difference resources of levels of trauma centers was key.
- Minimize secondary transfers as trauma destinations are considered.
    - Goal should be to an ACS Level I or II trauma center.
    - There may be circumstances for transfer to an ACS Level III, but that it is a thoughtful process with consideration of avoiding subsequent secondary transfers.
- Use of the Rural Trauma Team Development Course decision tree is highly recommended.

Discussion on the document included:

- Mr. Bjorn states that perhaps neurosurgery being listed may be too restrictive, as this could be applicable to the loss of any service that results in de-verification by ACS.
- Mr. Bjorn also expresses concern about distances and times in the hemodynamically unstable patients transfer if this bypasses a Level III hospital. Dr. King concurs and expresses that sometimes secondary transfers will be necessary to ensure stabilization in those patients via general surgical services at a Level III that is closer in distance/time.
- Mr. Bjorn expresses that bypassing general surgery to get to neurosurgical services may result in increased mortality.
- Ms. LaChance states it would be helpful to have three categories in the plan – the existing ACS Level I and II, non-ACS verified hospitals (Trauma system hospitals), and then add an ACS Level III category. There is potential harm is a patient bypasses a hospital with surgical capability and is closer than a Level I or II hospital.
- Dr. Ontengco is concerned about comparing Level I or II to Level III as there is a big difference.
- Dr. Sholl re-emphasizes importance of undifferentiated patients should move to a regional trauma center. It has been the standard in Maine, and we need to continue to aim for that. There is a contingency in this document that if the transferring physician believes that time is of essence and neurosurgical is not a concern to move the patient to a Level III facility. We need to ensure the patient receive the same standard of care across the state and equitable access.
- Mr. Petrie speaks of concerns for EMTALA violation possibility and that a sending facility needs to find the closest facility to fix the hemodynamically unstable patient, even if level III.
- Dr. Dinerman states that this document does do this and sets the goal to go to a Level I or II but that in absence of neurosurgical issue, the patient could go to a Level III, if unstable.
- Dr. King speaks of the large population base in Lewiston/Auburn and CMMC can handle surgical needs rather than the distance of transport to MMC or EMMC. The key is to communicate. Concern is ground transport within this catchment area of high population and time to an OR.
- Dr. Sholl agrees that figuring out the language around this is key, and that the plan does have a place for Level III trauma centers and the possibility of transfer to that facility based on the patient condition, and this document does account for that.
- Mr. Bjorn states a plan that bypasses a level III if the patient is unstable is not preferential and that there are trauma plans in other states that incorporate Level III services.
- Dr. Sholl states that we are close that and we need to aim for Level I or II but allow for selected unstable patients to go to Level III after suitable evaluation and have a clear carve out for what meets the standard.
- Mr. Bjorn states our system has existed with three trauma centers and our state no longer has that and we need to rewrite the whole plan to address this and that CMMC should try and achieve ACS level III as soon as possible. Dr. King states that leadership at CMMC is moving towards this.
- Dr. Ontengco states that this document will have a long length, and that we cannot predict how the system will grow and evolve. One challenge may be that if a level II exists close to a Level III, the

patient being transferred would be better served by the full spectrum of care at a Level II even if just a few miles further than a Level III. What would happen in that situation and should this plan address this from a higher perspective. Level III is a different level. Mr. Bjorn states that a Level III is still held to having a surgeon within 30 minutes. Dr. Ontengco states concern about making a long-lasting document and not just thinking of the situation with CMMC.

