



Civilian Trauma Centers Provide a Training Environment Which is Directly Relevant to Military Surgical Teams

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Disclosures

Presenter has no interest to disclose.

AMSUS and ACE/PESG staff have no interest to disclose.

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At the conclusion of this activity, the participant will be able to:

- The learner will understand the importance of the Joint Trauma System Clinical Practice Guidelines and how they serve as a key component for Forward Surgical Team clinical training.
- The learner will recognize civilian trauma casualties have clinical conditions which are relevant to the deploying Forward Surgical Teams.
- The learner will identify the value of the Joint Trauma System Clinical Practice Guidelines as a training model for Forward Surgical Teams.



Agenda

- History of Military Civilian partnerships
- Evolution of Army Trauma Training Detachment (ATTD)
- Use of Clinical Practice Guidelines (CPGs) as a core piece of ATTD curriculum
- Use of Quality Assurance to evaluate relevance and adaptability
- The way ahead...





- Desert Storm – Desert Shield
- GAO Reported
 - Only 1 of 20 medics had seen any injured patients
 - BG Don Trunkey – Congressional Testimony
- First site of military-civilian medical training partnership was in Virginia
- Joint Trauma Training Department started in Houston



Evolution of ATTD

- Reflects changes in theater
- Joint Trauma System – Joint Theater Trauma System established in CENTCOM in 2004
- Department of Defense Trauma Registry
- CPGs developed
- JTS ‘Operational Cycle’





- Initial Memorandum of Understanding with University of Miami and Jackson Health System was signed 10 September 2001
- Initially designed to expose members of the FST to trauma
- Cadre is a key component in ensuring relevance and relating trauma care to the deployed setting
- ATTD possesses a unique ability to adapt the Program of Instruction to meet the needs of the individual rotating team in accordance with their theatre of operation and team structure (FST, FSE, FRST, SORT)



- Institute of Medicine Report – ‘To Err is Human’ 1999
- CPGs create a foundation to train units by decreasing variation in practice related to injuries
- First Four CPGs were developed in 2004 and has expanded to 48 CPGs
- CPGs are the individual chapters of our military trauma textbook
- CPGs serve as the ‘Common Language’ between services and echelons



CPGs are Key to ATTD Curriculum

- CPGs serve as the primary ‘fund of knowledge’ and reference upon which the ATTD curriculum is built
- Incorporates CPGs as cornerstone of team clinical training in all lectures, scenarios, and in the clinical environment
- Ideally teams incorporate this concept into their units upon deployment
- CPGs are relevant to all members of the FST, irrespective of MOS/AOC





- 14 day course that focuses on team building and clinical exposure
- Phase I (Training)
 - Didactic
 - Interactive hands-on training and simulation
 - Situational Training Exercise
- Phase II (Clinical)
 - Trauma Resuscitation Unit (ATLS and ICU care)
 - Trauma Operating Room



Validating Method

- A de-identified logbook of all patient encounters is kept
- Measures team efficiency during primary survey
- Team correlates CPGs relevant to patient injuries and plan of care
- Tracks procedures, skills, and cases performed during clinical rotation





Results

- Reviewed logbooks of 16 team rotations from May 2017 to November 2018
- Teams average 45 patients in 6 24 hour clinical coverage days (averages out to roughly one patient every three hours)
- For each patient, an average of 3.6 CPGs were relevant (range 1 to 8)
- All 16 rotations received a patient that covered 6 core CPGs relevant to the FST (Documentation, Hypothermia, Extremity Injuries, Burns, Damage Control Resuscitation, Severe Head Injury)





- This study was designed to evaluate the current relevance of ATTD
- To ensure the program has remained flexible and adaptable to different theatres of operation, various FST structures, and all team personnel
- To assess the relevance of patients seen in a Level 1 trauma center in relation to patients seen in current theatres of operation
- To evaluate how the program allows for incorporation and implementation of relevant CPGs





- How this information can be used
- Inline with the CGs #1 priority of readiness
- Can be used as a guide to establish other military-civilian relationships
- Experience gained and lessons learned when providing care to real patients cannot be replicated with simulators and exercises



Conclusions

- Army FSTs have greater trauma clinical exposure at civilian Level I Trauma centers then that of military treatment facilities in volume and mechanism of injury
- The clinical exposure at a Level I Trauma center is relevant to military surgical teams, based upon CPG exposure
- Provides opportunity for all elements of FST to perform team approach on deployment relevant injury patterns
- ATTD has remained flexible and adaptive through 16 years of training and injury patterns remain relevant





Questions?



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