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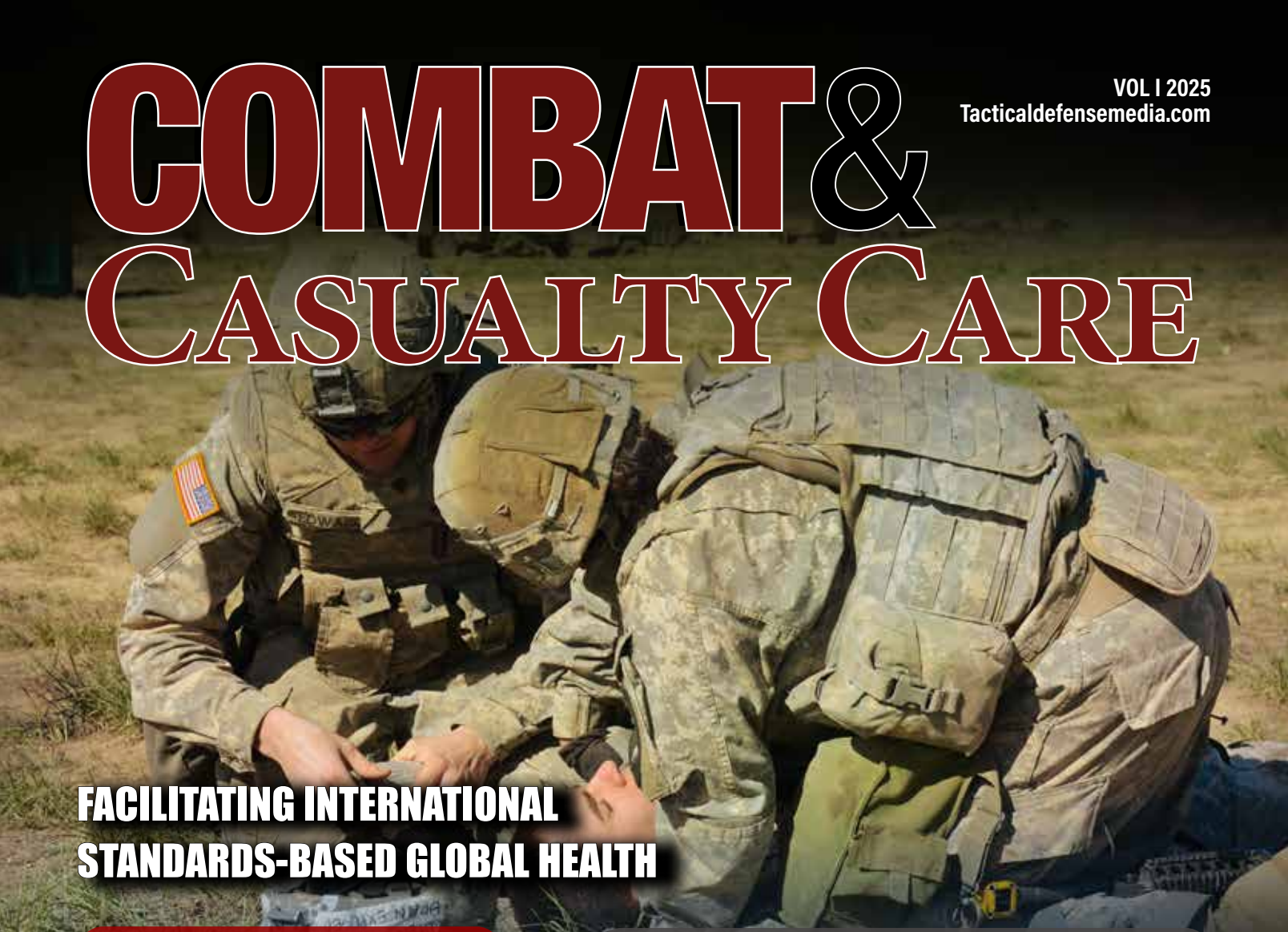
COMBAT & CASUALTY CARE



FACILITATING INTERNATIONAL STANDARDS-BASED GLOBAL HEALTH

COMMANDER'S CORNER

MG E. Darrin Cox
Commanding General
18th Theater Medical Command
Ft. Shafter, Hawaii

