



Committee on En Route Combat Casualty Care (CoERCCC) Meeting Minutes, 03-04 2022

Prepared by: Mr. Thomas Rich

Note: The meeting was initially planned for February, but COVID and other restrictions made it necessary to move it to March.

DAY ONE (Thurs, 3 Mar)		
Virtual Information: https://connect.apan.org/coercc-mtg/		
Toll: 1-212-287-1861		
Toll Free: 800-369-2065		Code: 6085634
Hilton Tampa Airport Westshore		Gasparilla Room 3-4
Time (Eastern)	Event / Topic	Presenter / POC
0800-0815	CoERCCC Welcome & Administrative	COL Cunningham / Mr Rich
0815-0845	CoERCCC Hail & Farewell Committee Documents	COL Cunningham/Mr Rich
0845-0930	CoERCCC Review of Past Meeting Due-Outs and Status	COL Cunningham / Mr Rich
0930-1015	Recent Deployed experiences 24 th MEU HKIA MASCAL	LT Kevin Hunt
30 Minute Break		
1045-1130	CENTCOM ECCN/ERC case and topics	MAJ McDonald, MAJ Salgado, MAJ Ruben
1130-1215	TACEVAC and ERC CPG structure	COL Cunningham
1215-1300	Joint Trauma CTS update	Teresa Duquette-Frame/COL Baker
60 Minute Lunch / Break		

Attendance: 31 In person and ~20 additional personnel virtually

DAY #1

0800 Day #1/3 March 2022

1). Admin Remarks and Introductions (COL Cunningham/Mr. Rich)

COL Cunningham the Chair for En Route Committee, convened the meeting and welcomed meeting participants. COL Cunningham briefly reviewed the agenda and welcomed VIP guests, members, presenters, and invitees. Mr. Rich, CoERCCC Program Manager reviewed internal business rules and administrative announcements.

Issue: DD 3104 (Replacement for DHA 4700 OP4 replacement) delays

Discussion: There have been numerous delays of the full release of the new DD 3104.

Recommendation: Request a high-level update request from JTS to DHA J-1

2). CoERCCC Hail & Farewells

COL Cunningham informed the group that we have recently gone through a fairly substantial membership turn over. He thanked those that had served and were now moving on to other challenges. The USAF membership is still completing their review and will send an update to Mr. Rich NLT 31 March 2022. An updated membership list was sent to Subcommittee Leads.

Issue: Finalize membership review

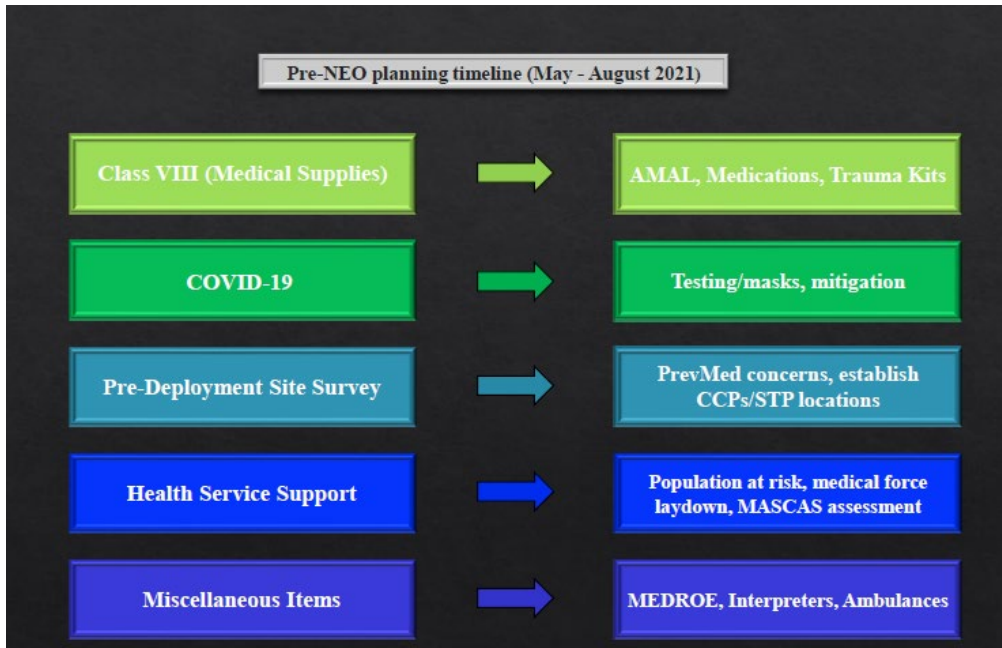
Discussion: The USAF membership is still completing their review

Recommendation: After completing their review send an update to Mr. Rich NLT 31 March 2022

3). Recent Deployed Experiences 24th MEU HKIA MASCAL (LT Hunt)

LT Hunt started the discussion with a detailed review of the 24th MEUs involvement in the HKIA MASCAL.

