



Committee on En Route Combat Casualty Care (CoERCCC) Meeting Minutes

Date: 06-07 Mar 2024

Location: San Antonio, TX

Dial-In:

06 March 2024 - DAY #1

1.0 ADMIN REMARKS AND INTRODUCTIONS (COL CORD CUNNINGHAM)

COL Cunningham, the Chair of the Committee on En Route Combat Casualty Care (CoERCCC), convened the meeting and welcomed meeting participants. COL Cunningham briefly reviewed the meeting's agenda. Mr. Dominick Sestito discussed transportation and logistical information for participants. Room participants did introductions.

2.0 REVIEW OF PAST MEETINGS (COL CUNNINGHAM)

COL Cunningham reviewed past and current deliverables, their status, and his perspective on how to get them across the finish line. COL Cunningham also discussed the biggest challenges facing the En Route Care community.

Biggest ERC Challenges

- LSCO(MASCAL)
- INDOPACOM
- Arctic/Cold Weather
- Skill sustainment
- Common operational picture/planning
- PMI/MEDLOG
- Patient Monitoring
- Decision Support
- Documentation

Ongoing challenges faced with LSCO, and the inability to have air superiority. ERC will be focusing on ship and ground transport much more at future meetings, moving away from an "air-only" mentality for patient evacuation.

"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 ERC of the wounded, injured, or ill persons." This distinguishes it from CASEVAC which no longer has medical personnel providing ERC per the joint publication."

HMCS Walsh – CASEVAC no longer has designated medical personnel.

COL Cunningham – JP 4-02 First aid and Buddy aid show up as medical care by everyone but the Army, they identified that this is care rendered by non-medical personnel in the ATP. CASEVAC medical treatment is being performed, but not by "designated" medical personnel.



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Subcommittee Review and Expectations

- Policy and Doctrine(P&D): Cunningham and SCPO Walsh
- CPG and PI: LCDR Ferguson
- Education and Training: HMC Wayne Papalski & LCDR Dana Flieger
- Handoff and Documentation (HO&Doc): SMSgt Matt Harmon
- Research and Product Steering(R&D): Mr. George Hildebrandt and Col Maddry

Main Projects Update

- Tactical Evacuation Guidelines
- DD3104 (HO&Doc) subsequent review after significant changes
- JROCM 049-19 MM-PM ERC-P service circulation(foundational document)
- Medical Direction IPAT
- NAEMSP Gov Chapter Medical Direction Position Statement
- ERC Capability Levels and Common Tasks(P&D,Tng&Ed)
- Establish NRP as minimum skill for certain level ERCT(ng&Ed)
- Medical Direction Guidance, Tier4 TCCC, OPG (CPG/PI)
- Defense Readiness Reporting System items(P&D)
- Cross level common skills at service ERC schoolhouses (Trng & Ed)
- Prep for Evacuation inputs to CoTCCC (HO&Doc)
- InterfacilityTxfr, ERC Patient Packaging, & Vent, & ERC
- Advocate for FY24-26 POM Research Funding (R&D)

Discussion followed review of Project Updates, and SMEs from the audience gave feedback and knowledge updates on the proposed list.

Lengthy discussion on ICTL's and how they define the task and not a scope of practice document.

3.0 DEPLOYED CASEVAC/MEDEVAC EXPERIENCE (SFC HERRERA)

Operation Inherent Resolve CENTCOM MEDEVAC Mission Review C Co/3-82 GSAB "All American Dustoff"

22 y/o male with multiple blast injuries from a One-Way UAS (OWUAS) attack

M: Blast from Unmanned Explosive Drone

I: Multiple fractures and shrapnel injuries to the left upper extremity. Shrapnel injuries to the face and neck area and a possible fractured ankle.

S: Serious but stable condition

T: Intubated. LUE wounds treated and splinted. Sedation and pain management provided.



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Lessons Learned from MSN 20240128.oir1

- The transport legs are long, so triage and assessments on ground needs to be accurate. Communicate early with other sites in case there is a need to make multiple turns so you can stagger aircraft if necessary.
- Ensure you have enough drugs/oxygen to sustain the flight. We had 1 tank exchange in flight at 50% FiO₂ for Leg 1.
- Scene was chaotic given the fact that it happened on our post. Tough to juggle the duties of a PSG and 1st Up Medic.
- Get Battle Damage Assessments done early to ensure that you have the ability to launch if/as needed. Aircraft assessments are just as important as patient assessments.

Issues & Discussion

1. Issue: Braun Fluid Pump does not have a good charge life especially with colder temps.
Discussion: Charge life is one point of discussion all Team Sites seem to echo. From what we can tell, the pumps seem to keep a charge for roughly a week off of A/C power.
Recommendation: Keep inside and charged to keep battery life.
2. Issue: Patient comfort during long transport times.
Discussion: The different levels of care range vary in length with some being upwards of 3 hours. Patients get quite uncomfortable laying on litters for extended periods of time.
Recommendation: Consider carrying extra blankets or order/carry litter padding to ensure adequate patient comfort.
3. Issue: Communication with alert patients in flight.
Discussion: Communication while aircraft running has always been difficult. From getting a proper report from the sending medical personnel to communication with an alert patient while in flight.
Recommendation: Consider purchasing David Clark communication headsets to assist in patient care and patient reporting.
4. Issue: Eagle Suction has been reported as having issues turning off during the summer months.
Discussion: This is something that was reported to us during our relief process. Unknown if this an issue with ambient air temperatures above a certain range or some other factor involving summer months.
Recommendation: Check equipment regularly and store accordingly based off outside temperatures and/or environmental conditions.
 - Rehearsals: spend the time to train ground medical teams on patient packaging and aircraft loading procedures.
 - ECCN's: We did not have the opportunity to train with ECCN's prior to our departure from Fort Liberty. If the opportunity is there, it would be suggested to build that relationship early.
 - Flight Surgeons/APAs: Stay engaged in what your Flight Paramedics are doing.



