COSCCC Meeting
5-6 March 2018
San Antonio, TX

Meeting Minutes

30 March 2018

Mr. Dominick Sestito

5 March 2018

1). Admin Remarks and Introductions (Col Stacy Shackelford): Col Shackelford, the Chair of the Committee on Surgical Combat Casualty Care (CoSCCC), convened the meeting and welcomed meeting participants. Col Shackelford briefly reviewed the meeting's agenda. Mr. Dominick Sestito discussed transportation and logistical information for participants.

2). Deployed Surgeon Presentation (LTC Mark Jackson): LTC Jackson discussed his experience as a deployed Emergency Medicine Physician with 240th Field Surgical Team, during Operation Inherent Resolve, incorporating time in Al Asad, Fuheymi, T1, Al Quam and Syria. Locations were somewhat austere, and underdeveloped. LTC Jackson discussed many aspects of his deployment, addressing pitfalls and Gaps. More capabilities are needed to cover area support of the Role 2.

His mission was to:

- Provide resuscitation capabilities and establish role one at the NLZ (Called Role 1.5) and move into the Middle Euphrates River Valley (MERV) as needed
- Established Mascal, walking blood bank, and leadership
- Traveled a lot for supplies and equipment initially

Questions posed for discussion:

-What are we doing here? Why are we not training our surgeons to do surgery and our ER docs to do trauma?

-The Navy and AF model includes ER Docs why does the Army not have ER Docs in the FST? The FRST team includes ER Docs.

-If we only have one or two surgeons, who is going to resuscitate while the surgeons are in surgery?

-DO NOT remove the NCO's off the teams

Critical Capabilities – make sure they can do ATLS procedures! You need a EM physician in the ATLS to intubate, place central lines, chest tube, REBOA, and continue the resuscitation of patients. Have another EM Physician to triage and assist in the ATLS. Also, once patients go to the OR EM providers can complete the secondary survey.

Lesson Learned:

- Key was having the correct skills sets at the correct location in ATLS, OR, and ICU.
- The surgeons were in the OR with Patient One
- One of the EM physician was outside working with the walking wounded i.e. fast track patients under a camouflage net.
- The other or 2nd EM physician was in the ATLS tent continuing the resuscitation

- Traveled a lot for supplies and equipment initially
- Cared for many vehicle roll overs with Crush and burn injuries, did not need to transfer to Role 2

3). Deployed OR Nurse (LCDR Dana Wiley): LCDR Wiley was deployed with the Role 2 Navy Expeditionary Medical Unit (EMU), in support of Combined Joint Task Force, Operation Inherent Resolve. Serving as an advanced medical and surgical capability for US, coalition and Iraqi forces to defeat enemy forces and increase stability in the Area of Operations. Staffed with 17 Officers (2MSC, 7MC, 2Surgeons, 1CRNA, 1Ortho, 8NC) and 20 Enlisted.

Pre-deployment Training:

<u>FT Bliss Training</u>

- Combat Training/Weapons Qualifications
- 3 weeks
- Navy Trauma Training Course (LA Trauma) at LAC+USC Medical Center
- Worked along side LAC+USC staff at Level-1 Trauma Center
- 21 days

4). Emergency General Surgery CPG (MAJ Andrew Hall). Reviewed Summary Recommendations with the committee. The details of the CPG will be reviewed by the guidelines subcommittee, circulated to the CoSCCC for review, and then a teleconference will be arranged for detailed discussion. Following the teleconference, a final vote on the CPG will be held.

5). Wartime Thoracic Trauma CPG (CAPT Jared Antevil). Reviewed Summary Recommendations with the committee. The details of the CPG will be reviewed by the guidelines subcommittee, circulated to the CoSCCC for review, and then a teleconference will be arranged for detailed discussion. Following the teleconference, a final vote on the CPG will be held.

6). Performance Improvement in the Austere Environment (CAPT Stockinger). CAPT Stockinger discussed the importance of documentation for PI purposes, by comparing data compiled by hand in 2004 with limited connectivity, no TMDS, no scanners, no CPG's, no documentation requirements to today….with little to no improvements.

"You can't manage what you can't measure."

Documentation is not being enforced by line leaders.

