COERCCC Meeting
13-14 November 2017
San Antonio, TX

Meeting Minutes
18 Nov 2017

Mr. Dominick Sestito

<u>13 November 2017</u>

1). Admin Remarks and Introductions (LTC Cord Cunningham): LTC Cunningham, the Chair of the Committee on En Route Combat Casualty Care (CoERCCC), convened the meeting and welcomed meeting participants. LTC Cunningham briefly reviewed the meeting's agenda. Mr. Dominick Sestito discussed transportation and logistical information for participants.

2). Deployed CCATT Presentation (Dr. Ball): Dr. Ball gave a presentation on his experience as a deployed CCATT team member. During this deployment Dr. Ball was in CENTCOM. At present 2 Afghanistan CCATT teams, conducting 36 total missions and one MASCAL. There were many challenges in regards to resources and capabilities.

The cases Dr. Ball discussed were very diverse.(Cardiac Arrest, Cyanide Poisoning, and IED Blast)

Challenges faced:

- Unregulated missions are becoming more common as gaps in helicopter ambulance(dust-off) coverage increase
- CCATT equipment is designed for STRATEVAC involving long missions for ICU level care
    - Average 700 pounds of equipment on 4 litters
    - Aeromedical Evacuation (AE) Equipment averages 1000 pounds on 5 litters
- Planes for emergent takeoff are not configured for AE
    - MC 130 frequently utilized has a slick floor without stations
- Mission times average 30-60 minutes and frequently involve combat landings and take offs
- MC 130 has no electricity available on some aircraft
    - Required to use on battery power of equipment
- Most patients are best loaded by floor loading on rear of aircraft
    - High acuity of patients and allowing easier access for procedures
    - Faster on load times
    - Requires tethering to floor of aircraft for providers
    - Allows patient care during take off
    - Patients are frequently unstable and care cannot be stopped for take off
- Working in Full IBA

Dr. Ball then discussed the CCATT Lessons Learned.

- Adapt to a new and ever changing environment
- Increased flexibility and coordination with partners
- Increased emphasis on trauma and point of injury experience of providers, nurses and respiratory therapists

- Utilization of CCATT team members in hospital for mass casualty events.
- Close Coordination with AMC/AECT/TPMRC for complex rapid movements

3). JTS Director's Perspective (CAPT Z. Stockinger): Discussed the difference between "busy people" and "productive people" in respect to the transition to DHA, the deliverables of the committees and the JTS as a whole. Compared Deliverables CoTCCC produced over a decade and illustrated the path of success for the CoERCCC.
Message: "Set the standard of care and justify the existence of the committees."

3). Deployed CCATT/USS Bataan (MAJ Brian O'Connell) Dr. O'Connell gave a briefing over a MASCAL event. Patients stabilized aboard the USS Bataan.

Mission Background: 6 Foreign Nationals injured in helicopter crash in contested desert region. Members evacuated to USS Bataan for surgical capabilities and stabilization. 2 CCATT PTs, 4 AE PTs.

Mission Constraints:
- Equipment (Medications, Blood, Ventilation Equipment)
    - Maximum number of patients per CCATT team
        - 3 "critical" (ventilated) or 6 "lower acuity"
    - Propofol, ketamine, fentanyl, levophed, IVF
    - Thawed FFP, packed RBCS
- PT loading and configuration
- Flight Plan altered
- In-flight PT deterioration Medical Emergency declared
- Flight Plan altered many times

Lessons Learned: Hand off Standardization must be implemented, better real time and prior to arrival communications, better framework to convey full patient condition and changes

4). Commanding General AMEDD (MG Lein): MG Lein discussed the tasking of producing doctrine for the DHA transition. MG Lein outlined the DOTMLPF process outlining each task area and what needs to be addressed. First have to define the problem

D-"Where is the doctrine for ERC?" Where are your doctrine writers?
-It doesn't matter which service owns it.
-CoERCCC is tasked with telling DHA what the doctrine needs to look like.
O-What is the CCATT team going to be based on?
-What are the proposed threats of the future, not just now.(Resuscitative Care)
T-Standardize Training!
-Requirements, Cost, approved and standardized
M-What is needed
-Standardized equipment lists
L-Where are your Logistician on this committee? Need to account for specialized committee members.
-Currently only 5% compatibility of equipment throughout tri-services.
P-Questions to be answered pertaining to Personnel:
Who makes up a complete team? How Many? Are they properly trained? Officer vs Enlisted?
F-Where will training be conducted?