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- Communications: do not rely on being able to get up to date information on patient status.
- Facilities: No facility is created equal. A patient you get from one might not be what you get from another.
- Changing Environment: POIs are becoming a thing of the past. Most of our missions have come in the way of facility-to-facility transport. This has benefits but many challenges as well.
- Lighting: Due to weight issues and a stripped-down medical interior, lighting is an issue. Train low level light sources to operate in this austere environment.

COL Cunningham – are you getting active PARS say for blood or are you just waiting on 9-lines. Real time status cases or logistics status to adapt/predict where you may be going?

SFC Herrera - Yes, reports are frequent throughout the day, not just a once a day/24hr report...bed space, units of blood, facility capabilities etc.

1SGT Turner – PECC does not drop 2 missions back-to-back to the same unit unless it's a follow-on mission based on the proposed time frame for the first mission.

COL Cunningham – PECC deconflicts the missions and “over-categorization” of missions...tracking. Once they launch, actioned missions are launched so unless category changes, but they watch flight times, regulation hours etc.

CAPT Tobin- What is the biggest thing that needs to happen before you get on the aircraft as far as a capability gap...not “oh yeah that would be cool if” but what gaps should be prioritized?

SFC Herrera – Probably, venting, catheters to monitor urine output...but not one particular “right way”. My intent was to not get a t level of care, but “net-stock” or equipment standardization.

1SG Turner - SMOG pre-flight checklist provides minimum requirements before we walk out the facility with that patient.

4.0 US ARMY AEROMEDICAL RESEARCH LAB UPDATE (MS. KINSLER) – MISSION

Mission: Integrating the Sciences of Aviation and Medicine to Optimize Human Protection and Performance

USAARL was started to combat aviation fires under initial research for fire resistant material, aviation life support in event of a crash, and human in the aircraft was finally breached...leading to Human Performance Research.

En Route Care Research

- Patients
- Providers
- Equipment
- Environment
- UAS
- Spine Injury Prevention
- Cervical Spine Injury Prevention
- Head Injury Prevention



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ERC Platforms and Chambers USAARL

USAARL UNCLASSIFIED 11

Aircraft and External Testing USAARL

USAARL UNCLASSIFIED 12

En Route Care in Future Vertical

- The Future Long Range Assault Aircraft (FLRAA) will be the Future Vertical Lift (FVL) platform used for MEDEVAC operations
- FLRAA will specifically challenge casualties and medical providers with unique environmental factors of acceleration, speed, and vibration
- En Route Care (ERC) provider performance will be challenged by delayed evacuations, long flight times, and environmental extremes
- Crash safety and survival during MEDEVAC/CASEVAC is not yet known for FLRAA



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- Larger back cabin area allows for multiple options for litter stack configurations (2 stacks of 3, 3 stacks of 2, etc.)

Future Challenges

- FLRAA and UAS platforms will create potentially unique environmental stresses on patients and care providers.
- Large numbers of casualties/patients will require movement, possibly after prolonged care, requiring ERC providers to perform more complex and numerous critical medical tasks.
- Joint equipment test standards will require amendment not only to include new platforms, but also anticipated future environments (such as Arctic operations).

5.0 SMOG UPDATES (1SGT TURNER)

Reason for the SMOG updates, previous versions, supplementary handbook, and path of the future.

Previous version of the SMOG gave algorithms which were easy to use but often very different at unit level SOP's so as a community we needed to set left/right limits.

NDAA 2012 all critical care flight medics would be flight paramedic and critical care trained.



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CY24 SMOG



- Critical Care Flight Paramedics
- Options vs Algorithmic
- Training Scars (Analysis)
- Format of Flight Reference Cards (FRC)

