

# Military—Civilian Partnerships in Training, Sustaining, Recruitment, Retention, and Readiness: Proceedings from an Exploratory First-Steps Meeting

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The American College of Surgeons (ACS) has a long history of collaboration with the US military, dating back as far as World War I under the leadership of the principal founder of the ACS, Dr Franklin Martin, who was also a Colonel in the US Army Medical Corps (Fig. 1). The principle mission of the Military Health System (MHS) surgical force during times of conflict is the provision of combat casualty care and the subsequent recovery and rehabilitation of the injured soldier. This focus of care and proficiency reaches a pinnacle during each armed conflict and is rapidly lost after each episode, as the MHS shifts back to garrison and home station care at medical treatment facilities (MTFs). The prolonged armed conflict during Operation Iraqi Freedom and Operation Enduring Freedom witnessed an unprecedented improvement in military combat casualty care with the development and maturation of the Joint Trauma System (JTS).<sup>1</sup> As with previous conflicts, however, the proficiency and retention of critical skill sets is at risk with the reduction in the numbers of casualties. One potential solution to the loss of institutional memory between conflicts is for the MHS to partner with a permanent civilian surgical institution with trauma expertise. The ACS, through its Committee on Trauma, has provided the leadership for development of trauma centers and trauma

systems in the US based on the experience of the military in Korea and in Vietnam. More recently, the Executive Director of the ACS, Dr David Hoyt, and the then-Undersecretary of Defense for Health Affairs, Brig Gen Dr Jonathan Woodson developed a formal partnership, titled the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS).<sup>2</sup> One of the major focuses of the MHSSPACS is preservation of the key elements of the JTS. A fully integrated military—civilian trauma system, as was described in the recent publication from the National Academies of Sciences, Engineering and Medicine, would not only preserve the JTS structure, but also has the potential to decrease preventable deaths after trauma.<sup>3</sup> The Academies report outlines the key steps in developing a continuously learning military—civilian trauma system that would sustain a military surgical workforce prepared for deployment, assure access to trauma care throughout the US, and provide rapid response to mass casualty and disaster situations.

The MHSSPACS recently brought together representatives from select civilian trauma centers that provide training, readiness, and sustainment platforms for military personnel, along with other interested parties from both the military and civilian sectors (Table 1). The purpose of the meeting was to:

1. Create a vision for the expansion of civilian centers as a critical resource for combat medical readiness using collective intelligence from existing platforms.
2. Define the optimal resources that would guide the selection and implementation process for additional trauma centers as needed.
3. Design a collaborative process that is inclusive and meets military medical readiness needs, while augmenting civilian mass casualty/disaster response.

This article summarizes the proceedings of that meeting and lays the groundwork for the next steps toward accomplishing these 3 goals.

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**Abbreviations and Acronyms**

ACS	= American College of Surgeons
C-STARS	= Center for Sustainment of Trauma and Readiness Skills
JTS	= Joint Trauma System
KSA	= knowledge, skills, and abilities
MHS	= Military Health System
MHSSPACS	= Military Health System Strategic Partnership American College of Surgeons
MTF	= medical treatment facility
UMCSN	= University Medical Center of Southern Nevada



**Figure 1.** Colonel Franklin Martin, MD, FACS; US Army Medical Corps. (Reprinted courtesy of the archives of the American College of Surgeons).

### The Clinical Readiness Project: Maintenance of Expeditionary Currency and Competency

#### **Presenter: Captain Eric A Elster, MD, FACS, USNR**

It is well recognized that clinical skills must be maintained by constant practice. This presents a challenge for many military surgeons and surgical teams, given the current reduction in the number of casualties treated while deployed and garrison assignments to low-volume and low-acuity facilities. Additionally, pre-deployment training surveys, observations, insights, and lessons indicate that the clinical-specific pre-deployment training provided does not consistently and/or adequately prepare individuals to quickly assume their medical duties when deployed.<sup>4,5</sup> To address this problem, the MHSSPACS has worked with the MHS to develop the Clinical Readiness Project, designed to capture and sustain the skills necessary to meet expeditionary needs. The project includes 4 key components:

1. periodic assessment of knowledge and abilities aligned with a relevant curriculum;
2. pre-deployment assessment of procedural skills;
3. appropriate training and retraining when necessary, focused on areas of need identified using a standardized assessment; and
4. development of a measurable “readiness” value of pre-deployment practice.

This project for general surgery was initiated by bringing together subject matter experts from the Army, Navy, and Air Force Medical Corps who had extensive deployment experience. The project was focused on the needs of the expeditionary general surgeon, that is a surgeon who would be deployed in a far-forward surgical base and who must be capable of performing damage-control resuscitation and damage-control surgery. Also participating in the initial week-long meeting were

civilian trauma leaders and a psychometrician dedicated to this project. Using the Clinical Practice Guidelines of the JTS, as well as additional materials from textbooks and curriculum, an extensive list of knowledge, skills, and abilities (KSA) was developed, divided by topics, and linked to one universal domain (Fig. 2). The KSA were further vetted by 150 additional military surgeons who rated them for their importance to patient care and frequency of use. Through a series of additional meetings, a question bank of close to 600 items aligned with these 8 domains has been developed to assess knowledge points. A beta test will be distributed in early 2018 to assure validity and to establish a passing metric. The curriculum on which these test items is based will also be developed in 2018. Individual skills assessment will include demonstration of the ability to perform a fasciotomy; place a resuscitative endovascular balloon occlusion of the aorta catheter; perform a craniotomy, thoracotomy, and a damage-control laparotomy; place a vascular shunt; and debride and cover a wound with a negative pressure device. The goal of this project is to include periodic assessment of knowledge and abilities aligned with the relevant curriculum and pre-deployment assessment of procedural skills (Fig. 3). Where deficiencies are identified, training and retraining in focused areas will be provided.

The KSA blueprint sessions have been conducted in other areas of medicine in addition to general surgery, with the focus on the need to keep entire medical teams ready for deployment. Tri-service representatives from anesthesia (MDs and certified registered nurse anesthetists), orthopaedics, critical care (MDs, registered nurses), and emergency medicine (MDs, registered nurses) have defined their scope of expeditionary practice and developed 2,800 KSA organized into 52 domains by specialty. A KSA-based readiness metric has also been developed

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