Committee on Tactical Combat Casualty Care
Meeting Minutes

5-6 August 2014

Westin Atlanta Airport Hotel
Atlanta, GA

Tuesday, 5 August 2014

Military Health System Transformation **Lt Gen Doug Robb**

General Robb described the organization and structure of the new Defense Health Agency (DHA). The mission of the DHA is to assure both a medically ready force and a ready medical force for the future. Medical care now accounts for 10% of the Department of Defense's (DoD's) annual budget - about $60 billion and medical costs are likely to continue to rise. Management activities represent only a small part of DoD's health care costs, but opportunities exist for a properly organized management headquarters to effect change and reduce costs via shared services. Reform of the Military Health System (MHS) is directed at creating a more globally integrated health system built on our battlefield successes like the Joint Theater Trauma System, and developing standardized clinical and business processes for shared services that produce better health care and better health throughout the DoD. Savings in health care costs in the first fiscal year since the DHA stood up have exceeded projections. Eighty-five percent of the savings are due to shared services. The two directorates within the DHA that will have the most impact on TCCC are Research, Development, and Acquisition and Education and Training.

Combat Medic Presentation **SFC Scott McHugh (1st SFG)**

SFC McHugh presented a case of a casualty with a gunshot wound to his right upper arm whose treatment at an aid station included a fresh whole blood (FWB) transfusion. Because evacuation from this remote location was difficult, the medical staff had prepared for FWB transfusion by typing the blood of all Americans and allied indigenous personnel (creating a walking blood bank) and stocking the needed supplies and medications. After a transport time of 30 minutes to the aid station followed by initial care and administration of TXA, a transfusion of one unit of FWB was completed within one hour after injury. This resuscitation was successful and the casualty's recovery was managed locally. This scenario demonstrates that life-saving FWB transfusions using a unit-based walking blood bank can be safely accomplished in remote areas where banked blood products are not available and MEDEVAC is difficult. SFC McHugh pointed

out that inadequate training in TCCC for the medical officer involved in this operation was a significant problem in the management of this casualty.

TCCC Update **Dr. Frank Butler**

The Assistant Secretary of Defense for Health Affairs (ASDHA) MEMO of 14 Feb 2014 will facilitate TCCC training for deploying medical personnel.

The ASDHA MEMO of 07 JUL 2014 directs the removal of an eye patch kit from all service first aid kits and its replacement with an eye shield kit. This was promulgated via a Medical Material Quality Control Message.

DHA-MEDLOG has condemned the TK-4 tourniquet due to catastrophic failures and directed its removal from DoD inventories.

The US Forces - Afghanistan (USFORA) FRAGO of 21 Mar 2104 requires that everyone deploying to Afghanistan will have TCCC training; this includes doctors, nurses, physician assistants, and all combatants. It also requires that units will be equipped to perform TCCC.

In June of 2009, the Secretary of Defense (SecDef) required that Tactical Evacuation missions be completed within 60 minutes from the time of mission approval. The U.S. casualty fatality rate dropped from 13% prior to 2009 to 9% in the years following the SecDef directive.

The FDA may be able to help with approving military-only indications for medications, devices, and blood products. XStat, for example, currently has an FDA clearance for battlefield use only. CoTCCC interest items (dried plasma, ketamine, TXA, ondansetron) could be granted similar approvals by a DoD-FDA Military Use Panel established to review items of unique interest to the US Military.

TCCC Guideline Change 13-05 has been approved and recommends Celox Gauze and ChitoGauze as back-up hemostatic dressings when combat gauze is not available. (Reference: Brad L. Bennett, PhD, NREMT-P; Lanny F. Littlejohn, MD; Bijan S. Kheirabadi, PhD; et al: Management of External Hemorrhage in Tactical Combat Casualty Care:Chitosan-Based Hemostatic Gauze Dressings. *J Spec Oper Med* 2014:14:40-57.)