SEPSIS / FEVER	
History <ul style="list-style-type: none"> • Wound(s) with signs of infection. • Warm, Flush >100.4°F / 38°C • Diaphoretic, Chills <96.8°F / 36°C • Capillary refill time > 3 seconds • Abnormal vital signs: HR > 90 BP < 90, RR > 20/min. • Altered Mental Status • Decreased Urine output • Rash(es), Purpura • Immunosuppressed 	Definition <ul style="list-style-type: none"> • Life-threatening organ dysfunction caused by a dysregulated host response to infection. • Septic shock is a form of distributive shock. Keys to Success: <ol style="list-style-type: none"> 1. Early recognition 2. Identification of the cause of shock 3. Early, decisive treatment of the cause and initiation of cause-specific resuscitation.
Treatment <ul style="list-style-type: none"> • Initiate Monitoring: ECG, NIBP, SPO2, ETCO2, Temp • Supplemental O2, Goal > 60% • Check Glucose (<60 Hypoglycemia Protocol) • Attain (2) IV/IO sites. • Initiate IV/IO crystalloid therapy – 1000ml Bolus NS/LR achieve goal of SBP > 90 or MAP > 85 or 30ml/kg. • Initiate/Monitor Foley, UOP 0.3-0.5ml/kg/hr. • Temperature >100.4°F / 38°C consider Acetaminophen 1gram PO/IV (if not provided in the last 6 hours) • Persistent or Refractory Hypotension after 2L NS/LR, unable to maintain SBP > 90 or MAP > 85 <ul style="list-style-type: none"> o Administer Norepinephrine 2-12mcg/min IV. o Add Vasopressin 0.04 units/min SBP < 90 or MAP < 65. o Add Epinephrine 2-20 mcg/min SBP < 90 or MAP < 65. • Consider Antibiotic Therapy Ceftriaxone 2 g slow IV push or in 100 cc NS flow to gravity (immunocompetent) or Cefepime 2 g IV in 100 cc NS flow to gravity (immunocompromised) • Contact Medical Control for further if able. 	
Notes, Warnings, Cautions <ul style="list-style-type: none"> • Consider adding Vasopressin when titrating above 8-10 mcg/min IV norepinephrine. Continue it once started and decrease norepinephrine to MAP goal > 65. • Monitor overall respiratory status. Many patients who are critically ill with sepsis will need ventilatory support at some point in their management. • Record urine output if Foley in place. Decreased urine output is an indicator of patient deterioration. • Fever may not be present in immunocompromised, elderly, or those on immunosuppressive drugs. • All fever is not due to infection – evaluate for environmental / thyroid / toxic etiology. • In Trauma Sepsis, Blood is Preferred • Caution in over-resuscitation >5ml/kg/hr UOP, wet lungs, increased work of breathing. 	

STEWARD THE PROFESSION • DEVELOP LEADERS • DRIVE CHANGE

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- We identified that we need to implement options vice memorizing an algorithm with only one way to treat a patient one way....treating the patient and not the monitor and removed analysis paralysis overthinking the care that should be rendered....treat the patient and make a decision and go forward.



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- SMOG too large....removed over 100 pages.
- Adult/PEDS treatment that are the same were fused and merged to reduce redundancy

Future of the SMOG

- First IPR is 15MAR2024
- Joint Document
- References
- Medication List

CDR Thota – How often is this updated? When are the providers expected to read and understand this?

1SGT Turner – yearly, and the intent is that the first time you see the SMOG is in Paramedic school and not in the back of an aircraft...but that’s on the unit protocols.

COL Cunningham – The 23 was on Deployed Med, but I do not believe the 24 is posted there yet. 1SGT Turner hangs it on MILSUITE. But we will get it posted to the JTS website and Deployed Med.

Virtual Question – Are your questions from your test bank memorization based or scenario based?

1SGT Turner – I screen them all after strict guidance of how many easy, med, hard and scenario-based questions. I make sure there are no multiple answers etc.

Mr. Bruce Tarpey – Gave a brief overview of MEDEVAC DA4700, data gathering process and dashboard creation for Combatant Commanders to help project and allocate assets in LSCO. Bigger the repository, the better the information and decisions can be made.

6.0 MURU EMS APP (STEVEN BLOCKER)

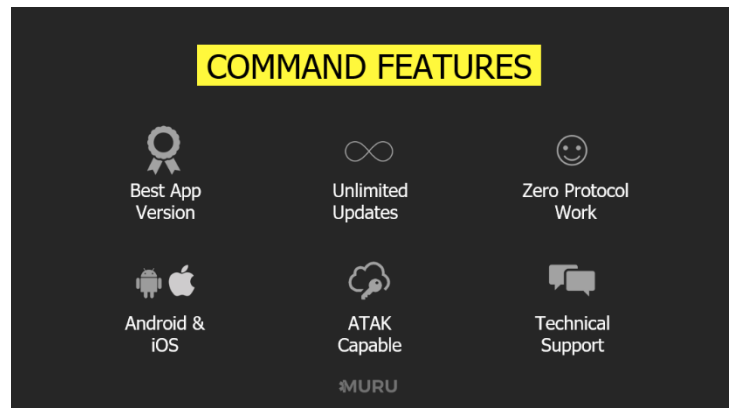
Displayed an off-line demo of the App.