- Mission Statement/Objective: Provide joint/sustained health service support (HSS) to noncombatant evacuation operations (NEO) at designated locations and to coordinate strategic aeromedical evacuation/over the horizon medical support to the Joint Task Force onboard Hamid Karzai International Airport (HKIA), Kabul Afghanistan.
- Pre NEO Medical Planning Considerations



- The situation on the Ground
 - Insufficient Force Package
 - Inadequate Medical Support
 - Non-Trauma Care Supplies Shortages
- HKIA Medical Common Operating Picture (MEDCOP): Complex AOR with delineation lines to break up sectors.
- MASCAS Vignette: Some warning provided the ability to react but the large number of patients and their status provided many negative factors that impacted the ability to render care.
- After Action Items:

<u>Positives:</u>	<u>Negatives:</u>
<ul style="list-style-type: none"> • Daily JTF-CR Health Service Support Sync • Communication between ground forces & medical stations. • Medical communications network (radios, MEDREG, etc) • Patient Movement Operations from POI – appropriate medical station • JTF-CR medical force integration during MASCAS event • Location of MEU/SPMAGTF-CR STPs. • JTF-CR MEDLOG support from NSA Bahrain. • Interpreters to facilitate patient care • JTF-CR/Task Force Medical integration throughout NEO. • Rapid MEDEVAC of U.S. WIA from HKIA to LRMC. 	<ul style="list-style-type: none"> • Army/Marine Corps medical force integration. • 24th MEU Medical Planner was denied request to travel ADVON to HKIA due to boots on ground limitations. • Non-trauma medical supplies (hygiene kits, bottles, formula) did not arrive until several days of NEO operations had passed. • SPMAGTF-CR deployed HKIA without their Medical Planner. • No NEO specific Medical Rules of Eligibility. • Higher HQ Medical Planners (JTF-CR/USFOR-A) retrograded 5-7 days in advance of the ISIS-K attack. • Available CENTCOM medical assets (ERSS, GST) were never deployed to offset patient demand. • Requested meds (Fentanyl, EpiPen) not available due to supply chain issues as a result of COVID-19.

Issue: A medical plan that was not fully communicated amongst the JTF before the mission

Discussion: medical planners and medical decision makers were not considered essential for the ADVON

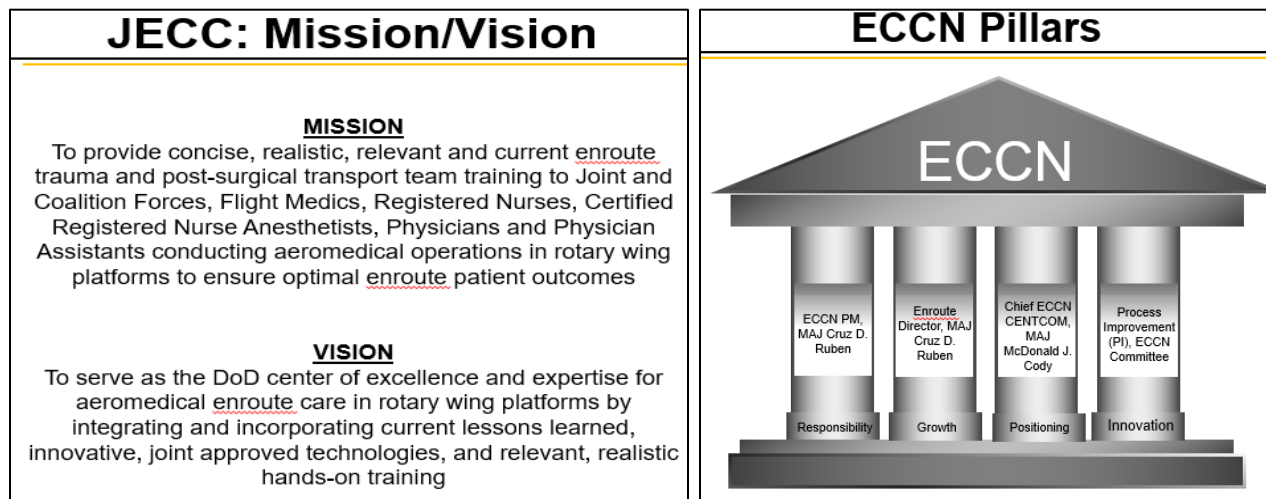
Recommendation: possible proposal from the committee for inclusion of medical planners/medical decision makers on ADVON

4). CENTCOM ECCN/ERC case and topics (MAJ McDonald, MAJ Salgado, MAJ Ruben)

The briefers gave a detailed update on the Enroute Critical Care Nurse (ECCN) Program Brief.

