

**COERCCC Meeting  
25-26th April 2018  
San Antonio, TX**

**Meeting Minutes  
4 May 2018**

**Mr. Dominick Sestito**

**25 April 2018**

**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 (CPT Hague/CPT Coccagna):** A presentation on their experience as a deployed CCATT team members. This deployment was in CENTCOM. There was only a 10 day overlap of incoming/outgoing ECCN's. There were many challenges in regards to resources and capabilities. Operating in different AOR's, their flight missions ranged from 5-80 and had flight times ranging from 20min to 3hrs.

Missions were overwhelmingly Coalition forces or Afghan Nationality with approx. 90% being Male. Most notable flights:

- Received an Intubated patient who was not on a ventilator
- Patients with limbs in a bag
- Transferring Afghan patients from Role III to Role I for transfer out

Lessons Learned/ Suggestions:

- JECC was invaluable pre-deployment training.
- Inability to meet and train with unit prior to deployment
- Inability to have trauma rotations prior to deployment
- Missing/broken/outdated gear
- Need for pre-deployment radio procedures
- Defining Lead Role ECCN vs Medic

Both had the ability to provide and take part in weekly training:

- Participated in weekly JTS dial-in
- Monthly JECC VTC's
- Brigade Surgeon Visits
- Medic Monday's

Overall they had a great experience with a wide range of support (CCFP's/EMT-B's)

**3). JTS Director's Perspective (CAPT Z. Stockinger):** CAPT Stockinger was on TDY travel and unavailable to speak to the committee.

**4). Ground Evacuation WG (George Hildebrandt)** Mr. Hildebrandt gave a briefing from the U.S. Army Health Readiness Center of Excellence with focus on:

- Facilitate crosstalk between stakeholders and enhance synchronization of action between inter-related efforts.

- To provide a 'holistic' view of status of ground evacuation efforts in order to better inform leadership (CDID, HRCoE, etc.).

- Air is the preferred method, but decision on use is METT-TC dependent.

- Dedicated medical providers, with flexibility to add higher-level medical capability

- Situational awareness of the regional medical capabilities (e.g., bed status, thoracic vs. neuro specialties, etc.) and capacities essential to ensure the patient is delivered to the appropriate treatment facility

- Each patient is critically managed from POI through successive roles of care  
CASEVAC assets augment MEDEVAC assets when capacities exceeded

Implications of future operating environments:

-Highly variable scope, scale, and tempo of casualties

-Extended evacuation times

-Challenged battlefield access

-Increased complexity of evacuation

Overarching goal:

Identify Treatment Capabilities for Ground Evacuation

-Required Training

-Ground Evac WG has identified 50 additional tasks required to train IOT provide En Route Critical Care.(baseline was 68W STP)

-Required Equipment

-Currently cross walking medical tasks with equipment.

-Address Identified Gaps related to Ground Evacuation

-Capability to maneuver with supported elements (AMPV/JLTV)

-Provide Critical Care during Ground Evacuation

Future Needs:

- Improving the current capability of the ground evacuation platforms and their providers
  - Medical: Closed Loop, Education, Types of Providers
  - Platform: Treatment Area, Stability, # of Providers
- Providing the needed Mobility, Survivability, and Sustainability for Ground Evacuation Platforms
  - Speed, Range, Stability(litter system)
- Increasing Situational Awareness for Medical Capabilities related to Ground Evacuation Platforms
  - Utilizing concept of Air Ambulance Roadmap
  - Improvements vs Replacement (platform & interior)

Lessons Learned: Hand off Standardization must be implemented.

**4). En Route Care Research Gap Analysis (Col Elizabeth Bridges):** Funding: Joint Program Committee for En Route Care (JPC-6), for 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 ERC.

#### GAP List Summary:

- ✎ There is NO evidence on the best way to care for orthopedic injuries during transport
- ✎ There is NO evidence on the best way to transport Chem/Rad/Nuclear injuries (it wasn't a category, other than 'infectious disease'/'infection prevention' which could cover biologic in CBRN)
- ✎ Limited amount of information on nutrition, patient safety, mental health, and burns
- ✎ More current/complete research may be needed with abdominal injuries (only 3 from 1967-2002).
- ✎ Larger body of evidence and well-documented gaps in Cardiac, Neuro [TBI], Pain, Trauma, Hypoxia and CAR (variable strength of evidence).