Individualized based on YOUR scope of practice

- Natural language
- Protocols
- Equipment
- Medications
- Certifications

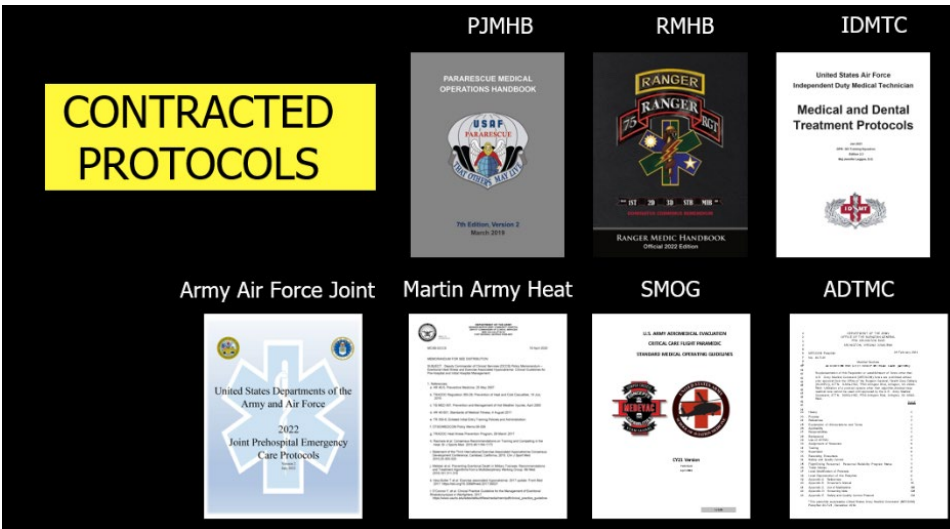
Layered integration

- Ex – Heat protocols – So ask a question about patient that is altered, and App knows to pull that requested information from the Army/AF Joint pub. But then if you add “altered from a run” it will identify “heat injury” and will refer to local SOP guidance based on type of question asked, pulling other content from additional resources.
- Update to the system to guideline it will notify the individual for major changes (med dosage) not something that can just sit in the background of the app, like a vent operation setting.

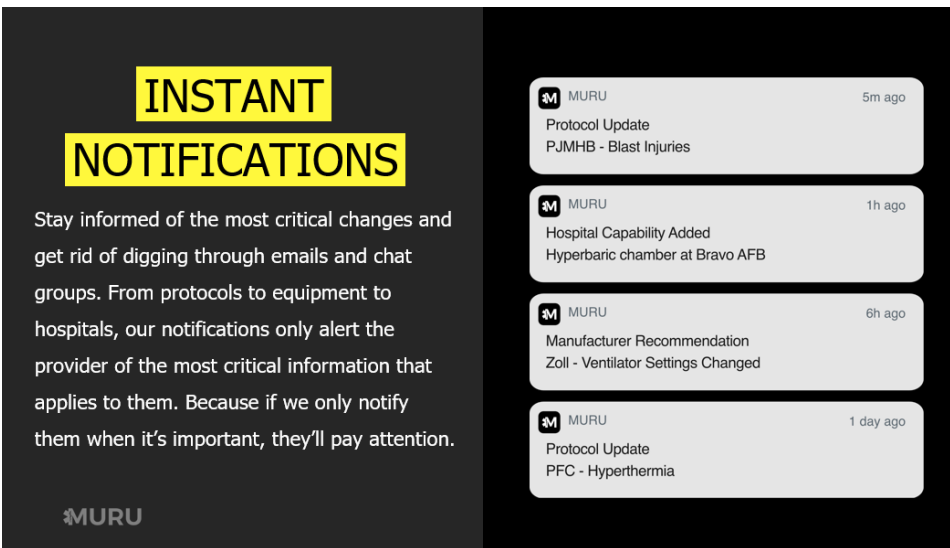




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Mr. Blocker then gave a live demo of the application capabilities.



COL Gurney – We are trying to unify the effort from documentation to registry input etc. For the community, we are trying to make the products we have better. This app is obviously very slick and could make things better, but it is almost a deterrent because it competes with other apps that are being used or implemented by DoD.

Mr. Blocker – We are already integrating with BATDOK. For Example...we are reaching out to hospitals that are heavily being utilized as well as working on PJ Medic Handbook to monitor and integrate the system from all clients. Content is great but actionable feedback is imperative. Working on getting on high side clearance sets.

CDR Thota - how is this layering into the workflow for registration documentation?

Mr. Blocker – We use their data sets to pass information back and forth. (JSON files) It's live.

Mr. Montgomery – How many DoD licenses are authorized? And how does it work as stand alone?



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Mr. Blocker – The only time this device goes online is to receive updates. There is nothing online. All is all built in. As far as licenses...I don't know...the answer is we got contracted with a few PJ contracts...but I would say the global version would be built out authorized and offered to everyone so no licenses would be needed.

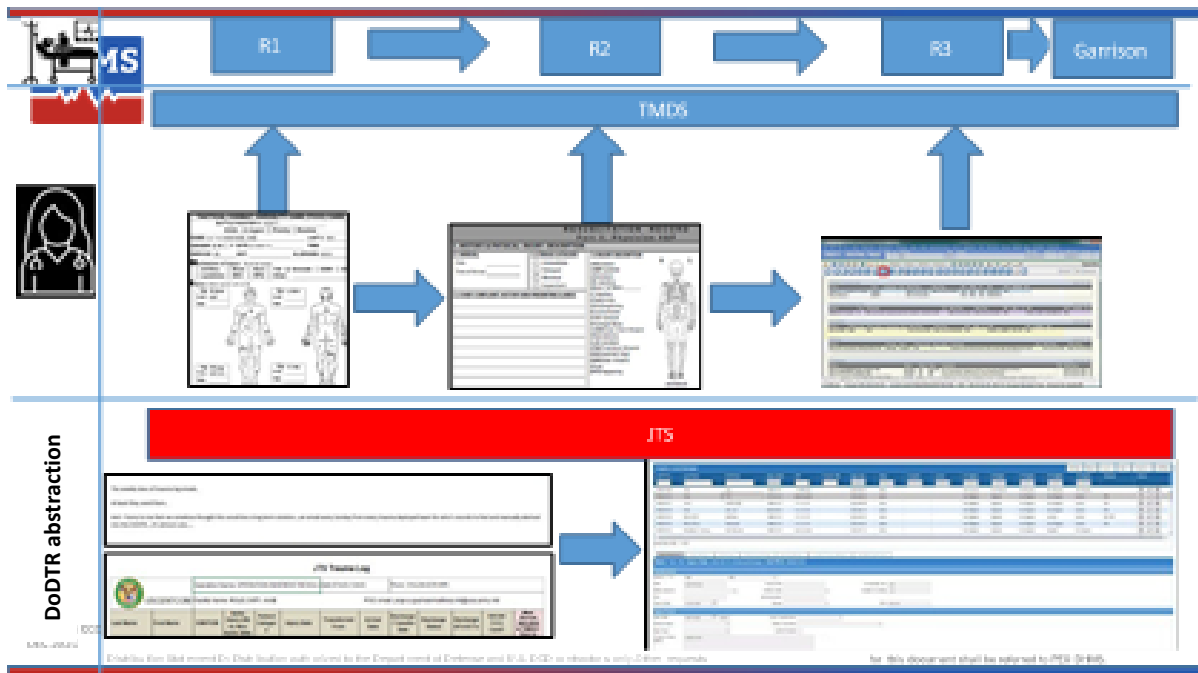
COL Cunningham – Where does the information reside and you need to get notified when an update comes out, and its running in the background, so how does incorporation work? I guess the question is the biggest challenge is version control and content migration based on who curates the info.