MAJ Salgado opened with an update:

- Readiness
 - The ECCN population is currently at 128% with the majority in FORSCOM
 - Current theaters of operation:
 - USCENTCOM
 - USEUCOM
- JECC
- ECCN Pillars



- ECCN Initiatives
 - PCC Guidelines:
 - [https://jts.health.mil/assets/docs/cpgs/Prolonged Casualty Care Guidelines 21 Dec 2021 ID91.pdf](https://jts.health.mil/assets/docs/cpgs/Prolonged_Casualty_Care_Guidelines_21_Dec_2021_ID91.pdf)
 - PCC Borden Institute Book, coming soon
 - Patient Packaging CPG
 - TSNRP Nursing Guide to Battlefield and Disaster Medicine Guide Updates.
- Chief ECCN USCENTCOM (MAJ McDonald)
 - Currently attached to CO Reserves- 11th ECAB, 7-158th GSAB
 - Seven Locations
 - Five ECCNs- four countries
 - MEDEVAC times vary by location- 30 min to 2 hours one way
 - Functions
 - POI

- Higher echelons of care
- Tail to tail transfers
- Challenges/Opportunities

<ul style="list-style-type: none"> • Access to required flight gear ALSE • Pre-deployment training with unit <ul style="list-style-type: none"> • Incoming unit has provided, suggest requirement for future • Unit's understanding of ECCN role • Standardization of testing and policies • Logistics for Class VIII • ECCN administrative actions/RL Progression • Difficult to move locations • Location of Chief- Admin 	<ul style="list-style-type: none"> • Ample time for education and training with medics and local units <ul style="list-style-type: none"> • Train with coalition forces, SOF, MWD, role units • MEDIC MONDAYS • Hot/Cold load- ACFT familiarization • Expand and progress on different ACFT • ECCNs are asset to unit • Well integrated • New environment for nurses, would like to continue CONUS • Advanced airway course
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- Workflow
 - Evacuation to higher echelons of care- 193 missions, 84 ECCN
 - POI- x 3
 - Whole blood given x 2
 - COVID transfers x 13
 - Military Working Dog X 0
 - Common Illnesses
 - NBI- mostly medical/
 - ABD pain
 - NBI Injury
 - Behavioral Health
 - BI (Host nation/coalition)
 - GSW
 - Blast

- Chief ECCN in CENTCOM (CPT Maler): CPT Maler presented a POI Case review for the group:

<p>DUSTOFF 69 launched for an Urgent POI 9line for a Local National Military Male with a GSW to the Abdomen.</p> <p>Upon arriving to HLZ waited 1.5 hours for the patient to arrive (approx. 2.5 hours from time of injury). No coalition partners on ground resulted in no care provided and no report received.</p> <p>Injuries: Single 2mm entrance wound above the umbilicus with minimal external bleeding</p>	<p>Assessment</p> <p>A: Intact</p> <p>B: Spontaneous and Unlabored</p> <p>C: Peripheral Pulses intact; but BP down trending</p> <p>D: Alert and responsive to pressure on the wound</p> <p>Care Provided Enroute</p> <ul style="list-style-type: none"> • Hemostatic and Pressure Dressing applied to ABD • 18G IV Access to RAC • 25mg of Ketamine IV • 2Gs TXA IVP • 30mls of Calcium Gluconate <p>Transported to Role 2</p>
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Tactical Considerations	Clinical Considerations
<ul style="list-style-type: none"> • No call sign and frequency • No known nationality before DUSTOFF launch • Delay in launch awaiting approvals and AH64 Apache support • Patient not at HLZ upon wheels down • Awaited 1.5 hours for patient to arrive at HLZ • Mission at night, good illumination • Pre-staged litter outside of helicopter instrumental in safety 	<ul style="list-style-type: none"> • No MIST or patient report received at POI • Language barrier prevented communication • No pre-pick up care provided outside of “dressing” to abdominal GSW wound • Care hampered by 7 layers of clothing • Short transport time approx. 15 minutes • Blood prepared on Thermal Angel




BARRIERS TO CARE







- Challenges/Opportunities
 - An identified issue with the seat system with less-than-ideal locking mechanism
 - Golden Hour Box was too small for x2 whole blood units




GHC Identified Issue



- Golden hour container brought by new MEDEVAC unit doesn't fit x2 whole blood units as designed.
- Problem: CENTCOM LTOWB bags are possibly overfilled and do not fit in the NAR 35-0014 container. The container does not close without force.
- DUSTOFF Team tested the GHC with expired blood products and determined that the container would not maintain the appropriate temperature over at 24 hour period.



- Solution: Continue utilizing legacy GHC.