MG Lein re-emphasized that the committee is not diversified with the professional areas needed to be successful.(Logisticians, Personnel men, Doctrine Writers). Start by defining GAP requirements. CoERCCC needs to be prepared to tell DHA what needs to happen before DHA tells CoERCCC what is going to happen and we are right back where we are, fighting the same fight we have been fighting for 30 years.

5). REBOA for Hemorrhagic Shock (LCDR Erik Hardy): LCDR Hardy outlined the algorithm for implementation of REBOA.

- SBP> 90 with little response to ATLS Fluid resuscitation
- No Major Chest Trauma
- Abdominal FAST or pelvic fracture positive
- Decide Zone 1 vs Zone 3

Potential pitfalls of REBOA:

- Late Decision
- Clinician Familiarity with Femoral Access and placement
- Failure to address chest pathology
- Balloon over inflation
- Duration of balloon inflation

Question posed "What if you need to move your patient in order to provide a better outcome?"

- Condition: Given the need to evacuate a patient with an inserted REBOA system in place
- Task: Maintain REBOA catheter system
- Standard: In accordance with the JTS guidelines for the use of REBOA for profound shock.

Who should be performing the Patient Transfer?

- CCFP
- ER/ICU Nurse
- Critical Care trained Physician/PA/NP

Goals for Training:

- Critical Care provider familiarization with the ER- REBOA Catheter system to ensure higher reliability of outcome.
- Monitor placement of device Enroute
- Need to inflate balloon
- Ensure proper placement and adjust for migration
- Document and capture clinical findings

- As this intervention becomes more widely used and more research is completed, disseminate JTS protocols to the Uniformed Forces.

6). CCFPP & MERT Training Partnership (LTC Mario Rivera): LTC Rivera gave a presentation about how Army MEDEVAC and RAF MERTs are "Apples & Oranges." They perform different Missions, Platforms, and ERCCC Healthcare Providers.

Comparison and Contrast:

- CCFPP Recertification Course
  - ❑ Main Audience: CCFPs
  - ❑ Length: Two (2) Weeks

- ❑ Healthcare Simulation & Training (~50% of Curriculum)
- ❑ Recertification Requirements:
  - ❑ NRP: Every Two (2) Years
  - ❑ FP-C: Every Four (4) Years
- ❑ MERT Course
  - ❑ Main Audience: Physicians, Nurses, & Paramedics
  - ❑ Length: Two (2) Weeks
  - ❑ Healthcare Simulation & Training ("37 Moulaged Simulators")
  - ❑ Recertification Requirements:
    - Three (3) Year Currency with an 18-Month Review/Update Phase

BLUF: In order to mitigate degradation of Enroute Combat Casualty Care skills, the Army (as well as Air Force, Navy, and Coast Guard) ought to consider collaboration with our coalition partners and counterparts, such as the Royal Air Force (RAF) Medical Emergency Response Teams (MERT).

7). Social Media and Medical Education (SFC Paul Loos): SFC Loos outlined strategy for Social Media for Education.

- Topic Identification from Medic Input
- Expert Consensus Clinical Practice Guidelines
- Podcasts
- Blog Posts
- Facebook Posts
- Instagram Posts
- Link in bio
- Auto Twitter feed
- LinkedIn

SFC Loos outlined how today's generational military are "Gen Z" and rely on quicker information portrayed through an image and not words. Anything can be communicated through images (Training, Case Discussions, Advertising, Quizzes, and Product reviews), and types of posts that are detrimental to your site (Political posts lose 50% of audience)

Ways PAO can assist:

- Photograph or record training events and release content
- Help register an official, unit website, logo and social media page
- Professional recording
- Award winning editing and production
- Fill out a simple request form
- Can give advice

3 things to take home: 1. Adapt educational marketing to your audience, 2. Social Media is a powerful educational platform if used properly, 3. Your medics are learning whether it's from you or an internet troll please get involved…even if it's through an old fashioned email

8). Whole Blood (MAJ Andy Fisher): MAJ Fisher discussed the "WHY" in Whole Blood use, Tactical Implementation and Training on Fresh Whole Blood. A review of data on DOW with hemorrhage/Shock/ATC and the implications for treatment were reviewed. (1) Stop the Bleeding!