BG Roger Giraud
Cmding General
Med Readiness Command Europe
Cmd Surgeon, U.S. Army Euro/Africa
Director, Defense Health Net Europe

CSM Victor Laragione
U.S. Army Medical Center of Excellence
Joint Base San Antonio-Ft. Sam Houston, TX

- Joint Austere Resuscitative Surgical Care
- Vital Signs-based Mental Health Monitoring
- Operational Medicine-focused Restructure
- Indo-Pacific Medical Support ■ Combat Medic Modernization
- Global Health Engagement ■ Med Readiness Europe and Africa

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STANDARDIZING A RECIPE FOR LIFESAVING CARE OUT THERE

The U.S. Department of Defense Joint Trauma System (JTS) has developed the first comprehensive Joint Austere Resuscitative Surgical Care (JARSC) Curriculum for Role 2 Surgical Team Training.

By CAPT Matthew D. Tadlock

Featured Interviews

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18th Theater Medical Command
Ft. Shafter, Hawaii

LEADERSHIP PERSPECTIVE

BG Roger Giraud
Commanding General, Medical Readiness Command, Europe
Command Surgeon, U.S. Army Europe and Africa
Director, Defense Health Network Europe

COMBAT MEDICINE FOCUS

Command Sergeant Major Victor Laragione
U.S. Army Medical Center of Excellence
Joint Base San Antonio-Ft. Sam Houston
Houston, TX

Departments

INDUSTRY PERSPECTIVE

MENTAL HEALTH CRITICAL TO TRAUMA CARE AND MILITARY RESILIENCE

NeuroFlow provides 24/7 digital monitoring of mental health indicators, offering immediate mental health resources and support when warning signs appear.

By Ellen Harvey

TRANSFORMING MILITARY MEDICAL DEVELOPMENT FOR THE FUTURE FIGHT

The U.S. Army Medical Materiel Development Activity (USAMMDA) has recently changed command, combining with elements of the U.S. Army Medical Research and Development Command (USAMRDC) to constitute a new organization, Operational Medical Systems, under the Defense Health Agency.

By OPMED Strategic Communications Office

Cover: U.S. Army Spc. Logan Edwards (left), an Olympia, Wash., native and medic and Spc. Analy Juarez, a San Pablo, Calif., native and medic, both with Company C, 296th Brigade Support Battalion, treat a casualty during training at Yakima Training Center, Wash., April 11. This training was part of lane that helped test numerous medical and Soldier skills including treating a casualty, evacuating a patient and calling for a medical transport amongst other things. (U.S. Army photo by Staff Sgt. Justin Naylor, 3-2 Stryker Brigade Combat Team Public Affairs)

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INSIGHTS

With environmental challenges, from severe weather to terrain variation, facing combat medical personnel globally every day, one constant remains: effective casualty care requires a skillset understood in any language, across any culture. The Volume 1 2025 edition of *Combat & Casualty Care* focuses on unique international perspectives medics operating in Europe and the Pacific have in effecting positive patient outcomes despite differences in environment.

Leading us off, very few combat-seasoned medical professionals would disagree that capable resuscitative treatment at point of injury is perhaps the most critical of "Golden Hour" achievements. Reflective of this is work being done by the U.S. Department of Defense Joint Trauma System (JTS) which has developed the first comprehensive Joint Austere Resuscitative Surgical Care (JARSC) Curriculum for Role 2 Surgical Team Training. With the perpetual challenge posed to Austere Resuscitative Surgical Care (ARSC) teams being the management of massive injury enough to enable survival in transport, a new curriculum introduced for the education and training of ARSC team members will now increase skills standardization across Joint force execution. These shared guidelines should minimize procedural gaps that in the past cost savable lives.

