Every Military Treatment Facility Should Participate in the US Trauma System: REALLY?

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So Simple, Even a Caveman……

Disclosures/Disclaimers

- No financial conflicts to disclose
- These are DEFINITELY my opinions……
  - but should be yours also
- The question is about ALL MTFs becoming trauma centers
- I am going to lose this debate!

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We Have Both Deployed to War

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I Will be Unable to Explain Why…..

- Jeff has not read the NASEM report
- Jeff wants us to violate the CORE principles of a LHS
- And for you civilians at trauma centers….
  - he wants to take your patients
  - he wants to dilute your volume and experience
  - he wants to waste your tax dollars

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NDAA Section 703

“(b) MEDICAL CENTERS.—(1) The Secretary of Defense shall maintain medical centers in areas with a large population of members of the armed forces and covered beneficiaries.

“(2) Medical centers shall serve as referral facilities for members and covered beneficiaries who require comprehensive health care services that support medical readiness.

“(3) Medical centers shall consist of the following:

“(A) Inpatient and outpatient tertiary care facilities that incorporate specialty and subspecialty care.

“(B) Graduate medical education programs.

“(C) Residency training programs.

“(D) Level one or level two trauma care capabilities.

“(c) HOSPITALS.—(1) The Secretary of Defense shall maintain hospitals in areas where civilian health care facilities are unable to support the health care needs of members of the armed forces and covered beneficiaries.

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Medical Treatment Facilities (MTFs)

63 MTFs in 34 states, the District of Columbia, and Guam

McChord AFB
Fairchild AFB
Malmstrom AFB
Minot AFB
Grand Forks AFB
Mountain Home AFB
Ellsworth AFB
Hanscom AFB
Beale AFB
FE Warren AFB
McGuire AFB
Travis AFB
Hill AFB
Offutt AFB
Dover AFB
Wright Patterson AFB
Buckley AFB
Andrews AFB
USAF Academy
Bolling AFB
Whiteman AFB
Peterson AFB
Nellis AFB
Scott AFB
Vandenberg AFB
McConnell AFB
Langley AFB
Edwards AFB
Seymour Johnson AFB
Vance AFB
Kirtland AFB
Los Angeles AFB
Pope AFB
Tinker AFB
Luke AFB
Shaw AFB
Cannon AFB
Altus AFB
Little Rock AFB
Davis-Monthan AFB
Charleston AFB
Columbus AFB
Sheppard AFB
Holloman AFB
Dyess AFB
Robins AFB
Barksdale AFB
Maxwell AFB
Goodfellow AFB
Moody AFB
Eglin AFB
Keesler AFB
Eielson AFB
Tyndall AFB
Laughlin AFB
Hurlburt Field AFB
Elmendorf AFB
Patrick AFB
Hickam AFB
Randolph AFB
Lackland AFB
MacDill AFB

Integrity - Service - Excellence

● Hospital recommended for downsizing

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The Medical Services Fig Tree

The Bell Jar, By Sylvia Plath

"I saw myself sitting in the crotch of this fig tree, starving to death, just because I couldn't make up my mind which of the figs I would choose."

"I wanted each and every one of them, but choosing one meant losing all the rest."

"…as I sat there, unable to decide, the figs began to wrinkle and go black, and, one by one, they plopped to the ground at my feet"

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WAR ON THE ROCKS

Good commentary requires resources and we work to generate those resources through web traffic. When possible, please share this article using the hyperlink rather than printing it or copying-and-pasting.

The Pentagon's Fig Tree: Reforming The Military Health System

warontherocks.com/2016/09/the-pentagons-fig-tree-reforming-the-military-health-system/

9/25/2016

- Conflicting missions
  - operational readiness ("go to war mission")
  - primary health care all beneficiaries
- Priorities at odds
- Volume and cost/efficiency
- This will NOT change by isolated edict for trauma center status

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Minority of DoD research goes to trauma