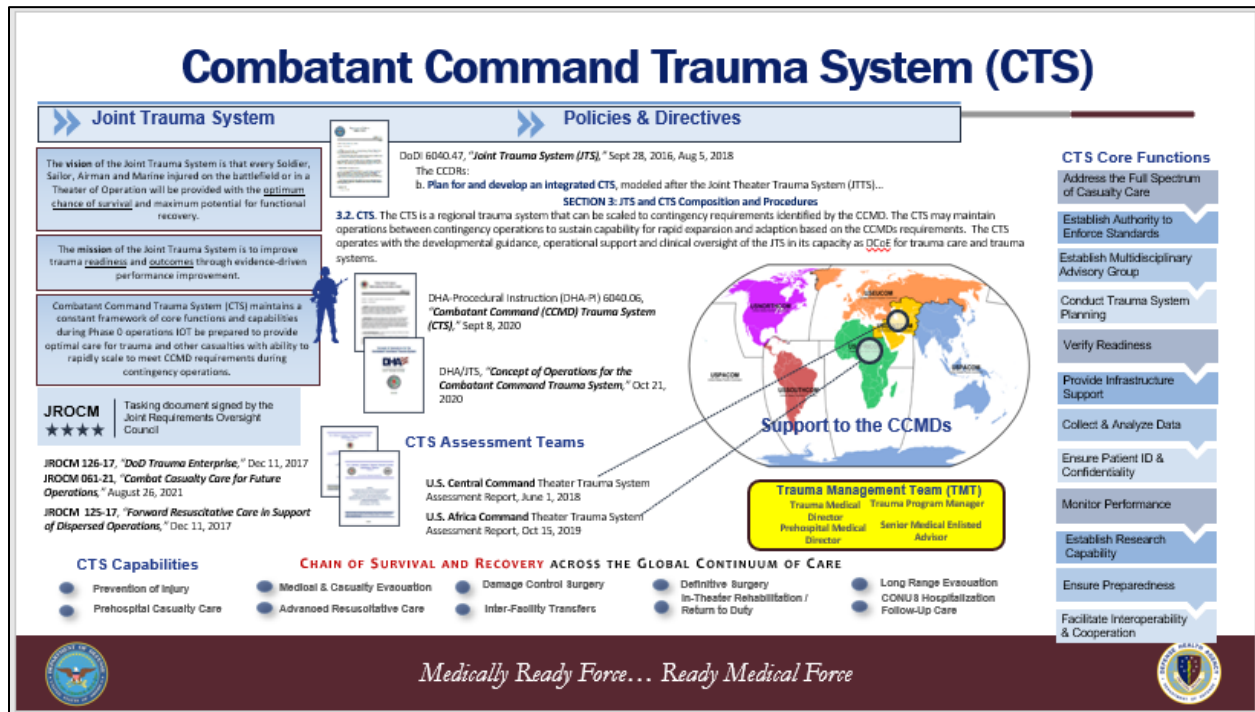
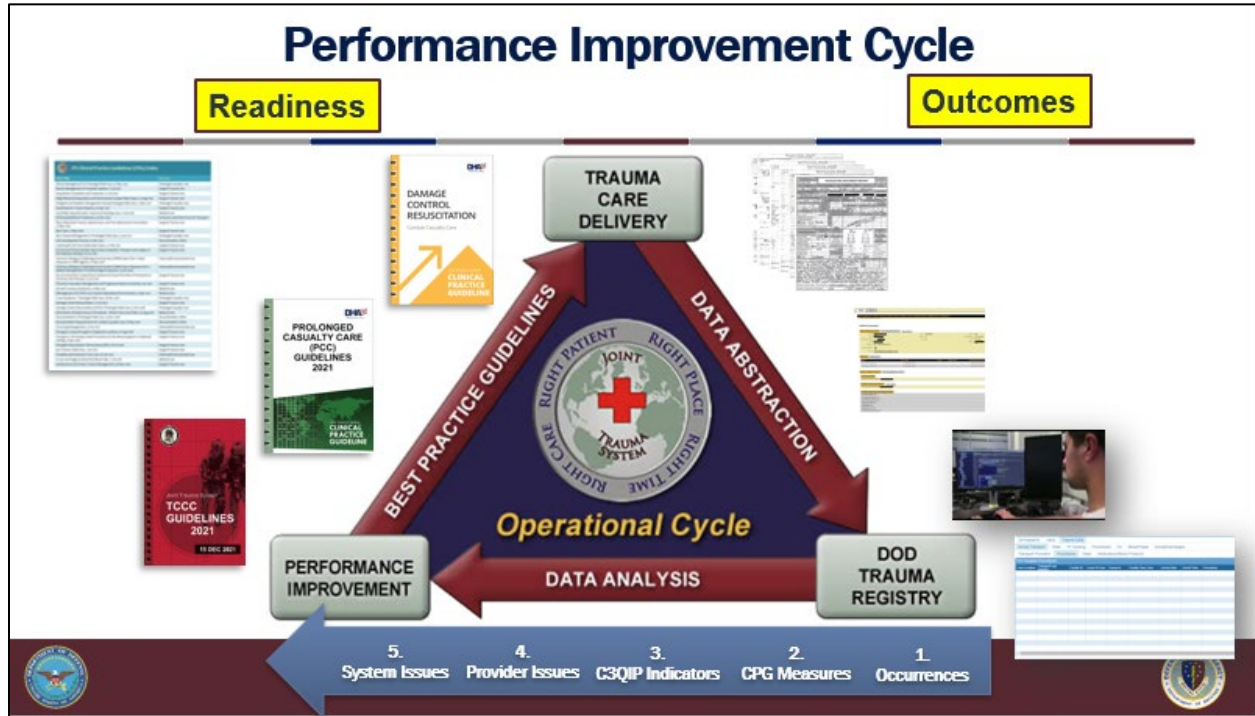


5). TACEVAC and ERC CPG structure (COL Cunningham)

Provided an update on current status on TACEVAC and ongoing ERC CPG

6). Joint Trauma CTS update (COL Baker & Teresa Duquette-Frame)

COL Baker started the discussion with an overview of the current status of the Joint Trauma System's Combatant Command Trauma System.