From field to facility, quality combat medicine is only as good as the leadership encouraging its practice. All the way from 18th Theater Medical Command, Ft. Shafter, HI, recently promoted Commanding General, MG E. Darrin Cox, leads this most senior command within the Indo Pacific Command area of operations (AO), assisting U.S. Army Pacific (USARPAC) with three key initiatives: Global Health Engagements (GHE), Medical Logistics, and Operation Pathways. From synchronized support to robust infrastructure, effective interoperability to ensure medical response where and when it is needed throughout the AO is front and center. Flipping the globe, we land smack on the European subcontinent at headquarters Medical Readiness Command, Europe and on top of Commanding General BG Roger Giraud's desk. Taking a multifaceted approach to training, readiness, and real-world deployment in support of GHE, the command is charged with supplying world-class medical care to enhance the readiness of U.S. Joint and coalition forces.

Of course, no military medical leadership portfolio is complete without a senior combat medic who connects closest with those who wield the tools of a lifesaving trade. Hailing from Corpus Christi, TX, Command Sergeant Major Victor Laragione brings years of 68W experience to today's combat medic modernization effort. Enhanced Combat Medic Proof of Principle and other initiatives are better preparing the combat medic of today for the Large Scale Combat Operations (LSCO) and Multi-Domain Operations (MDO) environments of tomorrow.

And what better way to tie this issue together than a look at how the Defense Health Agency (DHA) is refocusing efforts on an Operational Medicine (OPMED) point of view, bringing existing medical units and new ones such as Soldier Medical Devices Project Management Office (SMD PMO) under the umbrella of OPMED prioritization. As always, feel free to send us your comments and suggestions. Thanks for the continued readership!

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By Matthew D. Tadlock MD, CAPT, MC, USN

U.S. Soldiers assigned to Charlie Co., 6o3d Aviation Support Battalion, 3rd Combat Aviation Brigade, prepare to load simulated casualties onto the HH-60M Black Hawk for Tactical Evacuation Care (TACEVAC) while training in accordance with Tactical Combat Casualty Care (TCCC) guidelines at Hunter Army Airfield, Dec. 10, 2024. (U.S. Army photo by Staff Sgt. Dean Johnson)

Role 2 surgical teams bridge the time and space gap between wounding and definitive management of injuries. They played a critical role during the counter insurgency operations that characterized the Global War on Terror. (Kotwal, 2016) (Shackelford, 2024) The military services developed multiple versions of these small surgical teams to meet the needs of a kinetic and geographically dispersed battlefield. (Baker, 2021) During COIN operations traditional R2 surgical teams were often split to meet operational needs. (Lesperance, 2023) However, while each service deployed smaller surgical teams characterized by fewer personnel and decreased weight and cube of medical materiel, standardized training did not occur. (Baker, 2021)

The 2012 Joint Publication 4-02 codified and defined the term Role 2 Light Maneuver as a light and highly mobile medical unit "able to conduct advanced resuscitation procedures up to damage control surgery" that can set up as its own military treatment facility, in a "fixed building" of opportunity, or on a "naval platform." (Joint Publication 4-02, 2012) However, this definition did not address a major issue of these small and often single surgeon teams - their use was predicated on rapid resupply and timely casualty transport to maintain capability despite their limited capacity.

Recognizing this capability evolution and the potential risk to mission and risk to force, in 2019, the Department of Defense Joint Trauma System published comprehensive clinical practice guidelines (Northern, 2019) addressing the challenges faced by these teams. The CPG further refined the definition of small highly mobile teams as Austere Resuscitative Surgical Care – "an advanced medical capability delivered by small teams with limited resources, often beyond traditional timelines of care, and bridges gaps in roles of care."

AUSTERE RESUSCITATIVE SURGICAL CARE

ARSC teams are more agile and maneuverable than standard R2s, allowing them to provide a surgical/resuscitative capability closer to the point of injury in battlefield or contingency environments. ARSC teams are assets to military commanders because they potentially decrease the risk to force by improving survival from injuries and other military health threats.