Mr. Blocker – This is 100% accurate, not an “92% solution” We do not just download a new PDF ...we will get the update copy in advance, work with the authors, when allowed to publish it, we would. It takes time. If we didn't have advanced notice, it would take time for the update and push it out.

SMSgt Anderson – This is an instantaneous tool to make me more proficient as a medic for an answer that I typically have to refer to a manual. This is not a decision support tool; it is a smart resource tool. This uses smart technology through plain language, and it finds the actual answer within protocols and guidelines, not Wikipedia answers.

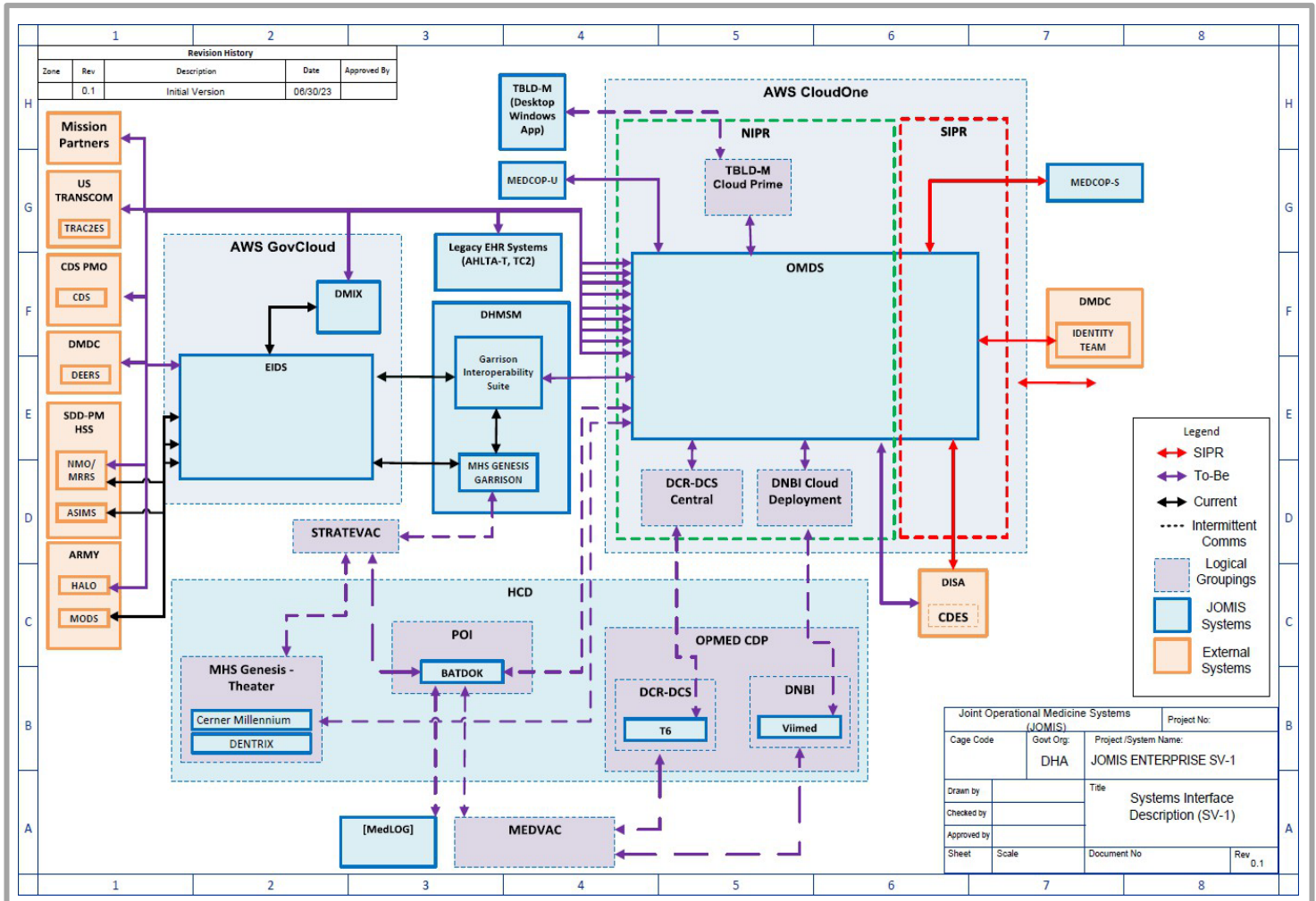
7.0 TATRC BUSHSIDE TO BEDSIDE: OPMED AUTONOMOUS DOCUMENTATION (CDR THOTA)

Currently this is how we get trauma records from TMDS and input them into the DoDTR. It's all manual and hand jammed. People email us spreadsheets or messages saying there are patient records which need to go into the DoDTR. This the future OPMED Data Flow which is 50% less cumbersome, faster and all automated.