TCCC Guideline Change 14-01 has passed and provides a prioritized list of ten options for fluid resuscitation for casualties suffering from hemorrhagic shock. Whole blood and blood components in a 1:1:1 ratio are at the top of the list and the crystalloids Lactated Ringers and Plasma-Lyte at the bottom. Normal saline has been removed from the list. (Reference: Frank K. Butler, MD; John B. Holcomb, MD; Martin A. Schreiber, MD; et al: Fluid Resuscitation for Hemorrhagic Shock in Tactical Combat Casualty Care. *J Spec Oper Med*: 2014:14:13-38.)

Joint Trauma System Director's Brief **COL Jeff Bailey**

Almost 90% combat-related fatalities occur before the casualties reach a medical treatment facility (MTF), and Eastridge found that 24% of these fatalities were potentially preventable. The JTS Performance Improvement (PI) cycle must be able to identify opportunities to improve in combat casualty care across the entire continuum of care, from the point of injury all the way to rehabilitative care. The information contained in the Department of Defense Trauma Registry (DoDTR) enables this PI process and allows us to develop best practice trauma care guidelines(we now have 42 Clinical Practice Guidelines), close capability gaps, shape education and training, and inform operational medical decisions.

TCCC Equipment **CDR Tyson Brunstetter**

CDR Brunstetter from the Defense Health Agency Medical Logistics office (DHA-MEDLOG) reviewed the progress made in the development and fielding of the Joint-Service First Aid Kit (JFAK). Prior to 9-11, service Individual First Aid Kits (IFAKs) did not reflect TCCC recommendations. In 2010, only one CoTCCC-recommended item was in all of the services' IFAKs – Combat Gauze. The JFAK Integrated Process Team was launched in 2012 to address this issue. Tremendous progress toward interservice standardization has been made since then. The Air Force is now purchasing the JFAK; the Navy has plans to purchase it; and the Army IFAK-II contains the JFAK Core Components (with the exception of the recommended quantities of pressure bandages and compressed gauze). The upcoming IFAK upgrade in the Marine Corps contains all of the JFAK core components except for the nasopharyngeal airway, which is carried by Combat Lifesavers and Corpsmen.

The Hartford Consensus **Dr. Lenworth Jacobs**

Dr. Jacobs is a Professor of Surgery at the University of Connecticut and Director of the Trauma Institute at Hartford Hospital. The "Joint Committee to Create a National Policy to Enhance Survivability from Mass Casualty Shooting Events" was initiated by the American College of Surgeons in an effort to ensure that victims from these incidents receive optimal treatment of their injuries that includes the best-practice prehospital care techniques used by the US Military in TCCC. The Hartford Consensus Working Group included selected individuals from public safety organizations, the Federal Bureau of Investigation, law enforcement agencies, fire departments, EMS systems, the trauma surgery community, and the military. The group met in Hartford, Connecticut on April 2, 2013 and again on July 11, 2013. Attendance at the second meeting also included representatives from the Federal Emergency Management Agency and the National Security Staff of the Office of the President.

These meetings have become known as Hartford Consensus I and Hartford Consensus II. The concepts put forth and supported by both meetings are referred to as the Hartford Consensus. The Hartford Consensus II Statement is a call to action that emphasizes that no one should die from uncontrolled external hemorrhage.

The Hartford Consensus calls for concerted action by all responders based on the "**THREAT**" concept. In the Hot Zone of greatest danger, law enforcement officers provide

Threat Suppression and, if feasible, control of extremity hemorrhage; in the Warm Zone which is less dangerous but is still not secure, fire and rescue personnel or other first responders provide **H**emorrhage Control and **R**apid **E**xtraction; and in the safe Cold Zone, Emergency Medical personnel **A**ssess casualties and prepare them for rapid **T**ransport to the most appropriate trauma center. The **THREAT** concept needs to be supported with public education programs (Run-Fight-Hide and hemorrhage control training), prepositioned trauma care equipment, and providing for an enhanced first response from law enforcement officers and bystanders.

Prolonged Field Care **SFC(P) Chris McNamara**

The Prolonged Field Care (PFC) working group was formed to develop ways to optimize care in scenarios in which evacuation is delayed and the casualty must be managed in field environments for extended periods. The trauma care required in such situations may go beyond the current scope of TCCC. Tactical Field Care and TACEVAC Care as performed in Afghanistan, a mature theater of conflict after many years of war, may need to be re-evaluated for use in other geographic combat commands where the casualties may experience much lengthier evacuation times.