"The challenge with traditional surgical teams, perfectly stated by Dr. Olgilvie almost a century ago, remains – massive injuries that would result in early mortality are likely unable to be effectively managed by teams that are too small, and the injuries that these teams can manage easily could likely endure a longer transport," said

Austere Resuscitative Surgical Care Curriculum Modules

- **Team Development and Dynamics:** Actions that enable the group to function optimally as a team and integrate various skillsets into a cohesive element to manage complex surgical patients in an austere setting.
- **Trauma System Integration:** Actions that ensure the ARSC team understands how the team fits into the overall Combatant Command Trauma System.
- **Clinical Operations in the Austere Environment:** Tactical actions that are essential for effective clinical operations.
- **Preparing to Receive Patients:** Actions which are integral to preparation for effective and efficient management of patient care and flow.
- **Patient Receiving and Management:** Actions taken individually and as a team upon receiving casualties.
- **Surgical Resuscitation in the Austere Environment:** Actions and knowledge required for successful surgical operations in the austere environment.
- **Post-surgical Care:** Actions and knowledge required for management of post-operative patients in the austere environment.
- **Austere Critical Care:** Actions required to address management of both surgical and non-surgical critically ill patients in the austere environment.
- **Patient Packaging and Transport:** Actions that are required to prepare a patient for evacuation.
- **Prolonged Patient Holding:** Actions that are necessary when patient evacuation is delayed and patients require unanticipated care in an austere setting.

DHA Defense Health Agency

DoD's Joint Trauma System Austere Resuscitative Surgical Care curriculum consists of 10 modules designed to support forward surgical teams from start to finish, ensuring effective clinical operations, optimum chance for survival, and maximum potential for functional recovery. (DoD graphic by Kim Farcot)

U.S. Army COL Jennifer Gurney, chief of the Joint Trauma System. "However, for these ARSC teams to be effective, they require education and training in addition to basic skills from specialty practice."

Published data shows approximately 24,000 surgical procedures were performed at R2 military hospitals and clinics from 2003 to 2018 in Afghanistan and Iraq. (Turner, 2017) R2 capabilities, including ARSC teams, provide lifesaving capabilities such as damage control resuscitation, damage control surgery, definitive surgery, massive transfusion, transfusion of fresh whole blood, treatment of communicable diseases, and the management of orthopedic injuries and other military health threats.

Despite the frequent deployment of non-doctrinal ARSC teams, there was no joint training program that fully prepared these teams for the strategic, operational, and tactical challenges of the far forward, austere, or resource limited environments. This lack of training standards was identified by an Inspector General report in June 2020 and resulted in current and future unacceptable risks to casualties cared for by these teams. These conditions set the stage for the development of joint ARSC curriculum.

DESIGNING THE JOINT AUSTERE RESUSCITATIVE SURGICAL CARE CURRICULUM

The JTS and the Committee on Surgical Combat Casualty Care created and led the ARSC curriculum development working group that included subject matter experts from each military service and Special Operations Command. The working group conducted an extensive analysis of all existing courses (military, civilian, and international) and curricula, and used the data to develop a comprehensive and modular ARSC team training curriculum. A total of 82 clinical and non-clinical common objectives and best practices from current courses were identified and 24 curricular elements were deemed required for both current military operations and the anticipated operational challenges of potential future large scale combat operations. Of the 12 military and non-miliary courses analyzed, only three included more than 50% of the recommended curricular elements. A common theme was identified: current courses and curriculum prepared ARSC teams for the war already fought, not future LSCO likely to be characterized by limited opportunities for rapid medical evacuation.

The ARSC curriculum includes 10 modules each focusing on different aspects of surgical care. The course is designed to support ARSC teams from start to finish - from small unit communication and coordination to tactical actions essential for effective clinical operations.

Efforts by the JTS to further resource training and education for ARSC teams is underway including using the ARSC curriculum to develop the Joint Expeditionary Trauma Training course not only for ARSC teams but all R2 teams.

"This curriculum directly supports Commanders and the warfighter," Gurney said. "Adding both the current service ARSC courses and the future JETT course to the JTS Operational Cycle will ensure that every service member injured in any theater of operations will receive the optimum chance for survival and maximum potential for functional recovery."