Col Bridges provided a GAP list from the research sub-committee with a current status. The next step needs to be:

#### Expert Review of Gap Lists.

##### Gaps:

- En route management/care of patients with spinal injury (with/without VSB requirement)
- En route stresses of flight (hypoxemia, altered glycemic control) – factors potentially associated with long term outcomes
- Number of patients evacuated with spinal precautions (adjudication of actual requirement)
- Standardization of statistical methods to calculate rates<sup>223</sup>
- Compliance rate for CPG during transport in patients with spinal injury (from AFMS gap analysis)
- CCATT outcomes of movement of casualties with thoracic and/or lumbar spinal fractures utilizing the Vacuum Spine Board
- CCATT outcomes of movement of casualties with thoracic and/or lumbar spinal fractures between (What AOR/what timeframe)

#### GAP review:

Review summary of entire library for topic (included/excluded documents)

- Were documents adjudicated correctly (include/exclude)
- Are there any documents missing (provide for inclusion)
- Review gap list (make recommended revisions based on available evidence)

#### **5). Mechanical Ventilation Methods in Transport of Critically Injured and Ill Patients by Critical Care**

**Air Transport Teams (CCATT) (Maj Joseph Maddy):** Maj Maddy outlined this study that was conducted under a protocol reviewed and approved by the Wilford Hall Ambulatory Surgical Center IRB and in accordance with the approved protocol.

The study aimed to:

- Describe ventilator settings of patients transported by CCATT
- Evaluate the influence of ventilator settings on patient outcomes (through 30 days)
- Provide data to improve utilization of existing CPG and identify potential gaps

#### Retrospective review

- CCATT medical records
- Patients requiring mechanical ventilation
- Transported Jan 2011 and Oct 2012

Data collected:

- CCATT Records
- Demographics, injury description
- Pre-flight vitals, labs, and oxygenation status
- In-flight vitals, labs, interventions, and complications
- Post-flight vitals and labs

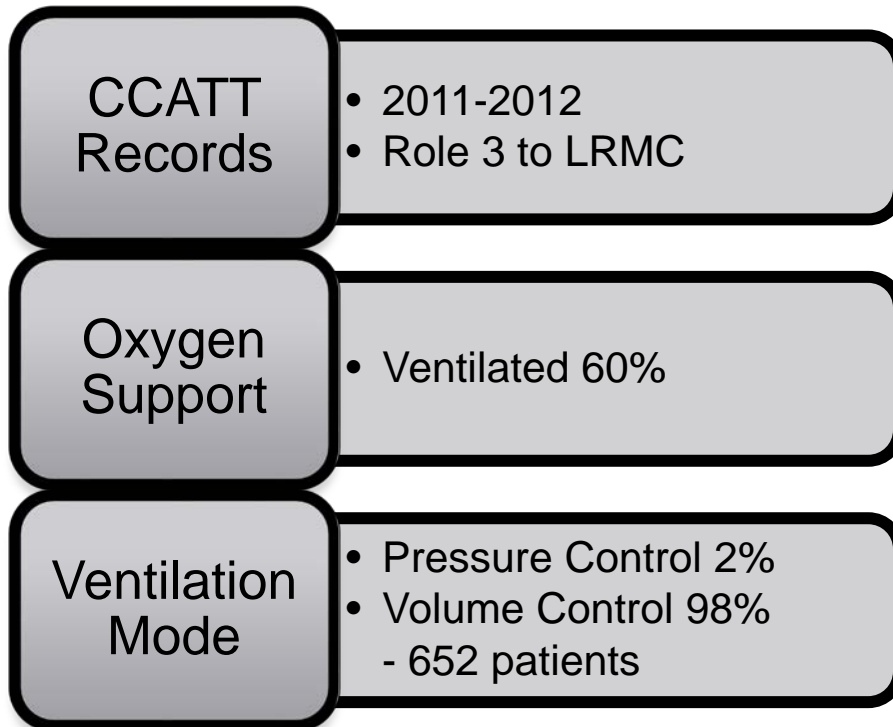
Department of Defense Trauma Registry (DoDTR)