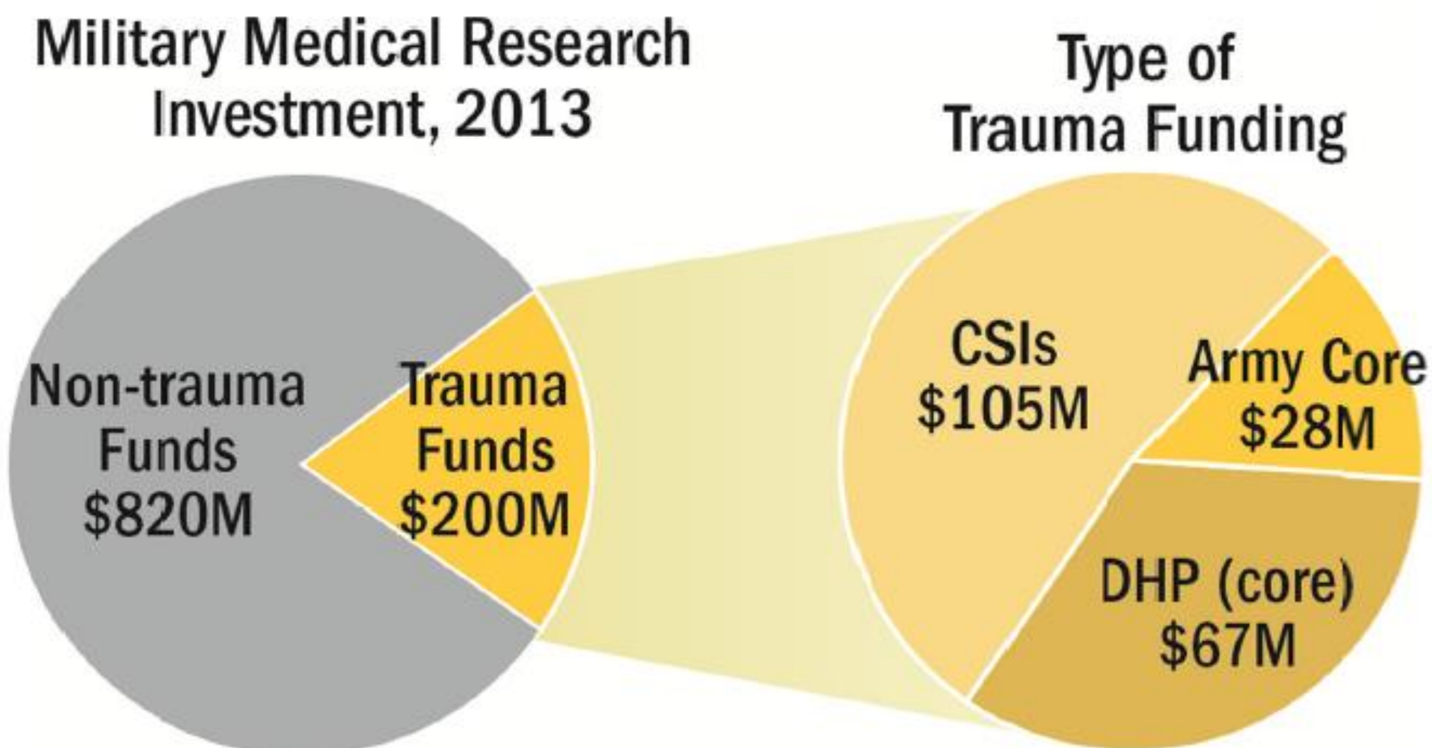
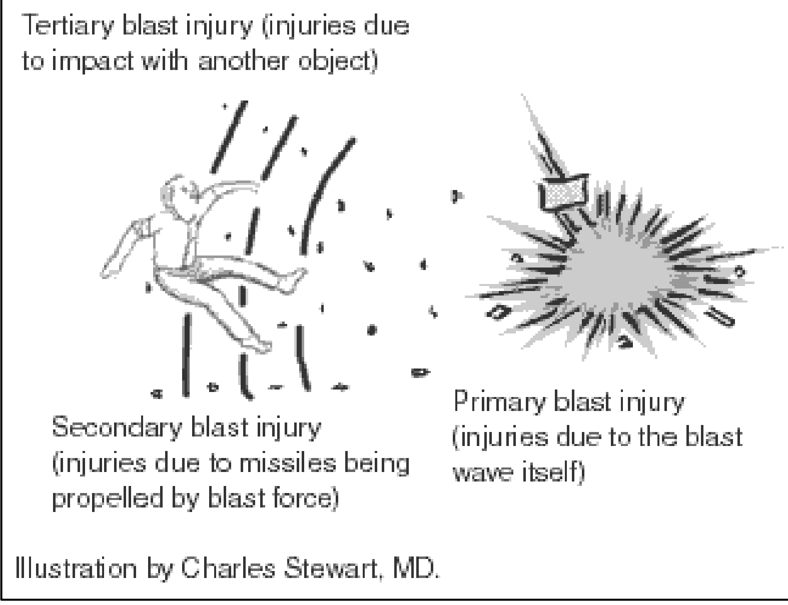