(2) Resuscitate active non-compressible bleeding to the best of your ability (This can be done by any well-trained troop)
-Assume the "at best scenario" is a Role 2.
-TCCC guidelines outlined and reinforced in order of precedence (FWB, 1:1:1, PRBC/FFP, FDP/FFP or RBC, Hextend, LR/Plasmalyte) with an overall goal of palpable radial pulse!
-Extend the Golden Hour
-Rapid Pre/In-hospital Transfusion
Why WB? – Give the patient what they are losing, don't make things worse with "clear fluids", keep it simple!
-WB is the simplest way to deliver functionality of lost blood. (Any mix of WB or its components is better than Clear Fluids!)
4 ways to WB:
-Cold Stored O-Low Titer (Blood Bank)
-ROLO (Requires pre-deployment testing/plan)
-Type matched (requires two Eldon cards)
-O for all (Requires a transfusion kit and one Eldon card)

Questions:
-Who manages the CS-LTOWB supply?
-Priority of implementation? (Medics, TACEVAC, Surgical Teams)
-Request Process? (Formal v. Informal)
Issues/standards with Training:
-Frequency of Titer Testing
-Universal OLO donor criteria
-Tracking
-Rh Pos or Neg
-FWB/FDP in CONUS
-Storage and Distribution

<u>14 November 2017</u>

1). Administrative Remarks (LTC Cord Cunningham): LTC Cunningham, the Chair of the Committee on En Route Combat Casualty Care (CoERCCC), convened the meeting. LTC Cunningham briefly reviewed the meeting's agenda for the day.

2). Deployed Medic Presentation (SFC Mickey Mottet): SFC Mottet briefed the group on his experience with the 4th FSMP consisting of 9 MEDEVAC Crew Members. Currently operating in UH-60L (x2) capable of carrying 2 Litters or 3 ambulatory (potentially more depending on equipment and removal of litters).

- Primary role is to provide DELOP support to ODA
- Secondary role as contingency MEDEVAC for TAAC-N (German "Nazgul" primary MEDEVAC)
- 36 CAT-A POI and 1 TACEVAC spread over 12 missions

Missions covered an estimated 62K sq/mi. Not a realistic mission to cover that amount of area.

9 Line Received: Time approx. 0110. Report stated 4 CAT-A w/ GSW and shrapnel injuries. They did receive a MIST report, but incomplete. The pickup location was at the objective, which was in hostile territory. Due to LZ unable to be illuminated properly and taking fire, Lead changed in flight. There was

no LZ marking or LZ control. Upon landing triage category and assessment, POI differed from triage in aircraft.

9 Line received: Time approx. 1750. Report IED while mounted in armored HMMWV. Initial report stated 3 CAT-A, but when they arrived there were 8 patients. Had to perform “dust landings” could barely see hand in front of your face. Once again LZ control was non-existent.

Key Take away:

- ❑ Current policy and doctrine are adequate but could use revision (aircraft type and configuration, crew make up, red crosses, etc.)
- ❑ Medical planners understand patients but do not understand our mission; allocation of resources,
- ❑ Priorities between AVN and AMEDD are not aligned (funding, resources, training, experience)
- ❑ Protocols are moving in the right direction, allow for flexibility in a dynamic environment
- ❑ Standardize medical training (Paramedic recertification course vs "on the job" experience)
- ❑ TPE medical equipment
- ❑ Replace Zoll M
- ❑ Replace Propaq with second defibrillator
- ❑ Replace Impact vent with SAVE II vent(due to simplicity but does lose some settings)

Use of an AXP (need to practice this more at NTC/JRTC)

**Recommendation for Position statement from JTS or with JTS approval on standardization of 2 providers (Paramedic Training) as a deliverable.

3). ECCN Operation Inherent Resolve (MAJ Adam Sokolowski): Mission I: 25y/o ISF with GSW to abdomen. Mission was to transfer from Coalition “surgical site” to Canadian Role II. Understanding was Exploratory Lap with Splenectomy. There was minimal time lost to REDCoN1 due to reserve sleep cycle and bulk of crew already in/near TAC. LZ was unknown as Pt was being transported, until later sparkled with IR Laser. Pt transfer conducted in up-armored SUV. Received French Documentation with IV sedation labeled in French. Turn over conducted by SEAL Medic.