- ISS
- Clinical events
- Mortality
- Outcomes up to 30 days

Statistical Methods:

- Frequencies and proportions
- Chi-square or Fisher's exact for categorical variables (%)
- T-test for continuous variables; Median [Interquartile Range]
- Significance set at  $p < 0.05$

Study Population:



-Abstractors trained, consensus review, serial meetings

Outcomes:

	Compliant median[IQR] n=322	Non-Compliant median[IQR] n=329	p-value
Post-Flight Respiratory Event	28%	34%	0.07
ARDS/ARF/VAP	2%	9%	<0.0001
Post-Flight Coagulopathy	18%	18%	0.90
DVT/PE	9%	11%	0.63
Post-Flight Cardiac Event	16%	16%	0.99
Post-Flight Hemodynamic Event	24%	25%	0.76
Post-Flight Renal/Urinary Event	13%	9%	0.05
Ventilator Days	4 [3-6]	5 [3-8]	0.004
ICU Days	6 [4-9]	7 [4-13]	0.009
Hospital Days	12 [5-37]	14 [5-38]	0.82
Survival	3%	5%	0.03

Conclusion:

- Over half of CCATT patients require mechanical ventilation
- Compliance with ARDS table recommendations is low
- Non-compliance is associated with more ventilator days, ICU days, and hospital days
- Non-compliance is associated with increased mortality

**6). The Center for Sustainment of Trauma and Readiness Skills Cincinnati (Maj Brian Gavitt):** Maj Gavitt gave a presentation about the CCATT Manual, to include content, background, references, and TTP's.

PEER Review Data showed:

- Reduction in deaths
- Reduction in complications
- Improved team communication

Challenges:

- Comprehensive review
- Limited by allowance standard
- Full Spectrum Medical Readiness Training
  - Broader specialty inclusion
    - Plastic surgery
    - Hematology and Oncology
- No clinical currency requirement

Portable format

- Paper
- Electronic

## Key content

- Allowance standard reference
  - Medication list
  - Standard medication dosing
  - Inventory location
- Rapid medical reference
  - CPG based management guidelines
  - Rapid clinical summary
  - Applicable across disciplines
- Aeromedical TTPs
  - Non-clinical applications
  - Go/No-Go
  - Documentation
  - Pre and Post Mission
  - Oxygen calculations
  
- Expanded Capability
  - Specialist contact information

Discussion was prompted on EnRoute Care Standardization, content, & development.

The Committee broke for lunch and convened at 1300 into assigned sub-committee working groups. The sub-committees concluded at 1700.

## **26 April 2018**

**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 Sea Based CASEVAC Presentation (LCDR Hamrick, LT Moore, HMC Pon):** LT Moore and HMC Pon briefed the group on their experience with the Fleet Surgical Team (FST) aboard the USS Bataan. Their overview covered Damage Control Surgery Team (Composition, Capabilities, ERC Training)

- Shipboard Role II Overview
- Mass Casualty/Patient Overview
- En Route Care Challenges

Embarked Teams aboard the Bataan:

- Fleet Surgical Team 6 (FST)
  - Capabilities:
    - Role II Afloat on US Navy Amphibious Ships LHD/LPD Class
    - Receive, Resuscitate, Operate and Transport Casualties
    - FSTs Do not own or transport any equipment, they are designed to fall in on installed gear and stocked medical supplies located on the ship.
- Expeditionary Resuscitative Surgical System 18 (ERSS-18)
  - Capabilities:
    - Role II Light Maneuver/Mobile Role II Surgical Team