The PFC working group is a Special Operations Medical Association/ Special Operations Medical Scientific Assembly-sponsored initiative. The group may recommend expanding the capabilities of SOF medics, but the it does not speak for the US Special Operations Command (USSOCOM) or its component commands. SFC (P) McNamara discussed various aspects of the group's work; materials relating to this effort can be found at: http://specialoperationsmedicine.org/Pages/pfcresources.aspx.

JTTS Prehospital Medical Director's Brief **LTC David Marcozzi**

LTC Marcozzi discussed his experiences during his tour as the Deployed Joint Theater Trauma System (JTTS) Prehospital Care Director. He observed that the JTS is working well and casualty care in deployed medical treatment facilities is better than ever. Prehospital casualty care also continues to improve, but documentation in this phase of care remains problematic. We cannot easily track casualty outcomes, since we still have multiple trauma registries and five separate electronic health records. LTC Marcozzi's priorities for improving prehospital care are:

- Documentation (one EHR from POI to rehab);
- Implementation (better TCCC training);
- Education (only SOF is currently up to speed), and
- Promotion (advocating for TCCC with influential stakeholders).

LTC Marcozzi also recommended that a JTTS be incorporated into each COCOM; that the TCCC Guidelines should become protocols; and that the US Army Forces Command and the US Army Training and Doctrine Command should be more involved with TCCC training and execution.

New Technology Pro and Con Presentations

XStat - Pro **Mr. Don Parsons**

XStat is a hemostatic agent that can be used to stop bleeding at junctional wound sites such as the groin or axilla. It consists of numerous chitosan-impregnated, expandable cellulose mini-sponges packaged in a clear plastic syringe-like applicator. It comes in two sizes, labeled 30 and 12, the latter being designed for injection into narrower wound tracts. When injected, the sponges expand from 3.5 mm to 4.5 cm. This expansion occurs within the wound tract, creating local pressure on surrounding tissues sufficient to stop severe arterial bleeding. The chitosan on the mini-sponges is a mucoadhesive hemostatic agent. Each sponge contains an x-ray detectable marker to assist in location and surgical removal. XStat is not indicated for use in the pleural cavity, the mediastinum, the abdomen, the retroperitoneal space, the sacral space above the inguinal ligament, or tissues above the clavicle. The sponges can be left in place for up to four hours before definitive surgical care and removal..

XStat can be much more quickly applied than a hemostatic dressing or a junctional tourniquet, and therefore achieves hemostasis more quickly and reduces blood loss. Since pressure is generated within the wound by the expanding sponges, the medic should not have to hold direct pressure manually. In a swine study conducted at the Naval Medical Research Unit – San Antonio and published in the Journal of Trauma, XStat was found to have a faster application time and less total blood loss than Combat Gauze, although survival was not significantly different.

XStat – Con **MSG Curt Conklin**

The technology is expensive. XStat 30 is currently in pre-production and costs $850 for a 3-pack. Projected full production costs of a 3-pack are $400 to $450. Sterility on all three injectors is lost once current packaging is opened. Single-packed XStat injectors are not available.

XStat Discussion

XStat is designed for use in narrow, deep penetrating wound tracts that are hard to pack with gauze.

XStat 30 comes in a three-pack because it is estimated to take between 2 and 3 injectors to control bleeding in inguinal wounds; having three injectors packaged together means that the medic will only have to open one package instead of three.

In Dr. John Holcomb's opinion, XStat is the only hemostatic device that is likely to work effectively to control bleeding in an injury to a subclavian vessel.

Abdominal Aortic Junctional Tourniquet – Pro **COL Samual Sauer**

The AAJT is an FDA-approved device designed to control junctional hemorrhage for up to 4 hours at multiple sites. It is light, small, and rugged. It works with a lower pressure over a broader area than its competitors. It ifs quickly applied, and has a lower failure rate than its competitors. There is already some evidence in the medical literature that the AAJT is efficacious in clinical use. It already has an National Stock Number

(NSN.)