Issues Identified: Taped BVM to ETT; Unknown Meds; Unknown temp; unknown blood loss.

In-Flight Issues: Unable to cut tape from ETT to monitor EtCO2; IV Fentanyl and Versed administered; utilized organic HPNK; VS stable; very short flight from LZ to Role II.

Mission II: 25-30y/o SOF member IED blast in convoy (up-armored SUV). SM opened rear passenger door to visualize obstacles and SUV ran over pressure plate IED.

Issues Encountered: Crew REDCOM1 in 8 min but due to Radio traffic relayed to aircraft: “launch authority would be delayed” 36min. Travel time to POI was 25min. LZ not cleared/not approved to land-cleared by SOF forces, additional 22min. Prior to landing, unable to utilize radio/communication devices as ground as SOF units. Essentially 2min before landing pilots made contact with ground elements.

Initial assessment:

-Emergency airway (field medic) with BVM ventilation

-Multiple penetrating wounds to neck and head with dressings applied, no other site of bleeding
-No palpable carotid, or femoral pulse
-CPR Initiated
-Pads placed
-Non-shockable rhythm
-Vampire protocol initiated
-EtCO2

In-Flight: Further assessment: Significant trauma noted to right side of head, face, neck; Bi-lateral Finger thoracostomy sites noted chest remained relatively unremarkable; Abdomen unremarkable ;Pelvis stable; Lower extremities unremarkable; Left shoulder has small/moderate amount of "peppering" noted.
SM transported to FST; Pt resuscitation continued in FST, but time of death called.

Recommendations:
-Increase in ECCN numbers at multiple areas of responsibility
-Great partnership with established MEDEVAC crew
-Blood capability and computerized tracking system
-Progression for new ECCNs was a little longer than outbound ECCNs

Lessons Learned:
-Training
-Situational Awareness
-OPS had limited SOF information, despite being our primary customer
-Limited ability to communicate with one another
-Equipment/Expendables
-Designated evacuation platform with impaired ECS
-Class VIII
-Time is important

4). Military Preventable Death (Dr. Judson Janak): Dr. Janak spoke on the studies being conducted on Preventable Death and the continuum of care. The preventable death performance improvement is a joint effort between the Joint Trauma System and Armed Forces Medical Examiner System to establish a mortality surveillance system based on a robust scientific methodology. The surveillance system will generate reports as part of a standardized mortality review process which generates preventable death metrics and opportunities to improve combat casualty care. The panel reviews and surveillance system will be based on a sound methodology using explicit definitions, criteria, panel composition, clinical information evaluated and explicit standard operating procedures based on both quantitative and qualitative analyses.

5). RSI vs. Sedated Intubation (MSgt Shawn Anderson): "This briefing is intended to spawn conversation, not provide specific recommendations."

<u>RSI</u>

Pros: Lower potential of inducing vomiting/ aspiration (Rocuronim); Less potential to buck at tube
Cons: Taking away natural respiratory drive; Must respirate patient manually; Failed intubation forces BVM or surgical airway

<u>Sedated Intubation</u>

Pros: Patient maintains respiratory drive; No manual respiration required; Have time to reattempt failed intubations; Removing paralytic step = quicker intubation
Cons: Gag reflex remains; Inc'd risk of aspiration

Is there a time or place when sedated intubation would be appropriate over RSI?
EXAMPLES:
Burn patient w/ actively swelling airway; otherwise has 100% respiratory effort w/ >90% 02 sat.
Extended transport time > 4hours, limited supplies.

Multiple amputation, with controlled hemorrhage, potentially combative. Given ketamine and versed for symbiotic dissociative/amnesic effects. Has 100% respiratory effort w/ sats dropping to below 90%. Needs multiple interventions including airway, needle decompression/chest seals and blood transfusion.