- Operate Ashore and Afloat as close to the Point of Injury as possible (historically an Afloat Asset)
- Receive, Resuscitate, Operate and Transport Casualties
- Expeditionary Trauma Team (ETT), Surgical Team (EST) and En Route Care (ERC) Components.
- Approximately 2700 lbs. of Gear – Roughly 30 Pelican Cases – 6 wooden pallets, or 1 463L Pallet “Airforce Pallet”
- Transport and Store 20 units of PRBCs and 20 Units FFP
- Special Operations Surgical Resuscitation Team (SRT)

#### Pre-deployment Training:

- Tactical Combat Casualty Care (TCCC)
- Combat Casualty Care Course (C-4)
- Emergency Warfare Surgery Course (EWS)
- Aviation Survival Training Course (ASTC)
- Navy Trauma Training Center (NTTC/ “LA Trauma”)
- Joint En Route Care Course (JECC)
- Surface Warfare Medical Institute (SWMI – Entire Team)

#### USS Bataan, Casualty Receiving Ship

##### Capabilities:

- 4 Operating Rooms
- 15-Bed ICU
- 45-Bed Medical Ward
- Lab and X-ray
- Frozen Blood Bank
- “Walking Blood Bank”
- Can receive via Surface or Air

#### Blood Bank

Capabilities: 130 Sailors are Pre-Screened / WBB Activated with Ship-Wide Announcement / Six Phlebotomy Stations Prepared (Dental) / Only Type-Specific FWB is Transfused, NOT Low-Titer O Negative FWB / Donor and Recipient Blood Types are Confirmed with Type-Specific Antisera Prior to Transfusion

- Frozen Blood Bank
- 400 Units pRBCs
- 50 Units FFP
- No Platelets/No Apheresis Machine

MASCAL at Sea - Six casualties transported by MV-22 to the USS BATAAN following a helicopter crash. Six (6) Patients Transported with Crash injuries – 1. Unstable Pelvis, requiring 6 units FWB 2. lower limb deformity requiring 4 units FWB, 3. severe facial laceration w Left anterior thoracotomy and Aortic cross-clamp, requiring 28 units FWB, 4. spinal injury, 5. Spinal injury, 6. Open lower leg fracture, requiring 1 unit FWB.

- via 2x MV-22
- Tail-To-Tail with AF CCAT On Ground
- Short Flight From Ship-To-Shore, < 15mins
- Long Wait on Flight Deck Prior to Debarkation
- Unreliable Impact Ventilators; Patients Hand Ventilated
- Unreliable Monitors, two batteries failed mid-flight

Patient Handoff:

USAF C-17 with Equipped CCAT Package; Ample Staff, Equipment, and Supplies

CCAT Officer Acted as Single Entry Point, Triaging Patients Which Delayed Entry onto Aircraft

Prolonging Wait Time on Flight Line While Patients were Connected to Equipment with Demonstrated Reliability Issues

**3). Senior Leader PACOM (VDML Louis Tripoli):** VDML Tripoli conducted an open and thought provoking discussion about the future of PACOM, possibilities of conflict in the area, obstacles, patient evacuation, and the re-structuring of the mindset and training of TRIAGE in an overwhelming MASCAL environment, where air superiority is not guaranteed.

**4). TRAMSCOM SG Comments (BG (Sel) FPaul Friedrichs):** BG(Sel) Friedrichs opened by stating”

“It is the mission and purpose of the CoERCCC to focus on strategic, patient first mentality, and put aside all service specific needs and wants.

“The committee must identify joint reps who focus on the “O plan”, and it is ok for things to be left out. It won’t be perfect. Each service must address Gaps and submit a CAPE to make valid requirements and get them back to the Combatant Commanders.”

“CoERCCC needs to partner with colleagues, by producing a Joint Med Planning Tool; working with resourcers and planners, and partnering with Line Leadership to produce valid requirements.”

“Right now there is an inability to articulate current “O Plans, and tactically implement them. There are no “good” plans in place outlining with great detail, such as CPG’s, but there are no resource requirements.”