COL Jennifer Gurney

"Good surgery must be done as far forward as possible. If it is too good, in the sense of too elaborately equipped, it will not be far enough forward, and if it is too far forward it will not be good enough."
—Dr. William H. Ogilvie, 1887-1971

The curriculum was approved by the CoSCCC in February 2024, published in July 2024, and is available online: https://deployedmedicine.allogy.net/learner/collections/featured/337246fc-fc70-488e-8304-4ed47e507449/contents/3996

NETWORKING CRITICAL MEDICINE ACROSS A MULTINATIONAL FRAMEWORK

U.S. Army MG (Dr.) E. Darrin Cox currently serves as commanding general of the 18th Theater Medical Command at Fort Shafter in Hawaii. He is board certified in both general and thoracic surgery and is a Fellow of the American College of Surgeons and the American College of Chest Physicians. Additionally, he holds an academic appointment at the Uniformed Services University of the Health Sciences, Bethesda, Maryland and has been awarded the prestigious The Surgeon General's "A" proficiency designator for thoracic surgery. MG Cox's previous command and staff assignments include: Commanding General of the U.S. Army Medical Readiness Command, West, as well as Director, Defense Health Network West for the Defense Health Agency, both located at Joint Base San Antonio-Fort Sam Houston, Texas; Command Surgeon, United States Army Forces Command, Fort Liberty, North Carolina; Commander, United States Army Medical Research Institute of Infectious Diseases, Fort Detrick, Maryland; Deputy Medical Corps Chief, Office of The Surgeon General, Falls Church, Virginia; Deputy Commanding Officer, William Beaumont Army Medical Center; Fort Bliss, Texas; Commander, Bavaria Medical Activity, Vilseck, Germany; Chair, Department of Surgery, William Beaumont Army Medical Center; Deputy Commander for Clinical Services, 31st Combat Support Hospital, Fort Bliss; Commander, 745th Forward Surgical Team, Fort Bliss; Chief, Thoracic Surgery, Walter Reed Army Medical Center; Chief, Thoracic Surgery, 10th Combat Support Hospital, Baghdad, Iraq; and Chief, Performance Improvement, Walter Reed Army Medical Center. He also completed a 4-year term as Consultant to The Surgeon General for Thoracic Surgery. His deployments include two combat tours to Iraq in support of Operation Iraqi Freedom, one to Afghanistan in support of Operation Enduring Freedom, and an operational tour to Honduras supporting Joint Task Force-Bravo.

Combat & Casualty Care spoke recently with MG E. Darrin Cox, Commanding General, 18th Theater Medical Command, regarding current mission optempo for Army and Joint medical personnel in supporting global U.S. and coalition forces, as well as challenges addressing the medical needs of future multi-domain operations.

C&CC: Provide an overview of 18th Theater Medical Command: what are your focus areas, what does the organization look like, how do you see your role in Large Scale Combat Operations (LSCO)?

