Decision Brief: Prolonged Theater Care

John Armstrong, MD
Chair, Trauma & Injury Subcommittee
March 5, 2024

Overview / Agenda

- Membership
- Tasking
- Summary of Subcommittee Activities to Date
- Findings & Recommendations
Membership

CHAIR
John Armstrong, MD*

Julie Freischlag, MD
Odette Harris, MD, MPH
Lenworth Jacobs, Jr, MD, MPH*

Carla Pugh, MD, PHD
Gary Timmerman, MD

*Board Member

Previous T&I Subcommittee Reports

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<td>Combat Trauma Lessons Learned from Military Operations of 2001 through 2013</td>
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<td>Battlefield Medical Research Development Training &amp; Evaluation Priorities</td>
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<td>Management of Traumatic Brain Injury in Tactical Combat Casualty Care</td>
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<td>Needle Decompression of Tension Pneumothorax Tactical Combat Casualty Care Guideline Recommendations (update to 2011 report)</td>
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<td>Supraglottic Airway Use in Tactical Evacuation Care</td>
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<td>Prehospital Use of Ketamine in Battlefield Analgesia</td>
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<tr>
<td>Needle Decompression of Tension Pneumothorax &amp; Cardiopulmonary Resuscitation TCCC</td>
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<td>Combat Ready Clamp Addition to the Tactical Combat Casualty Care Guidelines</td>
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Tasking

On September 28, 2023, the Assistant Secretary of Defense for Health Affairs directed the Defense Health Board (DHB) to recommend guidance on better integrating military-civilian training partnerships to improve prolonged field/in-theater care.
Prolonged Theater Care

• Principal Deputy Assistant Secretary of Defense for Health Affairs approved changing the name of the tasking from *Prolonged Field Care* to *Prolonged Theater Care* to better describe the spectrum of medical care provided in-theater

• Due to the urgency of the topic, findings & recommendations from Part 1 of the report would be deliberated in March 2024, followed by deliberation of Part 2 findings & recommendations in September 2024

TOR Objectives & Scope

• *Review the curriculum & experience* of current military-civilian trauma training partnerships.

• *Provide recommendations to best prepare DoD personnel* at military-civilian trauma training partner sites for prolonged field care in near-peer conflicts. Comment on the curriculum, locations, frequency of training, occupational specialties of participating DoD personnel, & best use of selection & performance criteria outlined in the Blue Book.

• Provide recommendations *to better integrate military-civilian partnerships* with attention to Direct Care MTF staffing & Regional Medical Operations Centers.
Problem Statement: The Future of Warfare

• Large-Scale Combat Operations
  o Multiple domains
  o High rate of casualties
  o Contested freedom of movement
  o Constrained medical logistics
  o Change in injuries

• Peer/Near-Peer Conflict
  o Changing warfighter demographics
  o Delayed, complex, lengthy evacuations
  o Stress on continental US (CONUS) healthcare systems
Background: Definitions

• Prolonged Field Care (PFC)
  o Point of injury care in resource limited, austere environments
  o Evolved from medical observations by Special Forces & Marine Corps
• Prolonged Casualty Care (PCC)
  o Care delivered by medics & corpsmen (conventional forces)
  o Provision of Tactical Combat Casualty Care beyond the “Golden Hour”
• Tactical Combat Casualty Care (TCCC): operational trauma guidelines

Background: Definitions

• Prolonged Theater Care (PTC)
  o Full spectrum & continuum of medical care provided by military medical & non-medical personnel from point of injury to definitive care, including PFC, PCC, prolonged hospital care in the combat zone, & prolonged definitive care in OCONUS MTFs
Timeline Comparison

Legacy Planning
- 1 Hour
- 1-24 Hours
- 24-72 Hours
- Definitive Care

Future Planning
- Field Care 1-72 Hrs
- Role 1 Unit Level Medical Care 24-72 Hrs
- Role 2 Trauma Care, Emergency Medical Treatment 3-5+ Days
- Role 3 Theater Hospital 1+ Week
- Role 4 Strategic Air Evacuation

Military Civilian Training Partnerships (MCPs)