7). CENTCOM Trauma System Assessment– (COL Stephen Linck): The purpose of the Theater Trauma Assessment is to determine the effectiveness of the transition from JTTS (2014) to CTS (2017), assessing program compliance and combat casualty care outcomes by identifying current CTS strengths and gaps and make recommendations for improving the System. Target for final report is late April and will include recommendations and identify OPRs.

- Methodology
  - JTS Reports
  - JTS sponsored calls (M&M, PI)
  - Surgical recommendations

  - On site interviews
- Final report will include
  - JTS Reports and summary (POI, MedEvac)
  - CPG Compliance (Training/implementation)
  - TCCC (Training/implementation)
  - Other opportunities for improvement
  - Conclusion
  - Recommendations with identified OPR

Other Opportunities for Improvement
- What is a Role 2? Need to better define the requirements
-Standardize IMIIT requirements by role
-Review impact of QA/patient safety
-Skill sustainment in theater
-Simplify access for deployed computer applications.
-Update EHR CPG
-Ensure equipment lists meet theater requirements
-Ensure trained personnel and supplies are sufficient to meet life cycle management
-Work with operational units to determine communication strategy for that outlines CCR requirements and highlights important information required for continuity
-Some still unaware of JTS CPG's..why??
-Further clarify minimal medical record requirements in CCR
-Evaluate requirement for additional surgeon or trauma nurse coordinator to named operations to support CTS
-Reassess risks and advantages of 90 day BOG program
-Develop and publish position paper outlining basic requirements and standards for expeditionary facilities.

COL Nessen: When we implemented the shortened rotations for surgeons "profis" to preserve our in-garrison skills, we gave up surgical leadership of FST's.
"Paperwork and administration are synonymous with leadership"
You make the decision to stay or go once in your career—I made the decision to stay because at that point in my career I was saving lives on the battlefield. Today, most surgeons are making the decision to go.

-Small unit tracking all weekly cases, missed injuries, false negative FAST, identified association of open globe with ICH, enroute care admissions, operative times (room and surgical times), calculated ISS, en route care provided, patients seen and operated on, over/under triage
-Small unit dispersed early entry operations, we have no data.
-Initial fielding of new capabilities, we have no data.
-Suggestions for how to transform or motivate the individuals.
-Every deploying unit needs a trained intrinsic system. Adding an extrinsic team is not effective.
-Provide real-time feedback!!!!
-How do you enforce requirements? Red/green charts?
-Hold people accountable on their OER's TF MED
-TF MED commanders dashboard needs to include PI participation
-When you don't have a physician leading the team, the other 5 things (besides PI) become the priority.

6 March 2018

1). Administrative Remarks (Col Stacy Shackelford): Col Shackelford, the Chair of the Committee on Surgical Combat Casualty Care (CoSCCC), convened the meeting. Col Shackelford briefly reviewed the meeting's agenda for the day.

2). Recently Deployed Surgeon (COL Jay Johannigman): COL Johannigman was recently deployed to Afghanistan and discussed the need for committee deliverables (focused empiricism).

What made JTS work?:

1. Right people in the right place with a CENTCOM surgeon who listened
2. Most of the early clinical leaders knew what "right looked like"
3. We are doing this all over again in Iraq
4. Bottom up instead of top down

We need better partnership with the ACS/COT. The number of vice chairs for region 13 are unlimited—more people could attend COT meeting. How does JTS impact the planning process? The TMD should have input.

JP 4-02 needs to codify the planning process to include TMD.

COL Johannigman's concerns as a trauma surgeon: Just because we can do it….should we do it????

- There is a limit to how small a team can be and still function effectively
- What's with the GHOST team concept
- Role II or Role III– who makes that call
- As pace slows and younger surgeons and medics are coming to the field
- Sometimes the hardest decision is who not to operate on
- Do we need to engage the MROE to stay current
- We have a lot of data leakage from the forward teams

3). Joint Staff Surgeon Updates (COL Christopher Lettieri): COL Lettieri discussed Forward Surgical Care and Evolution of the Joint Trauma System. He discussed recent developments and future opportunities outlined in the NDAA 707/708, KSA updates, Freeze dried plasma, and skills sustainment during deployment. COL Lettieri stated almost half of our providers deploy with zero training in the 6 months prior to deployment, and ¾ did not have all of the required training for deployment.