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So that way you can have an abstractor, researcher, or Combatant Commander have a single view of the data that's relevant and meaningful.

In addition to PI/QI we'll also be able to do research on this like MOI, injury patterns, resources and outcomes. Now you'll notice here it says synthetic data.

So why do we need these in OPMED? We have a lot of current problems with our trauma registry like missing data, incomplete data, and survivor bias. So Synthetic data solves these problems. Right now, there's only medicine synthetic data for inpatient admission. No synthetic trauma data set exists.

AI tools to solve gaps in data

- Missing data-> Transfer Learning
- Inconsistent data-> Random Forest and Gradient Boosting
- Complex data -> Multi-model Learning
- Timing discrepancies-> Reinforcement Learning
- Survivor Bias-> Causal Inference Models



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OMOP stands for the Observational Medical Outcomes Partnership. It's a common data model. Both the JTS and the MIP are moving to this.

- Common Data model
- Standardized tables (37), fields (394) and vocabularies (10)
- Used internationally
- Google Translate for data

All this is to create essentially creates a "Google Translate". Semantic interoperability means being able to have useful data that is computable. No matter what HER sends us discrete data in an HL7, Australia BATDOK or Japanese T6, anything, we'll be able to Map it into discrete data. Right now we don't have the ability for our registry to talk to other registries. So we're categorizing our data into discrete buckets like Visits Occurrence and Observations.

COL Gurney – reviewed the JTS Operational Cycle and highlighted that the JTS is working data and the registry during inter-war period. Better documentation, better tools to get into the registry, and in turn produce dashboards and briefs to Combatant Commanders when requested.

CDR Thota – all EHR's work on and offline, they all will go to the cloud through QR codes through a store and forward capability.

Col Sams – We all know paper documentation is easier and more convenient, this is about making patient care better in a LSCO/MASCAL environment. We will not be able to individually document and track and store paper documentation. These electronic data solutions are integral to our future successes on the battlefield.

HMCS Walsh – Shipboard is different, and Navy STRATCOM looks at this as a limitation based on mission. There will be times when the documentation will not move from the ship with the patient due to mission.

8.0 ROLE 1 SURGICAL PROCEDURES BRIEF FROM CoSCCC (LCDR HOUT)

Initially proposed to CoSCCC

- March 2023 CoSCCC – Tyler Scarborough presented "Non-Surgeon Surgeons" - Current Procedural Training Paradigms."
 - Reviewed Courses Above
 - ICRC War Surgery
 - ICRC War Wounds of Limbs
 - Does the CoSCCC Need a Role 1 Procedures Statement to make recommendations on procedural skills needed by non-surgeon Role 1 conventional caregivers for prolonged holding during LSCO?
- After March 2023 CoSCCC: Work Group Developed an early draft Role 1 Procedures Statement for CONVENTIONAL CAREGIVERS
- Reviewed at August 2023 CoSCCC



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- Strong Opposition from Some CoTCCC membership: Did not want to box in Medical Directors of conventional Medics & Corpsman to what they should or should not be training to.
- CoSCCC – Surgeons and CoSCCC membership should be involved any discussion involving advanced surgical procedures because we ultimately care for these patients at Role 2/3/4, throughout their ICU stays, and sometimes for prolonged outpatient care.
- **Role 1 Procedures Statement for Licensed Independent Caregivers**
- *Role 1 Caregivers*: Conventional Role 1 Caregiver with an NPI Number e.g., Physicians, NP, PA, IDMT, IDC's
- Survey DCoT
- LCDR Brittany Hout DSc, PA-C put together a list of procedures derived from all JTS CPGs → Reviewed by Ad Hoc Work Group

How Role 1 Procedural List Generated

- TCCC Tier 4 Skills
- CPGs
 - *Burn Care (CPG ID: 12)*
 - *War Wounds: Debridement and Irrigation (CPG ID:31)*
 - *Genitourinary (GU) Injury Trauma Management (CPG ID: 42)*
 - *Burn Wound Management in Prolonged Field Care (CPG ID: 57)*
 - *Acute Traumatic Wound Management in the Prolonged Field Care Setting (CPG ID: 62)*
 - *Ocular Injuries and Vision-Threatening Conditions in Prolonged Field Care (CPG ID: 66)*
 - Airway Management in Prolonged Field Care
 - Prehospital Blood Transfusion CPG
 - Mechanical Ventilation Basics CPG
 - Crush Injury Management in Prolonged Field Care
- SME Workgroup Input

GOAL:

Leverage the SOF PFC experience, list of recommended procedures, conventional role 1 licensed independent caregivers (e.g. Physicians, NP, PA, IDMT, IDC's) should be able to perform during LSCO during acute and prolonged combat casualty care

- Inform Education, Training, Curriculum Development, & Skills Sustainment
- Inform Non-Surgeon Emergency War Surgery Course (e.g., ASSET+ and COTS+ for non- surgeons)
- Inform Austere Resuscitative Surgical Care Curriculum Development
- DCoT Consensus Statement

The general session ended, and the room broke out into Sub-committee groups.