FIGURE 4-5 Funding sources for military medical research, 2013.
NOTE: CSI = Congressional Special Interest; DHP = Defense Health Program.
SOURCE: Data from Rasmussen, 2015.

Military goal is a ready medical force, civilian is optimal patient care.

Are Our Priorities at Odds?

YES!!!! But.......



ORIGINAL STUDY

Impact of Volume Change Over Time on Trauma Mortality in the United States

Joshua B. Brown, MD, MSc, Matthew R. Rosengart, MD, MPH,*† Jeremy M. Kahn, MD, MS,† Deepika Mohan, MD, MPH,*† Brian S. Zuckerbraun, MD,* Timothy R. Billiar, MD,* Andrew B. Peitzman, MD,* Derek C. Angus, MD, MPH,† and Jason L. Sperry, MD, MPH*†*

Br J Surg. 2015 Sep; 102(10): 1213–1219. PMCID: PMC4758415
Published online 2015 Jul 7. doi: 10.1002/bjs.9866

Association between volume of severely injured patients and mortality in German trauma hospitals

M. T. Zacher,[1] K.-G. Kanz,[1] M. Hanschen,[1] S. Häberle,[1] M. van Griensven,[1] R. Lefering,[2] V. Bühren,[3] P. Biberthaler,[1] S. Huber-Wagner,[1] and the TraumaRegister DGU®[4]