6). TCCC – It All Adds Up (Dr. Jeff Howard): Dr. Howard reviewed The Golden hour criteria. The key findings: (1) Case Fatality Rate decreased significantly after mandate (2) Median transport times decreased by more than half after mandate (3) Individual patients with ISS ≥ 25 (Critically Injured) transported within 60 minutes had significantly lower KIA mortality

Alternative Explanations were discussed: (1) Gradual improvements attributable to time trend ("CFR was going down anyway") (2) Impact of damage control resuscitation ("transfusion argument") (3) Possible harm from inadequate resources (role 2 inferior to role 3?) (4) Changes in wounding patterns over time (types and anatomical distribution of injuries) (5) Reduction in evacuation transport times (so-called "Golden Hour" argument)
2 Key questions posed: (1) What explanatory factors are associated with KIA? (2) How much did each explanatory factor contribute to the observed reduction in KIA after the mandate?

Alternative explanations were evaluated:
Gradual improvements attributable to time trend – Not Supported
Impact of damage control resuscitation - Supported
Possible harm from inadequate resources – Not Supported
Changes in wounding patterns over time – Supported
Reduction in evacuation transport times – Supported

Overall Lesson Learned: "Move the hospital as close to the point of wounding as it will go, bring clinical capability in all its forms as far forward as it can be sustained."

7). EnRoute Research Gap Analysis/ Aeromedical Evacuation Registry (Dr. Elizabeth Bridges): Dr. Bridges reviewed the DoD Trauma Registries and how they applied to Aeromedical Evacuation vs. Military EnRoute Care. The purpose of this scoping study was to conduct a systematic, integrative review of the literature and survey to develop a state of the science summary and identify research gaps specific to regulated en route care.
Results: A systematic review of relevant literature (e.g., PubMed, DTIC, military libraries, AMEDD website) and a hand search of military-specific conference proceedings (e.g., ATACC, MHSRS, ASMA, AMSUS, etc.) and clinical practice guidelines has been conducted. Over 1000 source documents were screened for appropriateness to the topic area and output organized to address current and future research gaps (e.g., time to transport, safe handoffs). Additional topics used for organization included aeromedical evacuation (AE) specific topics such as transport of a patient with entrapped air, hypobaria and hypoxia, and the association between these stresses of flight on morbidity (e.g., wound infections),

as well as consideration of other stresses of flight. En route care including pain management and infection prevention and the use of technologies for the detection of hypoxia and compartment syndrome were also addressed. In addition to trauma patients, research gaps were identified for patients with cardiac or pulmonary dysfunction. Considerations of all theaters of operation and operational events (e.g., wartime, disaster) were also included. The analysis led to the generation of a gap list. Additionally, an evidence table summarizing included/excluded documents and a reference library containing all resource documents were created.
Conclusion: This scoping study represents the first systematic integration of evidence to inform current knowledge and research gaps for regulated aeromedical evacuation and will serve to create a repository of evidence for this unique care environment.

Sub-Committee Round-up and Deliverables Presentations

8). Policy and Doctrine (Col Mark D. Ervin): Col Ervin gave a presentation discussing KSA (Knowledge, Skills, and Attributes), ERC Position Statement, and Lexicon. KSA's are important but should be held as a future project. At the next meeting the focus will be on the initial identification of ERC providers for KSA assessment.

The ERC Position Statement should succinctly declare CoERCCC's mission and vision and alight with the CoTCCC and CoSCCC statements. The audience includes line as well as medical leadership. The focus is the casualty, standardization, simplification, outcomes based guidance and continuous process improvement. The goal for the next meeting is to have a draft position statement for full committee review.

Col Ervin then discussed the Lexicon and the need to define "Stable/Hand-off", "Resuscitation", "Critical Care"(Stable/Interventions).
-Must create standards that are "Service Agnostic" but all inclusive.
-Discussion- Best way to address these concerns are through CPG's with supporting documentation as links within the CPG. Define capability for care and necessary skills/capabilities through billets (Rank/Title/ECCN/EMT??)
-Need to re-define Urgent, Priority etc with a focus on "Clinical Requirements" not mainly Operational definition.