Major concerns the CoERCCC needs to focus on:

- No CBRNE Plan (PACOM focus)
- How can/do we operate
- How do we provide trauma care
- Non-combatant evacuations
- Large scale evacuations
- We have no definitive plan, we are not prepared

**5). High reliability organization and applicability to the battlefield to reduce errors associated with combat casualty care (MAJ Johnnie Robbins):** The purpose of this study is to analyze the possible effectiveness of HRO tools to decrease preventable error in the deployed environment.

**Preventable error:** An adverse event attributable to error caused by medical management rather than the underlying condition of the patient. These events are considered to be preventable and often result in error because of a system design flaw (Kohn 1999; Joint Commission 2015).



Methodology:

- Systematic Review in PubMed
- Boolean Terms: High Reliability Organization, Hospital, and Error\*
- 2011-2015 (5 years)-70 articles
- 36 articles removed due to focus on reliability on “accuracy” of medical instrumentation devices
- 34 articles used for literature review
- Levels of evidence hierarchy based on modified evidence tables by Melnyk and Fineour Overholt (2005)
- John Hopkins Quality of Evidence Appraisal
- Findings organized by HRO concepts

*It is estimated that A patient will experience 24 handovers of care and subjected to an estimated 13 percent error rate associated with additional risks from handover (Robertson et al. 2014).*

<b>PREOCCUPATION WITH FAILURE</b>
<ul style="list-style-type: none"><li>• Address perception of elements that may lead to failure<sup>18-19, 22</sup></li><li>• Adverse Drug Prevention Bundles<sup>1</sup></li><li>• Assess triggers that may cause latent/active failure<sup>18-19</sup></li><li>• Aviation Black Box Principles to track failures<sup>3</sup></li><li>• Checklists<sup>12</sup></li><li>• Develop ways to standardize<sup>4</sup></li><li>• Encourage and reward near miss reporting<sup>13, 16</sup></li><li>• Error Prevention task force<sup>1, 32</sup></li><li>• Expedited and easy reporting mechanism for near miss, clinical deterioration<sup>20, 26</sup></li><li>• In situ simulation to identify latent errors<sup>14</sup></li><li>• Real time/Situation awareness of all error and potential for error<sup>5-6, 15, 30, 34</sup></li><li>• Share adverse events/near misses<sup>7, 8, 24, 31</sup></li><li>• Standardized handover that poses question to support accurate transfer of information<sup>17</sup></li><li>• Training on small events that lead to major events<sup>21</sup></li><li>• Understanding multiple facets of various factors (human, medical, material, equipment, facilities, systems) that lead to error<sup>11, 27</sup></li><li>• Utilize the Failure Mode Effect Analysis to prospectively look for way to prevent risk, and identify low level errors<sup>10, 24-25</sup></li></ul>

*Source: Created by author*

To build reliability, ERC providers require training on the most common platforms utilized for evacuation. This type of training will give the ERC provider an understanding of the environment utilized for evacuation. This will allow a collective mindfulness state to set the casualty up for success and avoid patient safety errors. AVOID PLATFORM AGNOSTIC TRAINING!