"Ensure that "traumatologists" of the Armed Forces maintain readiness and are able to be rapidly deployed and to ensure the preservation of critical warfighting medical skills"

- Joint medical readiness requirements council—JSS and OTSG, MHS level governance alongside the MDAG. MDAG will focus on health care.

JTS represents:

- Reference body for all trauma care
- Standards of care for trauma
- Coordinate translation of research into standards of clinical care
- Provide oversight for comprehensive trauma registry
- Coordinate incorporation of lessons learned into clinical practice
- Establish a Joint Trauma Education and Training Directorate
- Establish a personnel management plan for wartime medical specialties
- Provide oversight to Theater Trauma Systems

<u>3 parallel efforts for KSA's"</u>

Readiness Reporting Metrix, NDAA sec 725
Health affairs "Elster model" KSA project
Independent efforts by Services

<u>Medical readiness skills sustainment during deployed operations</u>
Need for skills sustainment during deployments.
Maintain medical readiness standards
Tailor deployment lengths of specialized medical personnel
Standardize deployable training technologies
Develop curricula for skills sustainment training
Golden hour policy established by Sec Gates 2009
Policy currently being addressed and revised
Not CENTCOM policy

<u>Recommendations</u> <u>(Summarized, 15 total recommendations)</u>

- Updates to Joint doctrine to address FRC in unique operating environments
- Assess Joint training programs related to the provision of FRC
  - Skills sustainment, and CME/CME
  - Ensure common baseline training for FRC activities
- Develop a list of key joint readiness KSAs related to FRC
- Review/Update doctrine and non-doctrine medical capabilities to provide FRC-related support to dispersed operations or operations in austere, remote, or contested environments
- Recommend common, scalable, modular, and rapidly available capability set
- Develop a Medical Planner's Handbook for Provision of FRC
- Develop evidence-based, integrated CPGs and standards for FRC
- Identify new tools/processes to increase effectiveness of FRC activities

<u>CAPT Via feedback on trauma training:</u>
Level 0 Basic military competencies
Level 1 Professional competencies
Level 2 Military professional competencies
Level 3 Platform specific competencies
Austere surgical team: MROE

4). Mil-CIV Partnerships (Col Jeffrey Bailey): Col Bailey discussed The Military Health System Strategic Partnership American College of Surgeons recently convened a meeting to explore the common elements of the current military training/sustainment platforms with the goal of developing best practices and optimal resources applicable to both existing and additional military-civilian collaboratives.

Why: Recent scholarly work and supporting legislation support the creation of a fully integrated military-civilian trauma system with uniform pre-deployment medical training, sustainment of trauma skills by participation in a unified US trauma system and maintaining the ability to respond to mass casualty and disaster events.

Deliverable: Publication of full proceedings in JACS

Concerns to overcome:

- Lack of clarity for billing practices
- Provision of malpractice insurance
- Portability of licensesure across state lines
- Lack of standardized readiness training across all 3 services
- Difficulty in demonstrating the value of the training
- Lack of validation of training against outcomes and performance improvement
- Ability to maintain the military identity, cohesion while at civilian centers

CoSCCC is the forum for consolidation lessons learned on civilian trauma center rotation
-Need a requirements document for mil-civ partnerships—what are the criteria for facilities to participate
-Main lesson from Ben Taub:
-Quality of care delivered at the civilian institution—how is it measured? TQIP

COL Nessen: I would like to keep trauma fellows in place for 3 years after fellowship
-There needs to be a KSA project to define the military Trauma/critical care blueprint—need names and timeframe
-4 trauma surgeons per service to define KSA's based on expeditionary scope of practice.
-Identify a time window (need 3-5 days in person visit)

Business items
Recommend updates to JP 4.02 Lettieri
How do we develop the framework for a trauma system
How do we define R2
Liz MS, Kyle Remmick
Recommend common capability set

10). CoSCCC Update (Col Stacy Shackelford): Col Shackelford briefed the committee on its current activities and deliverables. The year one deliverables for the subcommittees are as follows:

Clinical Practice Guidelines Committee

- DOTMLPF analysis of CPGs
- Identify CPG gaps and updates needed

- Wartime Thoracic Surgery
- Emergency General Surgery

Research Committee

- Research Top 10 priorities
- Journal Watch
- Abstract to MSHRS
- Manuscript Prep
- Submission of full results to CCCRP/ LITES
- REBOA