CTS Functions – Draft Key Performance Indicators

Address the full spectrum of casualty care	GCC CTS Instruction or Directive is published including PIPS program
Establish authority to enforce standards	TMT (TMD and TPM) formally appointed by SG and serve >0.2 FTE/week IAW DHAPI
Establish multidisciplinary advisory group guidance	TMT attended at least one DCOT meeting
Conduct trauma system planning	CTS Appendix to Annex Q, Medical Services is published
Verify readiness	JTS R2RA are conducted w/ deployed and/or in-garrison Role 2s (Pending R1, R3 & MEDEVAC Readiness Assessments)
Provide infrastructure support	TMT team has SIPR access/capability and appropriate work space
Collect and analyze data	Deployed medical units establish a casualty reporting policy and ensure patient care records are submitted to a DoD system of record for abstraction into DODTR
Ensure patient identification and confidentiality	GCC pseudo trauma name and pseudo SSN policy published
Monitor performance	TMT led and conducted PIPS process for deployed and/or DHA MTFs
Establish a research capability	A policy is in place to ensure research can be done
Ensure preparedness	TMT participated in GCC-level operational planning & exercise
Facilitate interoperability and cooperation	TMT participated in medical outreach with allies/partners

Medically Ready Force... Ready Medical Force

The CTS team asked for assistance from the ERCCC for current and future efforts. The policy subcommittee will reach out to the CTS team.

Proposed solution and due out was a ERC validation/survey along the lines of what the ACS/COT performs for trauma centers.

Verify Readiness - MEDEVAC
<ul style="list-style-type: none"> CTS Branch requests CoERCCC to lead design of MEDEVAC "readiness" assessment in a deployed CTS IOT "identify major gaps and determine mitigation strategies with leaders of the deployed unit".

The CoERCCC Plenary session ended at ~ 1430 CST. The Committee split into separate breakout sessions.

Breakout Sessions		
1400-1600	Education & Training	Papalski
		Bayshore Rm 1-2
1400-1600	Policy & Doctrine	Leasiolagi
		Bayshore Rm 3
1400-1600	Products & Research	George Hildebrandt
		Bayshore Rm 4
1400-1600	CoERCCC CPG & PI	Walrath
		Bayshore Rm 5
1400-1600	Transfer & Documentation	Jared Voller
		Gasparilla Rm 3-4

Major lines of effort include:

- JP 4-02 and Trauma Lexicon ERC terms(P&D)
- ERC Capability Levels and Common Tasks(P&D, Tng&Ed)
- Defense Readiness Reporting Reporting System items(P&D)
- Medical Direction Guidance (CPG/PI)


- Establish NRP as minimum skill for certain level ERC (Tng&Ed)
- Cross level common skills at service ERC schoolhouses (Tng&Ed)
- DA4700 OP 5 update and fielding (HO&Doc)
- Prep for Evacuation inputs to CoTCCCC(HO&Doc)
- ERC Blood Products, Patient Packaging, Vent, & ERC BH CPG(CPG/PI)
- Advocate for FY22-26 POM Research Funding(R&D)
- ERC equipment standardization editorial for R&D community(R&D)

DAY TWO (Thurs, 4 Mar) Virtual Information: https://connect.apan.org/coercc-mtg/ Toll: 1-212-287-1861 Toll Free: 800-369-2065 Code: 6085634 Hilton Tampa Airport Westshore Gasparilla Room 3-4		
Time (Eastern)	Event / Topic	Presenter / POC
0700-0745	Subcommittee Discussions	Subcommittee Leads
0745-0845	TCSG/TPMRC-E patient movement LL from NEO AFG	Col Donnelly and Lt Col Hancock
30 Minute Break		
0915-1000	Project Caladrius MTF Patient movement	CAPT Kotora
1000-1045	Medical Direction/MASCAL OPG	MSG Remley
1045-1115	Joint Trauma Lexicon Update	Mr. Rich
1115-1130	JTS CPG/PI update	Kathy
1130-1200	Lines of Effort CoERCCC discussion	COL Cunningham
1200	Closing Remarks – Cunningham / Mr Rich	


DAY 2

1). TCSG/TPMRC-E patient movement LL from NEO AFG


Col Donnelly and LtCol Hancock presented a brief on the Afghan NEO operations from a large-scale patient movement perspective. They highlighted some key points of how this NEO was both unregulated (most of the Ops) and regulated (Ad hoc obstetric medical attendant teams in Operation STORK LIFT). They also showed how proper readiness allowed many of the mission to succeed with proper risk management and mission assurance.