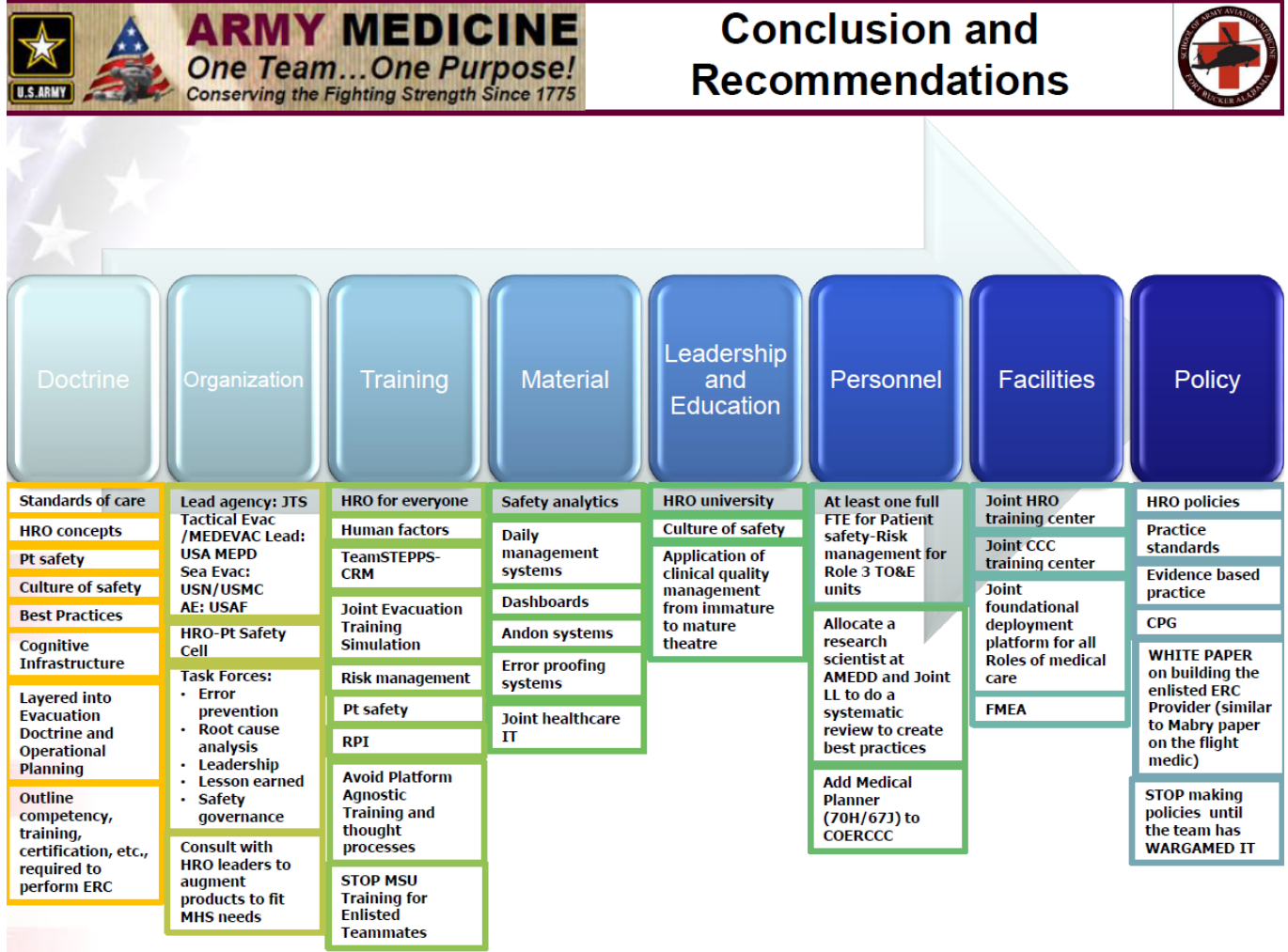
•Challenges:

- Attaining consensus in developing a standard and maintaining it.
- Every Service is different with various medical capabilities.
- Convincing the Warfighter/Congress
- Funding

•Opportunities:

- Every Service alone cannot provide the full spectrum of healthcare operations
- Maximize joint standardization such as handovers during enroute care
- Utilize robust process improvements to prevent, identify and mitigate and to redesign.

Conclusions and Recommendations:



**Sub-Committee Round-up and Deliverables Presentations**

**6). 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 align 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 “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 Operational definition.

## **7). CPG/Performance Improvement (CDR Ben Walrath):** CDR Walrath update on the CPG/PI Committees.

CPG Process:

- -At meeting- Identify required CPGs, prioritize, and select top 3 for drafting. Assign committee member as lead.
- Month 1- Assemble team of authors
- Month 2-3- Authors draft CPG
- Month 4- Lead coordinates metrics/evaluation criteria with JTS team
- Month 5- Distribution to CoERCCC for review/discussion
- Next meeting- Vote to approve CPG (2/3 majority)
- If approved, JTS technical writer review and submit for publication

First Priority CPG’s

- Ventilator Management-MSgt Lawrence Whitmore
- Blood Products (Vampire Protocol)-CDR Joshua Tobin
- Patient Packaging-CAPT Justice Parrott/Maj Kevin Semelrath

Next Meeting Agenda Priorities for CPG Sub-committee:

-Approve 3 CPGs

-Identify 10 CPGs needed. Select top 3 for draft.