Abdominal Aortic Junctional Tourniquet – Con **Dr. Mel Otten**

Dr. Otten observed that reducing or eliminating arterial blood blow in volunteers in the laboratory does not guarantee its efficacy in controlling bleeding from traumatic injuries. He noted that there are only three anecdotal reports of actual clinical use and posed the question of whether that is a sufficient evidence base to recommend its use in the field.

Dr. Otten also pointed out that it is a pneumatic device – this means that it may be rendered useless if hit by a bullet or by a fragment strike from a blast. He also noted that the device is expensive and that it has the potential to increase bleeding from vascular injuries proximal to the site of application.

AAJT Discussion Points

There were questions asked about how effective the AAJT would be in stopping bleeding from pelvic injuries? It was noted that it takes about one minute to apply the AAJT using a manual inflation technique.

Autotransfusion Tourniquet – Pro **Dr. Frank Butler**

The ATT works by progressively compressing the leg from proximal to distal as it is applied by rolling it up the leg. Blood from the leg (about 500 cc) is thus returned to the central circulation. The tourniquet, once in place, also reduces the amount of tissue that needs to be perfused by the casualty's remaining blood volume and by any resuscitation fluids given. Advantages of the ATT include:

- It makes blood (the casualty's own blood) available with minimal logistics
- It can be applied quickly
- The casualty's own blood is the best possible resuscitative fluid
- It reduces the perfusion area of the remaining blood volume and enhances the effect of resuscitation fluids in restoring perfusion to vital organs
- Use of extremity tourniquets for short periods is relatively safe

Autotransfusion Tourniquet – Con **CMSgt Tom Rich**

The elastic ring used in this device produces increased pressure on extremity tissues, which could potentially result in higher pain levels and tissue damage. The ATT can be applied for only two hours; also, blood pressure may fall markedly when the device is removed and blood from the central circulation returns to the extremities.

Autotransfusion Tourniquet - Discussion

All junctional tourniquets are approved by the FDA only for battlefield use by the military. There was doubt expressed that an effective transfusion can be produced by compressing the legs of a trauma victim who is in hemorrhagic shock, since the peripheral circulation would likely be significantly reduced in the shock state.

iTClamp – Pro **Lt Col Stephen Rush**

Lt Col Rush noted that the iTClamp is a spring-powered plastic clamp with metal teeth that bite into the skin on both sides of a laceration or puncture wound and pull the edges together. This closure increases local subcutaneous pressure that helps to control bleeding. It is useful for wounds at sites where tourniquets cannot be applied, such as the scalp or neck. The iTClamp is small, light, easily and quickly applied, and requires little training.

iTClamp – Con **CMDCM Eric Sine**

CMDCM Sine pointed out that each unit costs $113.00 and that a medic or corpsman would need to carry at least two. An equivalent hemostatic effect may be obtained by using a hemostat or a skin stapler. The iTClamp has the potential to be easily dislodged during patient movement. Also, since it is made of plastic, it may be easily broken during carriage..

iT Clamp - Discussion

Members of the group noted that if the iTClamp is dislodged it can be removed and re-applied.

New Business **Dr. Frank Butler**

Dr. Butler conducted an informal poll of voting members for their recommendations regarding the four devices discussed; the AAJT received the most interest from the group as a proposed future change to TCCC.

Wednesday, 6 August 2014

Combat Medic Presentation **TSgt Dan Warren and SSgt Lee Von Hack**

The speakers presented a scenario encountered on a mission to evacuate U.S. citizens from a UN compound in a foreign country. Mission aircraft came under heavy enemy fire on approach to the compound, resulting in four casualties. These casualties and their treatment were described.

Damaged aircraft landed to transload casualties onto other cargo planes for continued evacuation. For one casualty, who was in shock, a 3-unit field transfusion of O-positive fresh whole blood was carried out during the evacuation. Donors were identified by history only. There were poor communications during the evacuation with resulting confusion during the transload and during the follow-on care in an indigenous hospital. Several critical mistakes were made, including leaving tourniquets on the leg of one casualty for approximately 8 hours, resulting in an above-knee amputation from tourniquet ischemia.