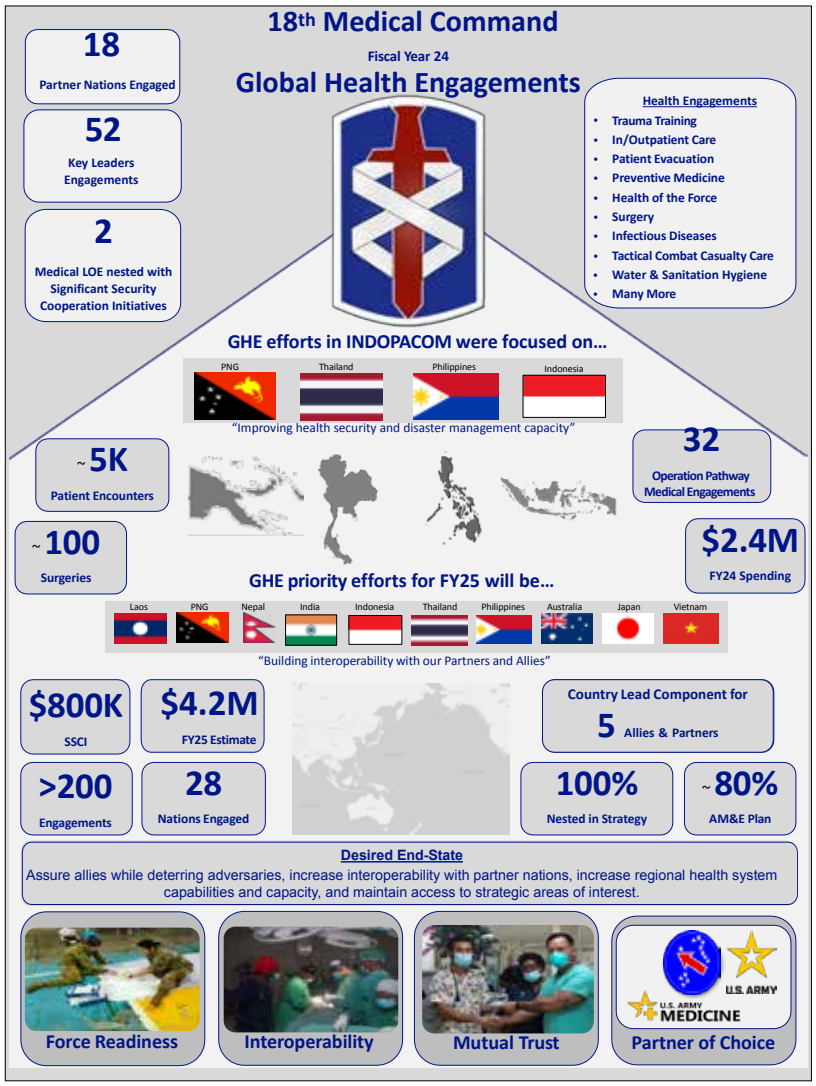
MG Cox: The 18th Theater Medical Command (TMC) provides a 2-star theater-enabling command for employment by United States Army Pacific (USARPAC) and, if ordered, to United States Indo-Pacific Command (INDOPACOM). As the senior medical command within the INDOPACOM area of operation (AO), 18th TMC provides adaptable, scalable, and multifunctional medical support capabilities tailored to meet specific mission requirements. 18th TMC: 1) synchronizes health service support (HSS); 2) establishes and maintains a robust medical infrastructure; 3) fosters interoperability with allied and partner nations; and 4) exercises command and control (C2) over assigned and attached forces.

With three key focus areas—synchronizing Global Health Engagements (GHE), building resilient Medical Logistics capabilities, and continuously transforming by designing and executing Exercises and Experiments— 18th TMC generates readiness that can project into the AO. During competition, we negotiate partner nation sharing agreements, preposition medical supplies, and experiment with patient evacuation platforms to provide the warfighter with options.

We are staffed to be the C2 medical node for assigned land forces and are built to be the Joint Theater Medical Command if directed. We are a total force organization, composed of active duty, reserve, and MTOE-assigned personnel (MAP) from medical and warfighting functions. For a theater enabler, we are small during competition, with approximately 130 personnel, but can rapidly grow to more than 200. We are a senior organization with Subject Matter Experts in every medical function, and we have built the framework to be able to distribute C2 nodes in multiple locations as required.

MG E. Darrin Cox

Commanding General
18th Theater Medical Command



18th Theater Medical Command, Fiscal Year 24 Global Health Engagements Overview (U.S. Army graphic courtesy of 18th Medical Theater Medical Command/Released)

In the Large-Scale Combat Operations (LSCO) environment, as the C2 medical node, our role is to synchronize efforts to clear the wounded from the battlefield, maximize return to duty, and overcome contested logistics. We will be operating in a highly contested and degraded environment, facing challenges such as Anti-Access and Area Denial capabilities, cyber-attacks on medical infrastructure, and potential chemical, biological, radiological, and nuclear threats. Our planning is focused on mitigating these risks and ensuring the continuity of medical support operations.

C&CC: China is a known threat, talk about the INDO-PACIFIC at large and what other aspects make it a challenge?

MG Cox: The Indo-Pacific is complex. The region contains three of the world's largest economies, seven of the largest militaries, and five of the United States' seven mutual defense agreement partners. Two-thirds of the world's population resides in the Indo-Pacific. The region accounts for more than 60% of the world's GDP, including more than 50% of world trade and maritime transport. Its 36 countries are arrayed over 16 time zones.

Overcoming geographic distances and associated time factors in the Indo-Pacific presents significant challenges. This geographic size influences our understanding and planning when it comes to logistics, mobility, and maneuverability as we provide HSS and force health protection to the warfighter.