<ul style="list-style-type: none"> ▪ Non-combatant Evacuation Operations (NEO) → Assurance & Deterrence (A&D) ▪ Operation ALLIES REFUGE <ul style="list-style-type: none"> ▪ 122k evacuees ▪ Began 15 August 2021 ▪ Passengers vs. patients 	
<p>823 evacuees aboard a U.S. Air Force C-17 in support of the Afghanistan evacuation</p>	

- Unregulated (i.e., NEO)
 - In-flight medical emergencies
 - Pregnancy
 - *Ad hoc* medical attendants
 - En route care records
- Regulated (i.e., patient movement, aeromedical evacuation)
 - Operation STORK LIFT
 - *Ad hoc* obstetric medical attendant teams




**Afghan NEO C-17 Mission
Kabul to Ramstein**



Lessons Learned - Nodes (Ramstein)

TOGETHER, WE DELIVER.


- 35k evacuated through Ramstein
 - Peaked at 21k evacuees on flight line in 11 PODs of <5k each
 - Served by 78 medics: EMEDS, Ground Surgical Team, En Route Patient Staging System
 - Saturated EMEDS, LRMC, 911
 - Ambulance service
 - 12 staff augmented by AE personnel
 - 4 ambulances and an ambus
 - 1150 patient transfers/54 days (baseline average 100/year)



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- Readiness is the cornerstone of risk management and mission assurance
 - Non-standard tasking and timelines
 - Mission necessitated personal risk for personnel
 - Prolonged exposure to transmissible diseases from an unscreened population
 - Quarantine and isolation could not be accommodated
 - Baseline vaccination status + COVID-19 vaccination
 - Unvaccinated aircrew quarantine 14 days off-line vs. 0 days in vaccinated aircrew
 - Credible exposure risk accepted – 1-5% per sortie
 - Air flow modeling
 - Assumption of 1% disease burden
 - "Fly-or-die conditions"

Taylor Crul / U.S. Air Force / Getty



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Issue: CASEVAC was an unintended component of pax movement during the evacuation

Discussion: Hidden medical cases presented during evacuee movement even including a gun shot wound and precipitous delivery


Recommendation: CASEVAC capability with designated personnel on flights designated just as pax movement should be trained for and resourced.

2). Project Caladrius MTF Patient movement (CAPT Kotora)

The group received a pre-decisional concept that reflects the tactical, operational, and strategic advantages proposed by Caladrius, and its support of MHS operational readiness via direct care delivery. CAPT Kotora went on to detail the project details and anticipated impacts for future fights.




Project Caladrius



MISSION

- **Quadruple Aim Performance Plan (QPPP)**
 1. Align Market & MTF **Ways** (Direct Care) and **Means** (KSAs) → **Ends** (Improved Readiness & Outcomes)
 2. Integrated system of systems
 3. Avoid duplication of efforts/services
 4. Improve experience of patient & family-centered care



SITUATION

- **Ready Medical Force:**
 - KSA generation/medical competence through delivery of direct care to beneficiaries
- **Develop COEs within the MHS**
- **Tyranny of Distance:**
 - Linking beneficiaries and MTFs capable of providing care challenging → CONUS redistribution plan
- **PPB&E, BAG 1 & BAG 2:**
 - Rising purchased care costs with declining MHS budget
- **Lethality through Survivability:**
 - Medical Readiness as the defining metric of MHS
 - contribution to NDS/NMS.

PLANNING CONSTRAINTS


- **Readiness and outcomes as the driving metric**
- Hold manpower, facilities, and budget as constants
- Addition of something = Subtraction of something else
- Must touch all bases (line, provider, ancillary staff, MTF, and family)
- Positive/Enriching patient experience

STRATEGIC CONSIDERATIONS


1. Maintain MTF care delivery model ISO local DHA markets (*Status Quo*)
2. Uncouple team readiness and benefit delivery.
 - Train in MHS when meets needs or seek outside opportunities when MTF cannot fulfill KSAs
 - Small/remote MHS markets may lack sufficient KSA exposure/opportunity (*Not Beneficial to DHA/MHS*)
3. **Develop COEs within the MHS & link MHS Beneficiaries to COEs via Caladrius → Improve readiness & outcomes**
 - Emphasis on KSA-rich, financially-expensive cases with direct contribution to patient/provider readiness.