Lessons learned included: A walking blood bank and fresh whole blood transfusion can save lives in the field; prior blood typing is required. Fresh whole blood transfusion is a tertiary option to be used only if typed and screened whole blood or packed red cells and plasma are not available. Receiving medics at transload points should get formal handoff briefing before assuming care for casualties.

Proposed Change - CricKey **LTC Bob Mabry**

LTC Mabry discussed a proposed change to the TCCC guidelines pertaining to the CricKey. There are three basic techniques with which to perform a surgical airway: tube over trochar, Seldinger technique (wire), or open surgical technique. The overall failure rate for surgical airways on the battlefield is 33%. In a cadaver study performed by LTC Mabry with Army 68W medics, the CricKey technique was faster than the open surgical technique. Dr. Mabry discussed several proposed versions of the wording for the proposed change to the surgical airway technique in TCCC and obtained feedback from the group on each.

Naval Special Warfare Tactical Medic Program **SOCS Andrew McPherson**

SOCS McPherson described the issues encountered in the SEAL community following the establishment of the SEAL Operator (SO) and Special Warfare Combatant Craft Crewman (SWCC) ratings. This training for these rates, when added to the Special Operations Combat Medic Program of Instruction at the Joint Special Operations Training Command, created an unacceptably long training pipeline for SEAL medics. This long pipeline, combined with the short career utilization of medics before they transitioned to operational leadership positions, forced NSW to seek a quicker way to field operationally competent SEALs with medical expertise. Their solution is the Special Operations Tactical Responder (SOTR) course. The 20-week course of instruction for the SOTR is designed to train selected SEAL and SWCC operators as NSW-centric combat medics. The course includes trauma rotations and academic instruction at the Spirit of Charity Trauma Center in New Orleans. SOCS McPherson presented a list of core competencies for the SOTR; the program has a maximum annual capacity of 96 new SOTRs and three classes have already graduated.

Proposed Change – Ondansetron **LCDR Dana Onifer**

LCDR Onifer proposed a change to the TCCC Guidelines that would replace promethazine with ondansetron as the drug of choice for treatment of nausea and vomiting secondary to trauma or to treatment with opioid analgesics. Ondansetron is as effective as promethazine as an antiemetic and has fewer serious side effects. Ondansetron is being used with increasing frequency for the treatment of nausea and vomiting in the emergency department. The position paper for this proposed change is currently being drafted and will be forwarded to the TCCC Working Group in the near future.

Dr. Onifer noted that, in the recent study by Freedman published in the Annals of Emergency Medicine, there were 48 cases of arrhythmia recorded in the Adverse Drug Events databases, 4 of which were torsades de pointes. The Freedman study includes

data gathered from multiple databases, conceivably covering many millions of doses. There were 12.9 million doses of ondansetron given in the US in 2009 in emergency departments alone; there were no incidents of arrhythmias noted after a single oral dose in this study.

Tranexamic Acid (TXA) Update - 1 **CAPT Zsolt Stockinger**

CAPT Stockinger presented the results of Joint Trauma System Process Improvement Review of TXA use in theater. Data in the PI review were analyzed in a manner similar to that in the MATTERS paper. The adequately statistically-powered RCT CRASH-2 provides the strongest evidence to date for a TXA-related mortality benefit (9% reduction in mortality). Using retrospective data for the largest available military sample, while not statistically significant, the JTS PI review suggests a TXA-related mortality benefit (12% reduction in mortality) similar to CRASH-2. The JTS study results also suggest an increased risk of PE; however the mortality benefit appears to outweigh this risk.

TXA Update - 2 **Dr. Frank Butler**

Dr. Butler presented a review of studies of TXA use in recent medical literature. He made these points:

- There is Level A evidence that TXA reduces blood loss in elective surgery patients.
- There is Level A evidence that TXA does not increase the risk of thromboembolic complications in elective surgery patients.
- TXA in elective surgery is given before surgical bleeding begins.
- Elective surgery is not trauma.
- The best way to avoid death from hemorrhage is to PREVENT blood loss rather than treat hemorrhagic shock.