Natural disasters pose another challenge. Earthquakes, typhoons, and tsunamis are common in this region. These disasters often lead to a significant number of injuries, internal displacement, and an increase in risk of waterborne and vector-borne diseases. These devasting and costly effects impact not only healthcare but also regional and global security.

C&CC: Global Health Engagements are significant in developing foreign partnerships and building capacity, share some of your successes and what is upcoming in this area?

MG Cox: Health cooperation, which has traditionally served as an avenue for humanitarian assistance, knowledge exchange, and partnership building, has demonstrated its potential as a non-provocative instrument of power capable of influencing public opinion and shaping relationships. 18th TMC's role in this region is to strategize, plan, synchronize, and provide oversight of GHEs to aggregate the effects of health cooperation to ensure we are supporting the theater assure-and-deter strategy.

Given our unique structure and position, 18th TMC can mobilize assets from throughout USARPAC, the Army Medicine total force, and the Defense Health Agency (joint force) to support health security cooperation across the entire theater. In FY24, 18th TMC synchronized more than 200 GHEs across 28 countries.

For example, our 8th Forward Resuscitative and Surgical Detachment (FRSD) executed a GHE at Port Moresby General Hospital in Papua New Guinea (PNG) to build trust, demonstrate combat-credible capability, and counter our adversaries' information advantage. The FRSD built readiness through high-volume trauma cases and prolonged care in a resource-constrained environment while enhancing partner capacity. The team integrated into the Emergency Department, Intensive Care Unit, and Operating Room, gaining valuable experience in an environment similar to what we may see in LSCO. The FRSD also enhanced interoperability working alongside our PNG partners. Follow-on rotations continue to strengthen partnerships, build interoperability, and provide valuable training.

Health security cooperation is also a valuable tool for the United States when working with international bodies. 18th TMC's Commanding General holds a key leadership position as co-chair of the Association of Southeast Asian Nations (ASEAN) Defense Ministers Meeting (ADMM) Expert Working Group on Military Medicine, a three-year co-chairmanship with Indonesia. This prominent role enables on-going engagement with the 10 ASEAN member countries, as well as eight additional dialogue partner nations, facilitating collaboration and advancing regional health security.

C&CC: How has and is force health system support evolving from an 18th TMC perspective and what do you see coming?

MG Cox: Due to the INDOPACOM's size, nothing is logistically easy. We are adapting new ways to support the warfighter. This means using,

developing, and employing technologies that distribute healthcare knowledge and capabilities to the lowest level while aggregating patient care information from that same distributed network to inform decision-making at echelon.

18th TMC works closely with partners such as the Army Medical Center of Excellence, Army Futures Command, Program Executive Office (PEO) Soldier, Joint Operational Medicine Information Systems (JOMIS), and the Joint Force to evaluate technologies for their applicability and usefulness in the Indo-Pacific. This spring, we will test multiple technologies during Project Convergence. We will conduct experiments to test the new prolonged care detachment (PCAD). Previously, we worked with the Navy to place an Army FRSD on a ship to identify challenges associated with an Army medical element afloat. Through various exercises, we continue to seek solutions to LSCO challenges of patient evacuation and contested logistics. We are testing novel approaches to moving patients throughout echelons of care, augmentation, and distributing medical supplies, including blood, where needed on the battlefield.

C&CC: Any final thoughts on challenges or opportunities to medically support the warfighter in LSCO?

MG Cox: We will see higher casualties at all echelons of care in LSCO. Time and distance challenges will dramatically impact HSS plans. Warfighters will face diseases and injuries different from the Global War on Terror. Lack of air superiority will challenge evacuation from the battlefield. We need to maximize return to duty to ease the burden of evacuation channels and to reconstitute the force. We must re-imagine triage, and we must incorporate technologies to ease the workload. Additionally, we must build resiliency in the force to withstand the rigors of the casualty volume.

The availability and proper positioning of Class VIII, including blood, remains a challenging logistical problem set. We are looking at various strategies, including the use of whole blood. Shelf-stable, dried plasma is a promising alternative. Historically, this was used by the U.S. during WWII and the Korean War but was discontinued due to infectious disease risk. I am optimistic that current research and modifications to dried plasma will make this an option again.