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PRE-DECISIONAL



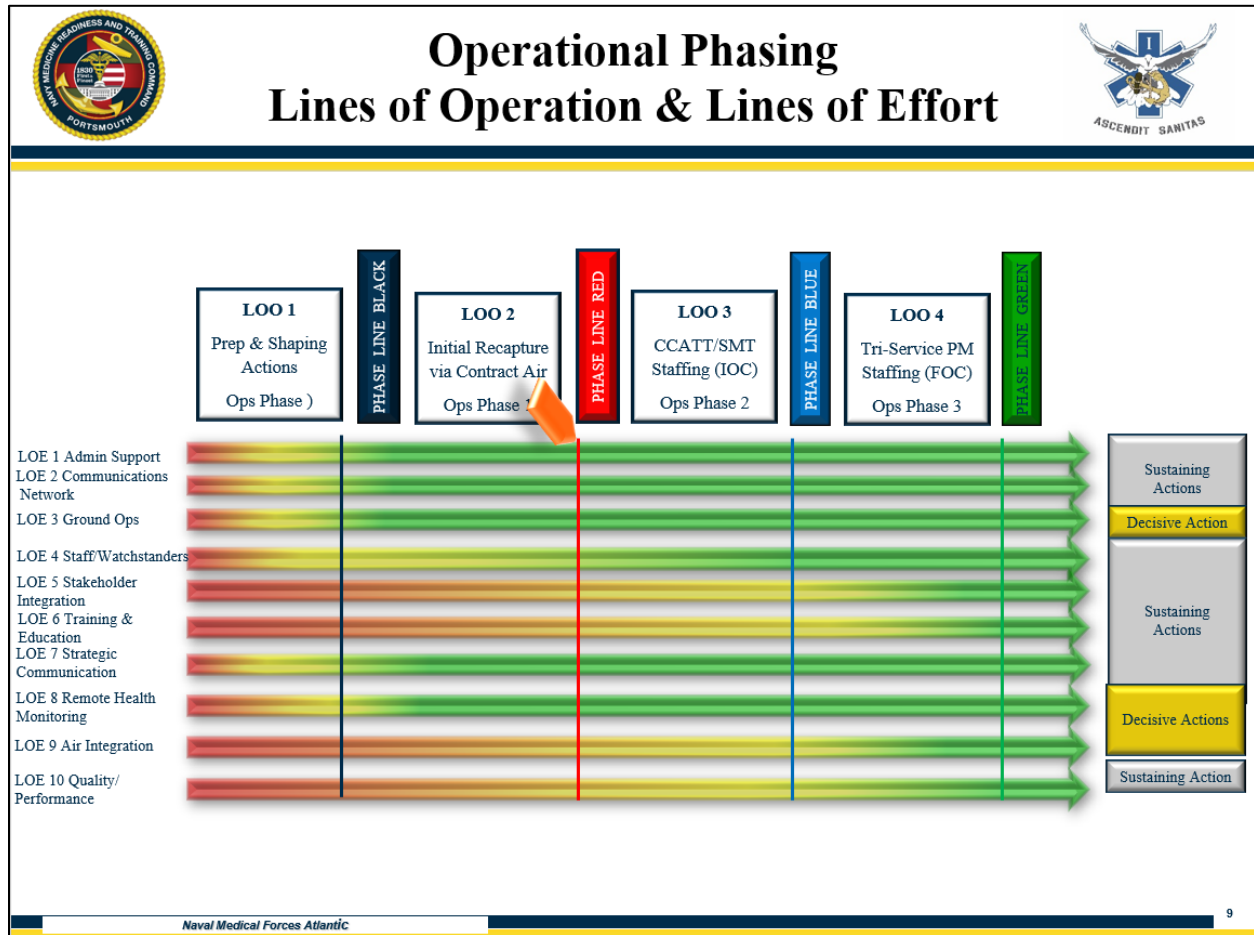
Level of Warfare: STRATEGIC

Improved Patient Outcomes & Satisfaction
 Beneficiary Care ← → Readiness
 GME & Professional Development
 KSA Generation + Confidence → Tactical Competence

<p>NDAAs 703, 706, 708, & 745</p>	<p>Joint DOTmLPF-P Change Request for Multimodal Patient Movement</p>
<p>DHA FY21 Campaign Plan KPIs</p> <ul style="list-style-type: none"> %CCCT Pax achieving KSAs % Non-CCCT Pax achieving KSAs Recapture KSA purchased care leakage Expeditionary Scope of Practice (ESP) for Enlisted Pax Ability of MTF to support KSA generation/training platform 	<p>JROCM 048-15-Joint Theater Patient Movement</p>
<p>Navy Surgeon General DTMs 2, 8, 12, & 16</p>	<p>DoDI 6010.22-National Disaster Med System</p>
<p>DoDI 6000.19-MTF ISO Provider Readiness</p>	<p>DoDI 3025.24-PH/Support of Civil Authorities</p>
<p>DoDI 1322.24-Medical Readiness Training</p>	<p>DoDI 3025.18-DSCA</p>
	<p>DoDI 6000.11-Patient Movement</p>

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Although there is no direct tasker or ask the committee needs to be read to support lines of efforts like this with SME input.

3). Medical Direction/MASCAL OPG(MSG Remley)

MSG Remley led a discussion on the need for a better detailed and formalized Prehospital Command Trauma System and MASCAL. Some of the main issues are: Ad hoc medical direction, variance in medic oversight, variable awareness, or training, and largely personality driven efforts. Many of these issues are addressed in the draft MASCAL Operational Planning Guideline that will be provided to ERCCC members for inputs.

“The Hypothesis” – How to improve battlefield outcomes

- 1) Training the entire fighting force in Tactical Combat Casualty Care
- 2) Tactical leader ownership of the casualty response system
- 3) Near-real time feedback from prehospital trauma registry data

“The Excuses”

“The success of the 75th Ranger Regiment is attributed to the size of their organization and that system cannot be replicated at scale”
-Following a presentation at a 2018 Army Medical Leaders Summit

1. Standardization of TCCC across the department (DODI 1322.24)
2. Department of Defense Trauma Registry (DODI 6040.47)
3. Casualty Response System (*The Missing Link*)

What is a “Casualty Response System”?