-Assign lead and composition of author team

-Future meetings- review metrics for approved CPGs

**8). 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.

**9). 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.

Actions:

- Reviewed & Updated Research Priorities in Following Areas:
  - Information sharing
  - Technology
  - Knowledge products/physiology
- Need to Consider:
  - Current Operational Needs & Challenges (CDDs)
  - Future Operational Needs & Challenges (A2AD)
  - Platform Agnostic
- Highest Priority – Publish Top Ten CoERCCC Priorities ASAP
- Other Planned Actions

- Review Gaps for Regulated Patient Transport Scoping Study (Liz Bridges)
- Oxygen Requirements for En Route Care Patients (Dario Rodriguez)

Review of DoD funded En Route Care Research

Timelines for Deliverables:

- Assigned POC to provide the following for each priority within 30 days
  - Description of the research priority
  - Research questions & development areas
  - Use case
- Chair/Co-Chair to complete manuscript and submit for publication by August 2018 (potentially with CoSCCC)
- Provide review of regulated en route care scoping study gaps over coming weeks (publish in Journal of Trauma)
- At Nov 2018 CoERCCC meeting
  - Review current DoD funded efforts
  - Review results of recent wargaming/exercises (JPC-6 & ISR, AMC, and TRANSCOM efforts)

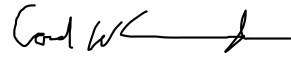
Updated Research Priorities:

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. Documentation (Joe Maddry)</li> <li>2. Hand Offs (John Lane)</li> <li>3. Commander's Risk Assessment Tool (Tamara Averett-Brauer)</li> <li>4. Maintain Normothermia (George Hildebrandt)</li> <li>5. DCR/DCS Timing around Transport (Andre Cap)</li> </ol> | <ol style="list-style-type: none"> <li>6. Transport Physiology (Liz Bridges)</li> <li>7. Monitoring (George Hildebrandt)</li> <li>8. Unmanned Transport (Anne Ritter)</li> <li>9. Intelligent Tasking (Jennifer Hatzfeld)</li> <li>10. Clinical Decision Support (Dario Rodriguez)</li> </ol> |
|---|---|

**10). Transfer of Care/Documentation (COL Kimberlie Bieber):** COL Bieber 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.



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Cord Cunningham  
LTC, MC  
Committee Chair

### Enclosure (1) – Meeting Attendance

#### CoERCCC Voting Members:

LTC Cord Cunningham  
Col Mark Ervin  
CDR Benjamin Walrath  
Lt Col Jennifer Hatzfeld  
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  
LCDR Erik Hardy  
LTC Mario Rivera-Barbosa  
LCDR Domenique Selby  
SSgt Caleb Washburn  
CDR Jeff Alton  
HMC Wayne Papalski  
SFC Joseph Buatti  
1SG Matthew Harmon  
SFC Joseph Hernandez  
1SG Branden Coughlin  
TSgt Jerediah Fontanos  
COL Stephen Linck  
LtCol Edward Mazuchowski  
Maj Kevin Semelrath  
MSgt Lawrence Whitmore  
HMC Richard O'dell

#### Subject Matter Experts:

Dr. Mary Ann Spott  
Harold Montgomery  
Dr. Judson Janak  
Dr. Jeff Howard  
George Hildebrandt  
Mr. Kevin Kelley  
Dr. Anne Ritter

#### COERCCC Staff:

Mr. Dominick Sestito  
Kimberly Smith  
Harold Montgomery

#### Additional Guests:

**RDML Louis C. Tripoli**  
Tamara Averettbrauer  
Dr. Elizabeth Bridges  
Mr. Dario Rodriguez  
CAPT Justice Parrot  
SFC Paul Loos  
LT Logan Moore  
Maj Heather Cohen  
HMC Larry Pon  
MAJ Genna Speed  
LTC Tristan Monchal  
Maj Brian Gavitt