****MEETING CONCLUDED @ 1648****



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7 March 2024 DAY #2

1.0 ADMINISTRATIVE REMARKS (COL CORD CUNNINGHAM)

COL Cunningham, the Chair of the Committee on En Route Combat Casualty Care (CoERCCC), convened the meeting. COL Cunningham briefly reviewed the meeting's agenda for the day.

2.0 MARITIME 920TH RESCUE WIN TMAT DEPLOYMENT ON THE USS CINCINNATI (LCS) LESSONS LEARNED (1SG MATT HARMON)

TMAT Overview

Composition:

- One physician (flight surgeon/trauma trained)
- One RN (trauma/ critical care trained)
- Two paramedics (flight/critical care trained)

Capabilities:

- Management of up to 6 severely injured (based on injury type)
- Management of up to 12 mod/min injuries
- Prolonged field care up to 48 hrs
- Designed for medium watercraft or large rotor. can break into two light teams

Exercise Objectives:

- The objective of the Air Force exercise (fury stallion) was to establish two ICL's (initial contingency locations) in addition to a mob (main operating base) to facilitate personnel recovery operations in a contested environment.
- In addition to the above sites, and anticipating over water rescue operations, a TMAT medium (4-person team) was to establish a CCP/PFC capability on the USS Cincinnati at sea.
- The exercise objectives for the TMAT located on the USS Cincinnati was to BPT to receive casualties from ongoing rescue operations in the area. hold casualties until evacuation windows become available and hand off patients to navy en route care teams and/or transport utilizing TMAT members on platforms of opportunity.

Ability to set up a GP Medium Tent in the Hangar Bay

Obstacles Encountered: One major limiting factor was simulation. It's difficult to determine the actual use case of class 8 expendables in simulation. we were unable to establish if our allotted equipment would have sufficed or required push pack resupply or use of ships medical supplies.

- Communications was a big challenge. use of radios and ships computer systems was difficult. although we had secured over the horizon radios with the team, the COMSEC fill changed and there was no way to correct without SKL. Ship's crew was aware of inbound aircraft but there was no way to receive 9-line or mist prior to arrival.



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- No en route care teams to pick up patients prohibiting realistic handoff and transfer of care.

Successes: The LCS class ship proved to be a promising platform for lily pad medical care, patient staging and even damage control surgery. Its speed, agility, helipad size and layout were force multipliers.



COL Cunningham: Comms issues – Was there any discussion saying we could do our 9-line in the clear or unencrypted?

1SG Harmon: No, we do not put anything out over the clear. Ukraine and the way Medics and Ambulances have been targeted have demonstrated the fails of the Geneva convention.

SMSgt Anderson: These are personnel recoveries not MEDEVAC and therefore not covered under Geneva convention. There are a number of things that have to be done in the “Red” downed aircraft, etc. TMAT is an En Route operating in the unregulated space, unlike AE, CCATT etc.

HMCS Walsh: This ship is a super small crew, space and people. Therefore, communications may be taken from a non-comms person. This is a known limiting factor for shipboard operations with smaller ships.

LCDR Nguyen: Navy En Route care teams that function on the MC side of the house, opposed to Navy En Route care still in development. This is a proof of concept, and hopefully shows the successes capable, but yet to be implemented by the Navy. This shows we can do Joint interoperability successfully.

3.0 SUB-COMMITTEE ROUND-UP AND DELIVERABLES PRESENTATIONS

Policy and Doctrine

Attendees: COL Cunningham, Col Mikeska, Col Sams, HMCS Walsh

- **Develop first CoERCCC Position Statement – Joint PMI/Material/ Equipment**
 - Proposed lead author (LCDR Ferguson)
 - JPMJAB Joint PMI/MEDEVAC/PJ etc
 - Outline Challenges, Recommendations



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- **JROCM follow up: Pending action?**
 - Position Statement
 - Accreditation on Medical Transport Systems – distill it down – international level of standards for ERC
 - Med Dir
 - Provider Exp and Recommendation per level
 - Equip Capabilities

Medical Oversight/ Expanded Scope/MEDCoE

- Training statement (Papalski)

Education and Training

COERCCC EDUCATION & TRAINING SUBCOMMITTEE

- Breakout led by LCDR Alex Nguyen
- Participants: 6
- Discussion Topics: TACEVAC Guideline revisions, split up between TACEVAC for non-medical providers and ERC Guidelines for medical providers (basic and advanced)
- Due Outs/Deliverables:
 - Separate and reformat the ERC Guidelines: May 2024
 - Separate and revise TACEVAC Guidelines: Sept 2024 Meeting
 - Revise pocket guide: Sept 2024 Meeting
 - Platform Information Slides: Sept 2024 Meeting
- TACEVAC CPG (edits/95% finished)
 - COA to split the TACEVAC CPG into two Lines of Effort
 - En route care guidelines needed from POI to Role 2
 - Take current CPG and gear it towards Tier 4 Provider
 - Work nomenclature to align with Provider level
 - When PCC releases Guidelines – realign Tier 2/POI CPG with what they are doing

Focus will be on technical details on what to do with the patient/ Providers that are actively providing patient care...not the movement process and responsibilities of regulated vs. unregulated

LCDR Thota – What is the reason for the need for a distinction...I do not understand the reason we care so much about the distinction.