- MCPs intended to provide pre-deployment training
- MCPs aid in the sustainment of critical wartime skills to prevent the "peacetime effect" or "Walker Dip"
- GAO identified MCPs as an important adjunct to training enlisted medical personnel, who comprise 66% of the total medical force
- MCPs distinct from training agreements with civilian hospitals for initial clinical skills acquisition
# Summary of Activities to Date

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<td>TOR Overview, Objectives, Guiding Principles, Report Timeline</td>
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<td>Brief on Strategic Priorities in Peer/Near-Peer Conflict Report Development: Report Outline</td>
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<td>Nov 8, 2023</td>
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<td>Brief on PFC/PCC in the Joint Trauma System</td>
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Guiding Principles

• Recommendations should be actionable & relate to a specific finding
• Recommendations should center on education & training as it relates to the care delivery paradigm in peer/near-peer conflict & the evacuation process, or in-theater care
• Recommendations should adhere to clear definitions of the setting/context of care
• Recommendations should identify/define all parties involved (i.e., who is being treated & who is providing the treatment)
Findings & Recommendations

Finding 1

A registry of military-civilian & Department of Veterans Affairs Administration partnerships has not been fully established or sustained; thus, the existing Joint Trauma System Military-Civilian Training Partnership Registry contains insufficient information to evaluate program performance or readiness skills of military medical personnel training at military-civilian training partnership sites.
Recommendation 1

Assistant Secretary of Defense for Health Affairs should review and report findings to the Secretary of Defense annually from the Joint Trauma System Military-Civilian Training Partnership Registry, consistent with requirements outlined to ensure implementation & sustainment of a comprehensive Joint Trauma System Military-Civilian Training Partnership Registry consistent with the requirements outlined in section 708 of the National Defense Authorization Act for Fiscal Year 2017.

Finding 2

Current active duty military medical forces may be insufficient to meet the demands future requirements of large-scale combat operations, & current models used to estimate personnel requirements against casualty estimates may be unreliable.
Suggested amendment: ASD(HA) should issue a report annually based on the needs of the DoD.

Clarice Waters, 2024-03-05T15:37:059
Recommendation 2

DoD should urgently update casualty flow models to determine the optimum size & structure of the active duty medical forces & rapidly recruit military personnel to meet these requirements.

Finding 3

Neither the Services nor the Joint Trauma System military-civilian training partnership registry adequately define, track, or assess wartime medical skills training for enlisted personnel at military-civilian trauma training partnerships.
Recommendation 3

Under Secretary of Defense for Personnel & Readiness, in conjunction with the Services, should oversee the standardization of the essential wartime medical skills of enlisted personnel & apply the requirements of section 708 of the National Defense Authorization Act for Fiscal Year 2017 beyond combat casualty care teams to the wartime training of enlisted medical personnel.

Finding 4

Despite the potential demand for standardized, just-in-time training for Army combat medics, Navy corpsmen, & Air Force medical service specialists during large-scale combat operations, there are no plans in place to develop standardized, just-in-time training for enlisted personnel.
Recommendation 4

Under Secretary of Defense for Personnel & Readiness, in conjunction with the Services, should develop standardized just-in-time programs of instruction for scaling the training of Army combat medics, Navy corpsmen, & Air Force medical service specialists to meet force flow & large-scale combat operations demands as reflected in military operational plans.

Finding 5

The Defense Health Agency does not define readiness gaps that should be filled by military-civilian trauma training partnerships through tracking of the clinical activity (relative to combat casualty & expeditionary medical care) of medical personnel at military treatment facilities.
Recommendation 5

The Director, Defense Health Agency, should develop a system to track skills related to combat casualty & expeditionary medical care acquired by credentialed & non-credentialed military medical personnel at military treatment facilities & use this information to support Service goals to guide entry into & sustainment of military-civilian trauma training partnerships.

Finding 6

The Defense Health Agency & Services do not have a joint system for tracking the knowledge, skills, or ongoing clinical activity across the clinical readiness life cycle & are unable to aggregate data to provide a composite picture of individual & military medical readiness.
Recommendation 6

Under Secretary of Defense for Personnel & Readiness should direct development of a joint system to track knowledge, skills, & ongoing clinical activity related to combat casualty & expeditionary medical care acquired by credentialed & non-credentialed personnel on an individual basis to inform the overall military medical readiness.