STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES

Trauma Prevention & Control Committee
Date October 16, 2018
9:30-12:00pm

MINUTES

Chair: Murray (absent)	**Staff:** Zimmerman, Don Sheets	
Members: Rick Petrie, Nate Morse, Lyndsy Bragg, Gail Ross, Comfort Hines, Guy Nuki, Matt Sholl, Tammy Lachance, Pret Bjorn, Norm Dinerman (phone), Anna Moses (phone), Amy Fenwick (phone)		**Guests:** HR Nanda Kumar

Agenda Item	Discussion	Action Items
Welcome & Introductions 0930h	Geno Murray unable to attend due to weather/trees down	
Approval of July 24, 2018	Motion by Petrie; Second by Hines; passed	
Membership	2019 Chair: Rick Petrie nominated by Bjorn & accepted. Petrie only nomination, committee opted to bypass the vote given no opponents. Rick Petrie is the new chair. Thank you, Geno Murray for your service; Geno will continue to serve as the System User. Motion to accept the following positions by Petrie, second by Bjorn: Passed Small Hospital Administration: Guy Nuki, MD Trauma Surgeon – Richard King, MD (CMMC Director) Rural Health CDC – Nathan Morse Injury Prevention CDC – Sheila Nelson EMS-C Coordinator – Marc Minkler MGMC EM Physician – Gwen Downs, MD	Zimmerman to send updated list to Petrie with contacts as well as list to MEMS.

Trauma Coordinator Team Update	• Trauma Coordinators, Petrie and Zimmerman met on the phone at the end of September. • MCOT meeting Wednesday November 7, 2018 at the Samoset Resort – please get the word out and pass along the flyers to your staff/EMS. There will be a focus on MCI. • EMMC is now *Northern Lights* (new branding): note that their neurosurgery coverage has improved; received a second grant from Rural Health for *Stop the Bleed* & and have kits available to those who want to teach. State data bank – approved by EMMC legal, IT and compliance approved, now waiting for MEMS. • CMMC: Dr. Richard King has arrived and is their new trauma director. He is anxious to join the group and is hoping to come to MCOT. They are working on injury prevention with "Matter of Balance" which is a one-day course. Their ACS review is in 2 weeks and after this has been completed, will be ready to make a move to switch to the state data bank for trauma. • MMC: Just had 2 ATLS courses (9th edition) last month.	Zimmerman to forward the flyers for MCOT
MDPB Update	2019 Protocols – Green Section: • Reviewing parameters around TBI – question arose if we considered hypertonic saline in the treatment of herniation, opted not to as many hospitals use mannitol, and EMS has goals around end-tidal CO2 in the field. • Burns (discussing with Dr. Carter @ MMC) – there may be a more simplified approach the 9-10-11 20/30 rule. • Crush Injury – looking at the National Model Guidelines put out by NASEMSO as there is little consensus on what to do with these patients. Consider adding $CaCl_2$ or Ca-gluconate. • Facial trauma – adding dental and ophtho here (ophtho is currently in Yellow Section); • Dinerman brings up destination decisions re: amputations that are not crush injuries i.e. destination for microvascular surgery – the logistics of flying these patients to Boston is something to be considered from a resource utilization/time and salvage of the limb. Could use help with this. Consider adding this to crush protocol. Would require a field decision to bypass trauma center in Maine to go to Boston –this was felt to be a decision best made at the centers. • Dosing of TXA discussed – will continue to rest on the evidence that we have (CRASH-2) and MATTERS and will be open to transition as the literature changes.	IRB/MOU from MMC to look at TXA use

	Dr. Sholl presented the current use of TXA since the protocol went live. Discussion: Concern as to patients who have received TXA as being identified as such (at the accepting ED or transferring ED); are the second doses being given? Are we missing patients with the current inclusion criteria? Should we consider *potential for shock* as an indication? MMC will be looking to do a study re: use of TXA in Maine. We will look into pediatric indications/use as well gyn/post-partum bleeding. Rick: there should be education around the use of warm IV fluids	
Technical Assistance Program/RTTD	PenBay – difficulty finding a time- pushed back until January (hospitalist/surgeon) Calais, DECH, Inland - CALS Discussion – Nuki prefers this as to the RTTD; would like to discuss. Rumford is interested CALS discussion: see attached presentation. • Trauma module – ½ day • Stop the bleed • Needs q4 year cycle to keep current • 2 days for a Provider course • Required to have ACLS, ATLS, PALS prior to participating in the first course • The comprehensiveness is a draw – addresses all time-critical illnesses. Could contextualized messaging from TAC into these – we can add to the curriculum (cannot take away from it). • Cost discussed. Concern that hospitals have time to free up their staff for a 1-day course may be difficult for 2 days – as well as the cost.	Zimmerman to reach out to Rumford; Petrie/Zimmerman to reach out to PenBay. Calais/DECH/Inland may want CALS (Washington County course coming up soon) – we will try and attend CALS course in the Spring at MidCoast. Maybe we could do a TAT between the 2 days?
Trauma Directors Meeting update	None (pending CMMC director)	
Trauma Case Review EMMC	Pret Bjorn presented on behalf of Dr. Fenwick. Discussed Management of Mild TBI – Discussion re: 1. Unnecessary transfers of low risk TBI 2. Resource utilization 3. Telemedicine option ME General has been having success in keeping patients at their facility with help of Telemedicine via MMC. Patients are admitted to the surgical team.	TBI Taskforce – Bjorn/Nuki/Sholl phone meeting to discuss further

	Discussion re: care of the trauma patient by IM/FM – this is not in their residency training, this is why they are uncomfortable. They are 1-step removed from the system. Sholl: Why admit? Why not observe in the ED – the ED providers understand the pathology/process well. Nuki: Concerned re: the messaging of transfers when patient is deteriorating. Hospitalists/providers have experienced difficulty in the past – and this is hard for many to forget/trust the system. Could the 3 Trauma Centers collaborate and make recommendations? Bring the hospitalists to this group as well? Set up education program/framework for this to work? What about a pathway to facilitate transfer? Have transfer center on high alert? And transfer service aware of situation? Fenwick/Bjorn/Bragg?	
Trauma Manual Review	Will need review/update	
Other Business	Morse: State FLEX grant notification – EMS/Sustainability grant, Small hospital improvement grant. ME General is submitting their Level 3 ACS application	

Adjourned 1158h

Draft completed 10/24/18

Approved 01/22/19

Kate D. Zimmerman, DO