Learning Trauma System

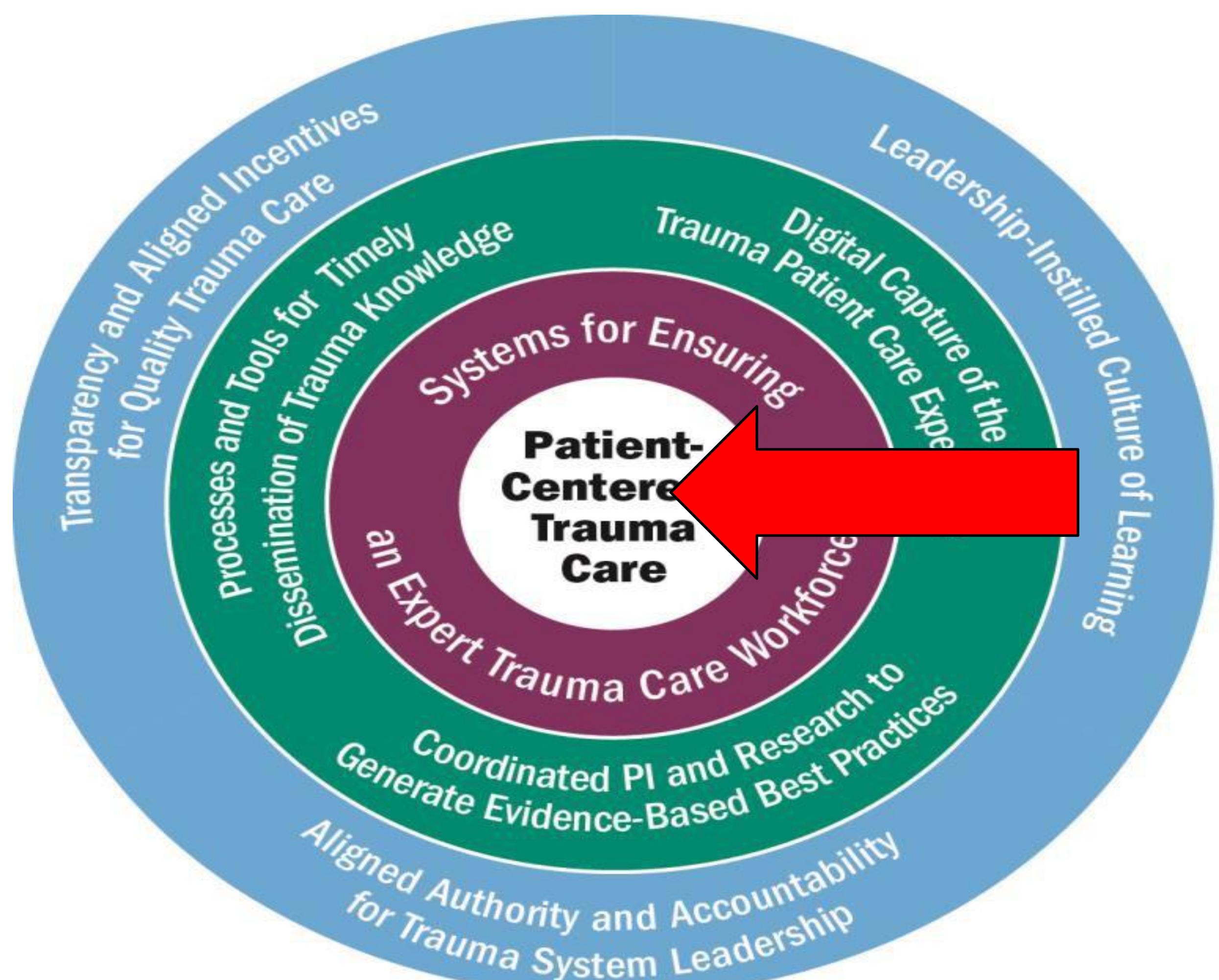


FIGURE 3-2 Components of a learning trauma care system. NOTE: PI = performance improvement.

Is this "patient centered"?

Is this Needs-Based?

American College of Surgeons | Committee on Trauma
Trauma Systems Evaluation and Planning Committee

American College of Surgeons Committee on Trauma
Needs Based Assessment of Trauma Systems (NBATS) Tool

Developed by the Needs-Based Trauma Center Designation Consensus Conference convened by the American College of Surgeons Committee on Trauma[1]

- Local population and trauma volume
- Existing trauma centers and layout
- Community need, Stakeholder support

We Need to Walk the Walk

- 6 months without a TPM at MAMC
- Where are the neurosurgeons going to come from?
- Funding for required CME/CE, NTDB, TQIP
- Inability to see civilians for outpatient f/u
- SAMMC – who covers trauma call?

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IV. Quality Trauma Care
V. Expert Trauma Work Force

Rec 9: Ensure ALL mil/civ trauma systems participate in QI process

Rec 10: Include prehospital care as seamless component

Rec 11: Develop military career paths & joint mil-civ training platforms

One Size DOESN’T Fit All

- Embedded full-time military staff
- Training site & teams rotate through
- Offer GME training rotations
- Outreach to MTFs for CME & MOC
- Provide call coverage opportunities

- or even............

Join the Party!!

C.B. DUNBAR
HOSPITAL
758
WIN
WIN
?

Possible Outcomes of Jeff's Plan?

1. Fills an unmet community need, enhances readiness, no adverse impact on local trauma system
2. New low volume trauma centers, little readiness benefit
3. Further dilutes trauma volume from local system, adverse impact system-wide
4. Fosters military-civilian competition, negative financial impacts, LESS willingness to collaborate

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Possible Outcomes of Jeff's Plan?

1. Fills an unmet community need, enhances readiness,
   no
2. Ne enefit
3. Fu
   ad
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Danger Opportunity

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What is the Right Answer?

Some Thoughts

- Prioritize our ”go to war” mission
- All-in or bow-out of primary care mission
- All military surgeons MUST be trauma surgeons
  - continuous MOC process, tied to pay/bonus
  - ? trauma fellowships for ALL
- MTFs become trauma centers where it makes sense