• **“A leader driven system designed to synchronize the planning, rehearsal, and execution of individual and collective tasks required to complete the mission while optimizing casualty outcomes”**

-Remley/Kotwal 2021

OPG is foundational to the DoD Prehospitalist

1. Trained/experienced in prehospital medicine systems
2. Set and exceed quality of care standards
3. Training & professional development of medics
4. Protocols / documentation
5. Direct and indirect medical oversight
6. Performance improvement & research
7. Leadership of prehospital team

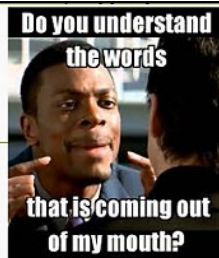
Many of these issues are addressed in the draft MASCAL Operational Planning Guideline that will be provided to ERCCC members for inputs.

3). Joint Trauma Lexicon Update (Mr. Rich)

Mr. Rich provided an overview of a current task to review and provide inputs for the Joint Trauma Lexicon by the CoERCCC.

What are we trying to say?

- Care Under Fire
 - “That doesn’t apply to us we will not be taking enemy fire”.
- Walking Blood Bank
 - “No, where the Service member is walking around and we take their blood to give to someone else. Where they are walking...”.
- Crisis Standard of Care
 - “This doesn’t apply in the deployed setting”!



Who owns a process that could help...maybe?



Defense Health Agency
PROCEDURAL INSTRUCTION

NUMBER 6040.03
August 21, 2018

Assistant Director, Combat Support Agency (CSA)

SUBJECT: Joint Trauma Lexicon

4. JTS CHARTERED COMMITTEES

- a. Develop trauma terms in support of this DHA-PI.
- b. Review, revise, and approve operational and clinical trauma terms submitted by internal and external SMEs for consideration of inclusion in the Joint Trauma Lexicon DHA-PI.
- c. Conduct a structured search of medical literature and DoD Issuances to identify commonly used terms in trauma care. This search will occur periodically as directed by the committees’ chairs.
- d. Conduct activities consistent with this DHA-PI with the purpose of identifying trauma-related terms and establishing definitions in support of trauma care, operational medical planning, performance improvement, and research in support of the following three categories:
 - (1) Terms for official DoD Issuances.
 - (2) Terms for academic publications.
 - (3) Terms used for research purposes.

It is US!

4). JTS CPG/PI Update (Kathy Robbel)

Kathy provided a brief but informative update on the new CPG process that the DCoT and its subcommittee's play critical parts for ensuring quality products. She went on to review the current CPGs in the works and some potential upcoming CPGs that will need reviews at different levels.

Clinical Practice Guideline Process

New CPG – Full Review

Criteria for a CPG Development

1. Relevant to the deployed environment
2. Potential for reduction of clinically significant variations
3. Frequency, prevalence or DQETS (prioritized)
4. Best practice/Evidence based/standard
5. Request from Theater/OTM/Service
6. Request Authority or CPG (PI, H&E)
7. Is CPG Required?

- CPG manager receives proposal for new topic or update (routine/rapid)
- CPG manager presents COAs to DCoT Chief, PI Chief and JTS Chief for decision
- If approved to proceed DCoT will initiate CPG process (identifies LA; sponsor, committee; crosswalks w/projects/proposals; provides literature/data retrieval support as needed)
- CPG manager will be lead for all communication to ensure version control
- Once draft received from LA it will be shared with PI to crosswalk with other CPGs and develop/update PI metrics to support CPG
- DCoT will review draft and determine course of action (review by individual SMEs, select committee or entire DCoT, review and vote by select committee or entire DCoT)
- DCoT CPG manager will lead consolidate/adjudicate comments with DCoT PMs
- PI Chief approves final draft
- Tech writer formats, edits, proofs CPG, routes for JTS Chief approval
- Tech writer routes for DHA PAO approval and publishes CPG

5). Lines of Efforts Review (COL Cunningham) COL Cunningham reiterated the top projects as:

- JP 4-02 and Trauma Lexicon ERC terms(P&D)
- ERC Capability Levels and Common Tasks(P&D, Tng&Ed)
- Defense Readiness Reporting Reporting System items(P&D)
- Medical Direction Guidance (CPG/PI)
- Establish NRP as minimum skill for certain level ERC (Tng&Ed)
- Cross level common skills at service ERC schoolhouses (Tng&Ed)
- DA4700 OP 5 update and fielding (HO&Doc)
- Prep for Evacuation inputs to CoTCCCC(HO&Doc)
- ERC Blood Products, Patient Packaging, Vent, & ERC BH CPG(CPG/PI)

DUE OUTS

- Next full in person meeting set for early Sept 2022
- Lexicon terms sent out to VM NLT 21 Mar 22 for first look
- Establish battle rhythm for subcommittees to meet at least quarterly with potential in person WGs for topics like TACEVAC Guidelines.

Minutes approved by:

COL Cord Cunningham, USA
Chair, Committee on EnRoute Combat casualty Care

COL Jennifer Gurney, USA
Chair, Defense Committees on Trauma