And posed these questions:

- Should we be giving TXA earlier?
- Should we change the indications for TXA?
- Should we use TXA only in casualties with non-compressible hemorrhage? This would eliminate the risk of adverse events in casualties with controlled hemorrhage.
- Should we use TXA in casualties with blunt torso trauma also?
- Or should we make no changes at present and just continue to follow the literature?

Dr. Butler also noted that since we now have better documentation of prehospital care that the JTS should do subgroup analyses of outcomes based on: 1) the time to TXA administration after injury; ISS; and controlled vs. non-controlled hemorrhage.

Proposed Change – Tourniquets **Col Stacy Shackleford**

Col Shackleford presented a proposal to change the wording of the guidelines to add clarity with respect to the following questions:

- During CUF, should the tourniquet be placed as proximal as possible on the

injured extremity vs. “clearly proximal to the bleeding site?”

- Should we explicitly specify “bleeding stopped” as a goal for tourniquet assessment in Tactical Field Care as well as elimination of distal pulse?
- Is more emphasis/clarification needed for when to consider tourniquet removal – should there be a mandatory assessment for possible removal at the two-hour point of tourniquet application time?
- Is single slit routing of the CAT tourniquet acceptable?

Col Shackleford will use input from the TCCC Working Group to further refine the wording of the proposed changes. A position paper explaining the rationale for this proposal will be drafted and forwarded to the group before the CoTCCC votes on the proposed change.

JTTS Prehospital Director’s Brief **MAJ John Robinson**

MAJ Robinson reviewed the in-theater prehospital care milestones that were achieved during his tour as the JTTS Deployed Prehospital Care Director. He focused his remarks on documentation of prehospital care. Compliance with TCCC card reporting improved markedly during his time in theater. JTS Combat Medic Conferences have also been initiated as a forum for medics to share combat experiences and discuss prehospital care issues of special interest to the medics. MAJ Robinson noted that there is still significant opportunity for improvement in prehospital care – TCCC Guideline changes are not rapidly transitioned to deployed and deploying combat units.

TCCC Strategic Messaging **Dr. Frank Butler**

Dr. Butler presented the channels used to communicate information pertaining to TCCC. These include the TCCC Guidelines, TCCC position papers as published in the Journal of Special Operations Medicine(JSOM), the TCCC curriculum, the Military version of the PHTLS manual, TCCC guidelines change packages (updated TCCC Guidelines, the position paper, and training slides for each change), and focused TCCC-related communications. These materials are posted on multiple websites and sent via email to the TCCC interest group. Anyone wishing to be added to this group can request that by emailing Ms. Danielle Davis (danielle.m.davis.civ@mail.mil).

PHTLS 8 Military and TCCC Curriculum Update **Dr. Stephen Giebner**

The Military Eighth Edition of the PHTLS textbook will go to press in November and will be in stores in December. PHTLS 8 Military will have 13 chapters on TCCC and other military-specific topics, including a new chapter on TCCC scenarios. The TCCC Curriculum update (version 140602) is out. This update is the first produced under our new practice of updating the curriculum file set annually. Changes made between annual updates will be distributed as change packages containing a PowerPoint covering the changed guideline and a paper explaining the rationale for the change. The curriculum will be posted on JSOM, NAEMT, MHS, and Special Operations Medical Association websites.

PHTLS TCCC Course - Program Report **Mr. Mark Leuder**

New sites are being opened in the US, and there has been an increase in teaching overseas. A course was recently taught in Singapore, and this month a course will be taught in Portugal. In October, a rollout in Germany will include Portugal, France, Italy, and Switzerland.

26 March 2015

Frank K. Butler, M.D. Date
CAPT, MC, USN (Ret)
Chairman
Committee on TCCC

Enclosures:

(1) Attendance
(2) Agenda

Enclosure 1

CoTCCC Meeting Attendance
5-6 August 2014

CoTCCC Voting Members

Col Jeff Bailey
CDR Sean Barbabella
COL Peter Benson
SGM F Bowling
Dr. Frank Butler
MSG Curt Conklin
Lt Col Joe Dubose
COL Erin Edgar
MAJ Kyle Faudree
Dr. Doug Freer
HMCM Mike Grohman
CAPT Matt Hickey
Dr. Ken Kelly
Mr. Win Kerr
CAPT Bill Liston
LTC Bob Mabry
LTC Dave Marcozzi
MSG Harold Montgomery
COL Kevin O'Connor
LCDR Dana Onifer
Dr. Mel Otten
Mr. Don Parsons
CMSGT Tom Rich
HSCM Glenn Royes
Lt Col Steve Rush
COL Samual Sauer
CMSGT Ryan Schultz
Col Stacy Shackelford
CMDCM Eric Sine
Mr. Rick Strayer
HMSC Jeremy Torrisi