COL Cunningham - There is a funding component to that distinction. Medical/Logistics/Training lines are somehow inadvertently tied to that.

HMC Herman – We need to get this out to close the gap between training and the ground level transport implications. We are currently missing a big group with an “air” focus.



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CPG Development/PI

CoERCCC CPG Committee, February 2024	
Attendance: LCDR Brian Ferguson, USN HMC Ryan Mooney, USN 1SG Jessie Turner, USA Lt Col Ricardo Sequeira, USAF LCDR Emily Raetz, USN	Discussion Topics: <ul style="list-style-type: none"> • Patient Packaging CPG • IFT CPG
Deliverables/Due Outs: Final Review and Submission for publication of both IFT and Patient packaging	Future Topics: We will review and update Prehospital Blood Transfusion CPG

Patient Handoff & Documentation

Attendees: Jared Voller, Matt Harmon, Bruce Tarpey, Shawn Anderson, Kevin Hunt, Kolby Rapp, Caleb Washburn

6-7 March Breakout Session:

Both breakout sessions focused on the DD 3104. Day 1 breakout reviewed the heavily revised document provided by WHS and ultimately resulted in going back to the original version produced by Coughlin. Second day focused on getting a final set of recommended changes to Mr. Tarpey for action.

Next 6 Months:

- Complete DD 3104 revision/update for final publication. Mr. Bruce Tarpey has recommended changes to original (Coughlin version). Subcommittee will reconvene approximately 45 days (o/a 26 April 2024) after CoERCCC Meeting to validate changes and submit for publication routing. Hope to be at final approval for publication prior to next meeting.
- Push Pre-Arrival Notification Criteria for CoERCCC input and recommendation. Will send to Cord as soon as possible. Possibly push for a CoERCCC vote at next meeting pending final review and input?

Next 12 Months:

NATO 9-Line Project. Establish comms with US NATO BDE leadership this week and propose to build a working group with NATO partners. Will build distro of SMEs and leadership once we have a pathway with NATO established.

Research and Development

- Initiate Top 10 Research Publication (every 5 years)
 - Initial publication 2021 – review for ongoing projects
 - BATDOK
 - Clinical Decision Support (Burn Navigator)



Committee on En Route Combat Casualty Care (CoERCCC) Meeting Minutes

- Intelligent tasking (need good documentation)
- Risk Assessment Tool update
- UAS Transport

****Meeting Adjourned @ 1435**

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Amilia O. Almosara, SOIDMT
SMSgt, USAF
Program Manager, Committee on En Route Combat Casualty Care

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Michael Van Gent, MD, FACS
LCDR, MC, USN
Chair, Defense Committees on Trauma



Committee on En Route Combat Casualty Care (CoERCCC) Meeting Minutes

Enclosure (1) – Meeting Attendance

JTS Staff:

COL Cord Cunningham (CoERCCC Chair)
SMSgt Mia Almosara (JTS AF LNO/ ERC PM)
COL Jennifer Gurney (JTS Chief)
Mr. Dallas Burelison (JTS Chief of Staff)
HMCM Justin Wilson (JTS SEL)
LCDR Michael Van Gent (DCoT Chief)
Mr. Dominick Sestito (JTS PM)
Danielle Davis (Ex. Admin)
Trevor Gipper (JTS A/V)
CDR Darshan Thota (JTS Data)
CAPT Travis Deaton (CoTCCC Chair)
Harold Montgomery (CoTCCC Co-Chair)
Mr. Bruce Tarpey (MEDEVAC Coord)
Mr. Tre Mosely (JTS JTET)
Mr. Rich Jarrett (JTS JTET)
Ms. Teri Duquette-frame (JTS OPS Chief) Dr.
Jonathan Stallings (JTS Data Chief)

CoERCCC Voting Members:

Col Joseph Maddry
Maj William Davis
HMC Aaron Herman
HMC Ryan Mooney
LCDR Alex Nguyen
Col Valerie Sams
1LT Caleb Washburn
1SG Jessie Turner
SFC Steve Gillis
LCDR Valerie Arneaz
MSG Jared Voller
LCDR Emily Raetz
COL Erik Jacobson
SMSgt Shawn Anderson
1SG Matthew Harmon Col
Marvin Mikeska
CPT Joshua Boswell
Mr. Kolby Rapp
CDR Autumn Riddell
Mr. Matthew Sovereign
Lt Col Richard Sequeira
HMCS Thomas Walsh

Virtual Guests:

CAPT Matt Tadlock (CoSCCC Chair)
COL Steven Gaydos
CAPT Joshua Tobin
LCDR Dana Flieger
HMCS Wayne Papalski
Mr. Russ Kotwal (JTS SME)
Lt Col Nelson Pacheco
SSG Gabriel Hernandez
Ms. Brittany Dickerson
LTC Sarah Snyder
Maj Adam Kruse
Mr. John Crowley
LtCol Lindsey July
MSG Jeremy Wicklin
SFC Brian Evans
PBS Dustoff
Maj William Davis

Subject Matter Experts:

Ms. Rachel Kinsley
LCDR Brittany Hout (CoSCCC Voting Member)
Mr. Steven Blocker