Highlights from the Committee on En Route Combat Casualty Care (CoERCCC) Meeting

06-07 March 2024 San Antonio, Texas

Theme: Observations from current conflict and preparation for Large Scale Combat Operations (LSCO)

1. **CoERCCC priorities:**
   - LSCO, Mass Casualty (MASCAL)
   - Indo-Pacific Command (INDOPACOM)
   - Arctic/Cold Weather
   - Skill sustainment
   - Common operational picture/planning
   - Primary Medical Inventory (PMI)/Medical Logistics (MEDLOG)
   - Patient Monitoring
   - Decision Support
   - Documentation

2. **JP 4-02:**
   a. Multimodal patient movement (MMPM) is the new term as the "regulated or unregulated movement of casualties using non- designated platforms of opportunity with medical personnel providing timely, efficient movement and en route care (ERC) of the wounded, injured, or ill persons."
   b. This distinguishes it from casualty evacuations (CASEVAC), which no longer has medical personnel providing ERC and this potentially poses a challenge with multiservice as well as allied partner terminology.

3. **Current CoERCCC efforts:**
   - Tactical Evacuation Guidelines (renamed En Route Care Guidelines)
   - Form DD3104 subsequent review after significant changes
   - Joint Requirements Oversight Council (JROCM) 049-19 MM-PM ERC-P service circulation (foundational document)
   - Medical Direction Integrated Practice Assessment Tool (IPAT)
   - National Association of EMS Physicians (NAEMSP) Gov Chapter Medical Direction Position Statement
   - ERC Capability Levels and Common Tasks
   - Establish Nationally Registered Paramedic (NRP) as minimum skill for certain level ERC.
   - Medical Direction Guidance, Tier 4 Tactical Combat Casualty Care (TCCC), Operational Planning Guide (OPG)
   - Defense Readiness Reporting System items type dashboard for strategic and theater leaders to ERC readiness
   - Cross-level common skills at service ERC schoolhouses
   - Prep for Evacuation inputs to CoTCCC
   - Interfacility Transfer, ERC Patient Packaging, Vent, & ERC
   - Advocate for FY26-28 Program Objective Memorandum (POM) Research Funding

4. **Medical Evacuation (MEDEVAC) operations** in vicinity of Tower 22 reported; Discussion - intelligent tasking, mission prioritization, mission and launch authorities, and benefits of a patient evacuation coordination cell (PECC) but there are challenges with scaling to LSCO casualty volumes. Review of mission evacuation priorities and feedback provided to ground units in areas of operation much like trauma systems are required to do within American College of Surgeons Committee on Trauma verification process.

5. **US Army Aeromedical Research Labs (USAARL) brief:**
   Ms. Kinsler presented research priorities: unmanned aerial MEDEVAC; flight paramedic task saturation study; task unloading by crew chiefs; need of 2 flight paramedics to perform critical care for complex patient MEDEVAC/ more than one patient.

6. **Updates for SMOG:** The Critical Care Flight Paramedic Standard Medical Operating Guidelines briefed.

7. **MURU EMS App** capabilities and functionality currently being fielded by USAF Pararescue and units of Fort Moore including installation EMS.

8. **Telemedicine & Advanced Technology Research Centers (TATRC) AI** - Heuristic Neural Networks presented by CDR Thota highlighted the use of assistive artificial intelligence (AI) to better categorize and prepare for patient types in multiple environments.

9. **Tactical Medical Augmentation Team (TMAT) Vignette** (USS Cincinnati): Shore-to-ship evacuation; USAF and USA to cross train.

10. **Medical Capability Development Integration Directorate (MEDCDID)** Medical Direction IPAT; medical direction at echelon especially in INDOPACM and LSCO and the absence of very formalized regulations and policy especially concerning ERC and prehospital medical direction in the Army; both appointment orders and JCCQAS privileging are important for regional commanders (RCs) and prehospital medical directors. This importance is stressed in the Commission on Accreditation of Medical Transport Systems (CAMTS) standards and is represented in the JROCM 049-19 Task 16 which is still awaiting final closure and action.

11. **MASCAL Triage** guidelines and improvements in our current system that lacks triage system that are scalable to LSCO.
    a. No single best triage system that can best serve all situations but acknowledge a better framework and training.
    b. AI can potentially help providers perform triage in MASCAL situations to maximize outcomes for the most casualties/patients; address the moral injury associated with expectant designation or withholding care.
    c. Members of CoTCCC are also working on MASCAL Triage development as well as CoSCCC and efforts will continue.

12. **ERC guidelines** with minor changes and circulation for voting by membership in the next few months. The ERC guidelines will subsequently align with CoTCCC and PCC guidelines reviews to ensure the best continuity.

The Joint Trauma System and the Defense Committees on Trauma – *Saving Lives with Data*.

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