Designated TCCC SMEs

Dr. Howard Champion
Dr. Paul Cordts
Dr. Warren Dorlac
Mr. Bill Donovan
Dr. Jim Dunne
Dr. Rocky Farr
Dr. John Holcomb

Dr. Russ Kotwal
Dr. Norman McSwain
Dr. Peter Rhee

CoTCCC Staff
Dr. Steve Giebner
Ms. Danielle Davis

Military Liaisons
CAPT (Sel) Keith Givens
CDR Carl Goforth
Lt Col Ed Mazuchowski
SGM Kyle Sims
CAPT Zsolt Stockinger
COL Hal Walker
Lt Col Rich Weber
Mr. Ed Whitt

Allied Liaisons
LCDR Wade Brockway

Guest Presenters
CDR Tyson Brunstetter
Dr. Lenworth Jacobs
Mr. Mark Lueder
SFC Scott McHugh
SFC (P) Chris McNamara
SOCS Andrew McPherson
Lt Gen Douglas Robb
MAJ John Robinson
TSgt Daniel Warren

Invited Guests
MSG John Dominguez
CAPT Barbara Drobina
LTC Duncan Gillies
SOCM James Holmes
Mr. Greg Housler
COL Caesar Junker
Ms. Allison Kumar
COL Robert Lutz
BG (Sel) Robert Miller
HM3 Jonathan Rocha
LTC Randall Schaefer
Mr. Thomas Shu

Enclosure 2

CoTCCC Meeting Agenda
5-6 August 2014

Tuesday – 5 August 2014

AM		
0800	**Butler**	**Admin Remarks and Introductions**
0830	**Robb**	**Senior Leader Remarks**
0900	**McHugh**	**Combat Medic Presentation**
0930	**Break**	
0945	**Butler**	**TCCC Update**
1015	**Bailey**	**JTS Director Brief**
1045	**Brunstetter**	**JFAK - Proposed CoTCCC Approval**
1115	**Jacobs**	**Hartford Consensus**
1145	**Lunch**	
1300	**McNamara**	**Prolonged Field Care**
1330	**Butler**	**TCCC Strategic Messaging**
1400	**Parsons**	**X-STAT - Pro**
	Conklin	**X-STAT - Con**
1430	**Break**	
1445	**Sauer**	**AAJT - Pro**
	Otten	**AAJT - Con**
1515	**Butler**	**Auto-Transfusion Tourniquet - Pro**
	Rich	**Auto-Transfusion Tourniquet - Con**
1545	**Rush**	**iTClamp - Pro**
	Sine	**iTClamp - Con**
1615	**Group**	**New Business**
1630	**Finish**	

Wednesday – 6 August 2014

AM

0800	**Butler**	**Admin Remarks**
0815	**Warren/Von Hack**	**Combat Medic Presentation - Van Hack**
0845	**Mabry**	**Proposed Change – CricKey**
0915	**McPherson**	**The New SEAL Medic**
0945	**Break**	
1000	**Onifer**	**Proposed Change - Ondansetron**
1045	**Stockinger**	**TXA Update I**
	Butler	**TXA Update II**
1145	**Lunch**	

PM

1300	**Shackelford**	**Proposed Change – Tourniquets**
1330	**Robinson**	**JTTS Prehospital Director Brief**
1400	**Marcozzi**	**JTTS Prehospital Director Brief**
1430	**Break**	
1445	**Giebner**	**PHTLS and TCCC Curriculum Update**
1515	**Lueder**	**PHTLS TCCC Courses**
1530	**Butler**	**CoTCCC Action Items**
1600	**Group**	**New Business**
1630	**Finish**	