9). CPG/Performance Improvement (CDR Brendon Drew): CDR Drew gave an update on the CPG/PI Committees.
Written Update
- -Transport CPG in draft
- -Next three targets
- -PFC TQ Conversion, CENTCOM Vampire, Packaging

Goals for the next year:
- -First 4 products published
- -First video on the app
- -Discovery (CCFP, SAR, CCATT, PFC and other existing expertise)
- -Pre-hospital and Emergency Care partnership

Concentration in the area of: Resuscitation during transport, care during transition.
What are pending GAPS and needed change?
- -Expanded mission sets
- -Equipment standardization and familiarization

10). Education and Training Committee (LCDR Erik Hardy): LCDR Hardy gave an update on the CoERCCC Subcommittee on Education and Training. The subcommittee currently has a membership of 17 individuals. The committee has been divided into two sections which are strategic and education & training. The focus efforts of the strategic group are to identify current lines of effort across the services, identify where the lines of effort overlap and future projects such as ERC CPG, ERC Application and ERC Podcast. The education and training group is focusing on creating building blocks of education and training "knowns", identifying common education and training objectives throughout the Joint continuum of care and defining patient centered ERC Requirements.

The execution plan is as follows:

- Identify common education and training objectives throughout the Joint continuum of care
    - Define the ERC role
    - Education and Training
    - Learning Objectives
    - Training Product end state

- How
    - COL DeJong's Work on Training Gaps as starting point
    - Teams are divided along service lines and roles
    - Teams will produce learning objectives for all lines of effort
    - Cloud based workspace on MilSuite
    - Product: Matrix of Role and Objectives will illuminate commonality of task

- Define Patient Centered ERC Requirements
    - Identify evidence based patient ERC care requirements across the continuum of care from POI to Definitive Care

- How
    - Team crosses service lines
    - Team will use current evidence to identify general ERC patient care needs at each level of transport
    - Cloud based workspace on MilSuite
    - Product: Capability to Match need document

The product expectations are to have a learning objective matrix that quantifies current training capability across the DoD ERC capability, create a ERC Standard Curriculum Based across the Spectrum, and Create or identify a tool for Battlefield Commanders to quickly educate them on ERC Capability.

LCDR Hardy then went on to discuss the different service's ERC Training along with their representatives and lines of efforts.

The overall goals are to one day create a virtual workspace using MilSuite or other alternatives, in two months have initial products returned to the CoERCCC Chair, to continue the planning and development of education support tools and to continue work with stimulated response.

11). Products and Research Steering (COL Cap/Lt Col Jennifer Hatzfeld): Lt Col Hatzfeld gave an update on the CoERCCC Research & Products Sub-Committee. The subcommittee approach was to review the CCCRP R&D portfolio, review the USAFSAM ERC literature review/scoping study, consider existing service requirements, and to have the subcommittee integrating discussion.

The subcommittees Top 10 Research Priorities are as follows:

1. Documentation
   - Identify minimal documentation elements
   - Simple, iterative, "what, why, when" supports not only hand-off but also on-going care (memory aide) and research

   Hand-offs
   - Identify optimal hand-off methods
2. Monitoring
   - Miniaturization, individualized monitors
3. Maintenance of normothermia during ERC
   - Blood warmers
   - Body warmers
   - TBI, fever
4. TBI transport
   - Motion effects
   - Hypoxia/ altitude effects
5. Optimizing timing of DCR & DCS interventions around transport
   - Decision support tools to integrate mode of transport, duration, resources
   - Decision support for staffing transport missions ("intelligent tasking")
6. Transportation risk stratification
   - Resource-adjusted "clinical stability" risk scoring
7. Physiology of cardiopulmonary decompensation in transport
   - Pulmonary complications, oxygenation
   - ECMO as a risk mitigator
8. Decision rules for intubation/extubation and transport
   - Outcomes associated with transport adverse events, delayed extubation (VAP rates, etc.)
9. Commander's risk assessment tool
   - Mortality effects of staffing & capability decisions
10. ERC Pain management
    - Assessment, monitoring, dosing

Top product development priorities are as follows:

- "Wand" (wireless scanning documentation device)
  - Record type/timing of interventions (grocery store scanner, RFID)
- Tele-documentation
  - Voice to text, from ground medic to evac team
- Effective blood warmers
  - Rapid, maintain blood functionality
- Individual patient monitors
  - Goes with patient, collects continuous data throughout continuum

- Decision support embedded in monitors
  - Guide DCR interventions, management decisions
- Autonomous intervention systems
  - Ventilation, resuscitation, etc.
- Oxygen concentrators
  - Optimized for transport
- REBOA for transport
  - Linked to monitors, autonomous systems, decision support

