



## Military/Civilian Trauma Integration Task Force

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MAJ MCWVARNG

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### Conflicts of Interest

- None
- This presentation does not represent the official views of the United States Department of Defense



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### Lessons learned and applied in EMS

- TCCC → TECC
- Tourniquets
- Pain management (ketamine, fentanyl)
- Airway adjuncts
- Field blood transfusion (really!)

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### How do we define "preventable death"?

- Those casualties whose lives could have been saved by appropriate and timely medical care, irrespective of tactical, logistical, or environmental issues.

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### Trauma deaths 2014

- 147,790 civilian trauma deaths
  - 10,000 children
- Assuming 20% survivable injury deaths
- 30,000 lives could have been saved

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### Is it possible?

- 2001-2010
- DoD wide KIA 16.4% and DOW 5.8%
- 75th Ranger Regiment: KIA 10.7% WIA 11.7%
- DoD wide: 25% preventable death rate
- 75<sup>th</sup> Ranger Regiment: Only one potentially survivable injury in 10 years, none with prehospital care.

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### Dec 6: FICEMS and CEMC

- Should we set a national aim for zero preventable deaths?
- What are the most promising innovative opportunities to improve prehospital trauma care?
- How can we apply the Learning Health System model to EMS?
- Are there actions we can take TODAY in EMS that could dramatically improve outcomes?
  - Pain
  - Rural trauma
  - Traumatic brain injury

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### Shift in Battlefield Care

- Evac times are longer
- Prolonged field care is the norm in many AOs
- Are there parallels in civilian rural settings?

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### Military resources are a familiar sight During Disasters



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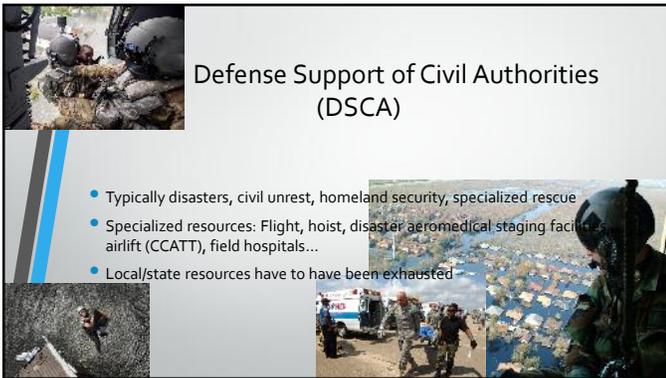
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### Defense Support of Civil Authorities (DSCA)

- Typically disasters, civil unrest, homeland security, specialized rescue
- Specialized resources: Flight, hoist, disaster, aeromedical staging facilities, airlift (CCATT), field hospitals...
- Local/state resources have to have been exhausted

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### What would it take to get:

- Military medics on civilian ambulances regularly
- Military ambulances as part of regional EMS system
- Joint training and operation

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### Medics in the Military

- 68W, Corpsman, Medical Technician (EMT)
- Flight Medic (Paramedic)
- PJ (Paramedic)
- SOCM Medic (EMT but can bridge to Paramedic)
- IDMT/IDC (Paramedic)
- 18D (EMT but can bridge to Paramedic)

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### Military Installation EMS

- Some contract, some military
- USAF: Service-wide protocols
- EMT-P becomes EMT-B off fed property
- Have to use local protocols off base
- On-base duties



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### Practical Hurdles

- Frequent transfers
- Need for orientation and probationary period
- Deployments are disruptive to civilian agencies
- Right commander + right JAG to sign off on it

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### Legal Issues

- DOJ involvement under FTCA
- US Attorney must certify if acting under scope of employment
  - Substitutes the United States as defendant
- Prior to 1989: Military employees at civilian training institution "primarily benefited the TI and not the Army"

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### 1989: The Deal

- US Atty will certify military trainee as "acting within scope of employment IF
  - The military makes an effort to have them covered under the TI's insurance rather than relying on FTCA
  - Quid pro quo with civilian trainees at MTFs- can't have this liability exceeding that provided military members
- "Borrowed servant" defense: Military trainee is "borrowed" by TI and therefore covered by TI's insurance
- Compliance was spotty

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### "Mission-Essential Skills Augmentation and Training"

- Standard Medical Training Agreement (MTA) forms approved by DOJ
- Surgeon General delegates limited authority to Regional Medical Commands to enter into MTAs
  - Delegated only for physicians
- Form 1: TI covers employee under their insurance
- Form 2: Invokes borrowed servant defense and FTCA
  - If TI is unwilling to agree to cover the trainee
- Deviations require JAG review

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### Sustainment of Trauma and Resuscitation Skills Program (STARS-P)

- Maintenance of clinical proficiency at civilian facilities
- Physicians, nurses, RTs

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### Medical Proficiency Training (MPT)

- SOF Medics (18D, PJ, SOCM)
- Required every 4 years to maintain credentials
- Hospital rotations
- Sometimes field rotations

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### Where are we now? Not much further along

- Still hashing these issues out, with some variability
- Duty status to have protection
- EMS agencies are usually happy with the idea of having military medics along
- Holdup is typically on the military side
- Moonlighting

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### Wright State University/Wright Patterson Medical Center

- Integrated civilian/military EM residency program
- Strong tactical division with 10 residents and several overseeing faculty
- Residents: it's part of their training
- Faculty: They're already trained

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### The Argument

- Residents participate, it's in the manual. They are covered for that which is within their duties.
- Faculty teach military residents
- Must remain proficient on operational medical concerns
  - Prehospital care
  - Prepanning
  - Displaced persons
- Residents require direct oversight

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### Wright State University/Wright Patterson Medical Center

- Created MOU with 88<sup>th</sup> Medical Group
- Faculty assigned duties for training residents
- Focus on continuing operational skills
- Posse Comitatus?
- MOU is with WSU, then WSU has MOU with agencies

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### Conclusion

- There are significant roadblocks to having military medics part of your EMS system
- We are (slowly) finding opportunities for more integration

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**WE WANT YOU!**

NAEMSP Military/Civilian  
Trauma Integration Task Force

- Reach out to Brent Myers if you are interested in joining the Task Force

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Questions?

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