- Dr. Dinerman suggests some word smithing to perhaps improve the document for these considerations, discussion around this by the group.
- Dr. King wants to change language to bring unstable patient to closest Level I,II or III trauma center. Dr. Sholl is concerned that the capabilities of these facilities are not the same and we need to recognize this. Dr. King state is that in terms of surgery, they are. Concern is that transport time in the bleeding unstable patient could result in mortality by bypassing a level III. Drs. Sholl and Dinerman state the document does allow for this and be cognizant of the goal of sending patients to Level I or II, but the individual situation may need a level III if both the sending and receiving physicians are in agreement of this.
- Dr. King is concerned about EMTALA considerations about getting a call as a Level III and if they do not accept the patient (which he states they would) and ramifications of this. Mr. Bjorn points out that EMTALA does not activate unless the facility actually receives a call and then declines a patient after getting this request, and this document prevents the call from even occurring with inappropriate requests and guides the transfer request call to the appropriate facility and Dr. Sholl states that this helps guide the physicians for EMTALA concerns and protects them.
- Dr. King is concerned about EMTALA if other trauma centers have been consulted or not and if he has that info. Mr. Petrie seeks clarification on this question, Dr. King rephrases if the Level III trauma center surgeon makes the determination to accept the patient if they do not know if a Level I or II has been consulted or should have been. Mr. Petrie states that the discussion between sending and Level III surgeon is based on capability of that facility to receive the patient, not if they should. Dr. Zimmerman states that this needs to occur to have physician-to-physician discussion for EMTALA and to help avoid secondary transfers to a Level I or II. Dr. Sholl states that this document helps with some sending physicians who may not be as nuanced on the differences of Level I, II or III centers and this document helps with some education on this.
- Ms. LaChance is concerned that the document states a sending physician to contact a Level III but no guidance to have to do this for a Level I or II and is ok to call the Level III first. Dr. Sholl states that this is legacy language and concern about what Level III services exist at that time or for that specific condition (e.g. burns vs. ortho). He states he can clarify this a bit in rewording.
- Ms. La Chance asks if it is always a surgeon who accepts a patient. Dr. Dinerman and Dr. Ontengco state that generally yes, but occasionally an ED physician may have to substitute for the time (e.g., the surgeon is mid-surgery in the OR).
- Mr. Judge expresses concern if this adding complexity to the plan and potential resulting confusion.
- Dr. Dinerman states that adding if the Level III is the more proximate hospital to have that discussion to give Level III the opportunity to accept or decline based on the particular presentation, but not obligate them if the condition exceeds the Level III management capabilities. Dr. King feels that he would accept any patient, and this complicates it – he does not need any information to make this decision and calling just complicates this.
- Dr. Ontengco states MMC would also just accept this patient but have clear comprehensive resources as a Level I.
- Mr. Petrie restates the word changes and seeks input and comfort on this. Dr. King states he is not, and states unstable patients need to not preferentially go to level I or II but to closest ACS verified (of any level) hospital with a surgeon, who is close to the hospital and is comfortable/experienced with trauma. Mr. Judge concurs.

- Mr. Petrie updates wording, Dr. Sholl believes this is now not something he supports. Dr. Zimmerman rewords, and discussion ensues.
- Mr. Bjorn suggests seeking a 3rd party ACS experienced reviewer. Dr. King supports an outside objective review of the state trauma plan. Mr. Bjorn states that perhaps starting with the paragraphs being reviewed today. Mr. Petrie asks for groups thoughts on this, Dr. Sholl states a full evaluation may not be possible due to cost and time, but if someone such as Dr. Rob Winchell may be a good resource due to Maine and EMS system familiarity if he is willing. Dr. Ontengco concurs. Mr. Petrie suggests sending to both Dr. Rob Winchell and Dr. Kristen Sihler, some concern about rationale for two, recommendation is to have Mr. Petrie and Dr. Zimmerman reach out to Dr. Winchell to review if willing, and then Dr. Sihler if he is unavailable.
- **ACTION: Mr. Petrie and Dr. Zimmerman will reach out to Dr. Winchell to review if willing, and then Dr. Sihler if he is unavailable, and report back to the group.**
- Mr. Petrie reads updated draft language, continued discussion on this ensues.
- Dr. Ontengco states that it feels that more discussion is warranted, and this meeting is already extended past end time of 1-hour meeting, and further meeting/discussion is warranted. Mr. Petrie apologizes for extending meeting, suggests meeting Monday January 24 at 11am to continue, due to the scheduled full TAC meeting on January 25 and need to present this info at that meeting. Workgroup agrees and notice will be sent out today.

Workgroup ended at 1:36pm

Next Workgroup Meeting - January 24, 2022 at 11:00-12:30pm
Next Full TAC Meeting – January 25, 2022 at 12:30

Draft minutes submitted by Marc Minkler (via notes, audio recording, and transcription) on January 26, 2022
Minutes accepted on April 26, 2022