Operational Committee

- Optimal Resources for the Deployed Roles of Care
- Red White and Blue Book

Education Committee

- Tri-Service expert consensus statement on trauma training
- Pre-deployment Joint care Curriculum

Austere surgical team committee

- Austere surgical team guidelines
- Austere CPG

The next topic of discussion was FRC JROCM 125-17. Items were identified and tasked to the appropriate Subcommittee:

- Develop a list of key joint readiness KSA's (R2M-readiness reporting metrics)
  - OPR Services/ED&TR Subcommittee
- Recommend a common capability set (personnel, materiel, procedures)
  - OPR Services/Operational Subcommittee/Austere
- Review/assess Joint training program POI's (programs of instruction) to ensure there is a common baseline
  - OPR DHA/ ED&TR Subcommittee
- Develop CPG's for FRC to include: OPR DHA/ CPG Subcommittee
- Review/recommend updates for Joint medical planners course and other courses
  - OPR OJSS/ Operational Subcommittee
- Conduct analysis to recommend new tools and processes to increase effectiveness and efficiency of FRC activities (OPR Services/ Research&Operational Subcommittee)
  - Simulation training tools for FRC
  - Review ongoing efforts and enhance data capturing processes for prehospital, PFC, and patient movement, and advanced forward medical care
  - Teleconsultation capabilities
  - Common, scalable, rapidly deployable medical materiel capability to provide advanced care in forward environment
  - Enhanced PMI for extended patient movement
- Update GME and CE POI's related to combat care courses
  - OPR DHA/ Education Subcommittee
- Revise Senior Leaders Executive course and other PME courses to ensure understanding of deployed trauma system, JTS, and FRC considerations
  - OPR DHA/ Education Subcommittee
- After development of KSA's related to provision of FRC, review and update personnel management sub-systems to ensure personnel with those unique KSA's are identified and managed in an effective and efficient manner. (Ask Elster 708d) (OPR Services/ Operational Subcommittee)
  - Trauma surgeon
  - General surgeon, ortho surgeons, anesthesia, OR technicians, OR nurses, ER physicians, critical care nurses, etc…

Action Items

Update 4.02 (2 year cycle)
DHPI/CTS guide for setting up a trauma system
Annex Q requirement—set up the plan
Joint Trauma System Assessment by ACS
Share
CPG Supply list Role 2/3 – Send to Voting Members

SHACKELFORD.STACY.A.1155040161

Digitally signed by SHACKELFORD.STACY.A.1155040161
DN: c=US, o=U.S. Government, ou=DoD, ou=PKI, ou=USAF, cn=SHACKELFORD.STACY.A.1155040161
Date: 2018.05.08 19:31:27 +04'30'

Stacy Shackelford, Col, USAF
Committee Chair

Enclosure (1) – Meeting Attendance

CoSCCC Voting Members:
CAPT Zsolt Stockinger
LTC Jennifer Gurney
Col Stacy Shackelford
CAPT Eric Elster
Col Randy McCafferty
CDR Mike Kearns
CDR Matt Hannon
LTC Jason Corley
CDR Virginia Blackman
Lt Col (res) Anne Rizzo
COL Elizabeth Mann-Salinas
Col Michael Charlton
MAJ Colin Frament
SSG Cedric Martin
Dr. Saafan Malik
CAPT Jared Antevil
COL Scott Armen
Col Jeffrey Bailey
PO1 Jeffrey Bentley
HMCS Michael Denoyer
Lt Col Peter Learn
COL Shawn Nessen
COL Christopher Lettieri
COL Kyle Remick
Col Jay Sampson
COL Jason Seery
Maj Andrew Hall
CDR Polk

Subject Matter Experts:
Mr. Ed Whitt
Dr. Russ Kotwal
Dr. Don Jenkins
Dr. Mary Ann Spott

Dr. Don Marion
Dr. Kenji Inaba
Ms. Elizabeth Mann-Salinas
Dr. John Holcomb
Mr. Richard Kollar
Jud Janak
Jeff Howard

COSCCC Staff:
Mr. Dominick Sestito
Darin Schwartz

Additional Guests:
CAPT Darren Via
COL Linck
COL Kurt Edwards
LTC Tristan Nonchal(France)
CDR Jacob Glaser