DELIVERABLES
-Outline of overview paper (Andre/Jennifer) – will send to working group to contribute
-Summary papers to publish (research working group members)
    -ECMO
    -Hand-offs
-War game exercise to refine gap analysis
What has your sub-committee accomplished?
    -Re-assessment of research priorities, plan for deliverables
What are your goals for the next year?
    -Deliver overview papers, plan war game, begin special topic papers, track/fund short term research priorities
What are the advances in your area of concentration?
    -Many projects underway; will report in next 1-2 years
How does your AOC impact the ERCCC/SCCC?
    -Close capability gaps, develop new capabilities

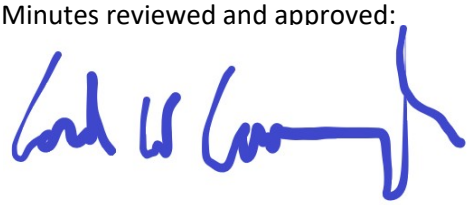
12). Transfer of Care/Documentation (COL Kimberlie Biever): COL Biever discussed documentation and patient handoff.

1. Continue mandatory use of 1380
2. Create a DD Form for evacuation documentation for patients moved to surgical capability
3. Create a DD Form for evacuation documentation for patients moved from surgical capability
4. Document the pathway(s) for documentation to get into patient records and to JTS
5. Continue use of MIST for prehospital through ED handoff; create a checklist for receiving person (unit)
6. Continue use of SBAR for all other patient handoffs after the ED; create a checklist for receiving person (unit)
7. Work with Education Subcommittee to integrate documentation training into curriculum for en route care
8. Update the Documentation/Patient Transport CPG and provide to CPG Subcommittee for review/action
9. Continue to search for innovative methods for documentation capture (transcription, video capture, audio transmit, TEMPUS PRO, Telemedicine, use of think tanks for solutions)'
10. Document the top research gaps related to documentation and patient handoff.

Discussion occurred amongst the group on if the current form meets the needs across continuum of care. It was suggested to incorporate information from both the CCAT & PCR forms. During discussion it was noted that there hasn't been a particular meeting about en route care documentation with CERNER.

Should there be checklists at different points of injury to pass the necessary information? There should be collaboration with the education subcommittee to ensure it is pushed at training platforms.

Minutes reviewed and approved:



LTC Cord Cunningham, MD, MPH Committee Chair 18 Dec 2017

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Enclosure (1) – Meeting Attendance

CoERCCC Voting Members:
LTC Cord Cunningham
CAPT Zsolt Stockinger
Col Stacy Shackelford
Col Mark Ervin
CDR Benjamin Walrath (Deployed)
Lt Col Jennifer Hatzfeld
LTC Steven Gaydos
CPT Lance Oldorf
Col Jay Johannigman (Deployed)
LTC Neil Davids
COL Kimberlie Biever
COL Andrew Cap
MAJ John Houk
LTC Mark Jacques
Col Chetan Kharod
CAPT Christopher Lucas
CDR Joshua Tobin
MAJ Donald Keen
Maj Joseph Maddry
CDR Brendon Drew
LCDR Erik Hardy
MSgt Shawn Anderson
TSgt Jerediah Fontanos
SFC Kristopher Hale
LTC Mario Rivera-Barbosa
LCDR David Goodrich
LTC Theodore Redman
MSgt Athena Sotak
SSgt Caleb Washburn
CDR Jeff Alton
HMC Wayne Papalski
CAPT Tracy Thompson
LCDR Elliott Ross
SFC Joseph Buatti
1SG Matthew Harmon
SFC Bjoern Pietrzyk
SFC Joseph Hernandez
Maj Daniel Cox
Col Russel Frantz
CDR Henry Casey
HM1 Richmond Roy

Subject Matter Experts:
Dr. Mary Ann Spott
Harold Montgomery
Dr. Judson Janak
Dr. Jeff Howard

COERCCC Staff:
Mr. Dominick Sestito

Additional Guests:
MG Brian Lein
Lt Col Antoinette Shinn
Maj Eric Ball
Tamara Averettbrauer
SFC Mickey Mottet
Maj Brian O'connell
Dr. Elizabeth Bridges (Dial-in)
Mr. Dario Rodriguez
Lt Col Vikhyat Bebarta
Richard Stefanski
CAPT Justice Parrot
SFC Erik Pelky
Sherry Fraley
LTC Kevin Cron
MAJ Adam Sokolowski
Col Michael Davis
SFC Paul Loos