The future fight will require military medical personnel to be distributed across the theater. We will have to rely on our network of partners and allies to expand our capacity. However, our current ability to do so is limited. We cannot use medications unless approved by the FDA. Our ability to assign US healthcare team members to partner hospitals, or vice versa, to expand our medical footprint is limited by US and partner nation credentialing and privileging restrictions.

Presently, GHEs are restricted to Humanitarian Assistance, Knowledge Exchanges, International Training Exchanges, and Exercise programs. Title 10 authorities restrict us from building partners' capacity. 18th TMC leaders have met with Professional Military Staffers to discuss this issue, and this is a focus area of Army Medicine senior leaders, among others. I am optimistic that with Congressional focus in this area, we may be able to "build medical partner capacity."

MENTAL HEALTH CRITICAL TO TRAUMA CARE AND MILITARY RESILIENCE

By Ellen Harvey, NeuroFlow

NeuroFlow gathers critical health insights to evaluate and enhance resilience programs. (NeuroFlow)

"Golden Hour" marks the critical window for lifesaving interventions after trauma. Combat medics and corpsmen understand this urgency - rapid assessment, decisive action, and stabilization within those first 60 minutes directly impact survival. Mental health crises demand similar swift response, as the progression from suicidal thoughts to action often occurs in an equally short timeframe.

Crisis response extends beyond the immediate trauma care in theater. In garrison and deployed environments, medics and corpsmen face a different kind of time-critical challenge. From 2001 to 2021, four times more service members died by suicide than in active combat. Each death represents a crisis where minutes mattered, just as they do in the Golden Hour. This reality requires new approaches to monitoring and intervention that work across all military environments.

Medics and corpsmen serve as critical sensors for both physical and mental health deterioration in their units. While vital signs help track physical stability, identifying mental health decline requires different tools and resources. The challenge intensifies when service members return to garrison, where the daily connection to medical support may become less frequent, but the risk of crisis remains.

SUPPORTING MENTAL HEALTH IMPROVE RESILIENCE & READINESS

Just as vital signs monitoring helps identify physical health concerns, NeuroFlow provides 24/7 digital monitoring of mental health indicators. This platform gives the military medical community an additional tool to track their unit members' well-being, offering immediate mental health resources and support when warning signs appear. When service members show signs of crisis, NeuroFlow automatically connects them with trained crisis professionals, creating a vital safety net beyond sick call hours.

The platform's impact is significant, 13% of service members using NeuroFlow have been identified as having mental health risk or potential thoughts of self-harm. These are unit members who might otherwise have gone unnoticed until crisis.

"We have the technology to understand at a population level who among our military population are struggling with their mental health," says Army Veteran and NeuroFlow Vice President of Innovation Matt Miclette. "This level of insight empowers military care teams and NeuroFlow responders to intervene early before these challenges manifest into a more serious crisis."

For example, a large military command leverages NeuroFlow to improve troop resilience. It identified that 49% of service members who registered for NeuroFlow had low resilience scores on the WHO-5 Well-Being Index. These insights empowered leadership to better support troops and deliver relevant resources through the NeuroFlow platform. NeuroFlow provides the military medical community a force multiplier - extending their ability to monitor and support their unit's mental health outside the clinic.

GAIN POPULATION-WIDE INSIGHT TO MAKE BETTER DECISIONS

NeuroFlow delivers insights beyond individual service member support by generating anonymous, population-level data that helps command and medical leadership evaluate and improve mental health programs. The secure analytics dashboard shows unit-level wellness trends, such as physical readiness metrics, while maintaining strict service member privacy.

"There's been a huge investment in military resilience programs and suicide prevention initiatives," says Miclette. "What is often missing, though, is the measurement and regular feedback loop to understand how these programs are performing and how the military can best allocate its resources. NeuroFlow provides the data and analytics tools to measure this impact and replicate these successes across units."

By combining support with early risk detection and population-level analytics, the platform helps the military medical community identify trends and allocate resources effectively. When minutes matter in mental health crises - just as they do in the Golden Hour - NeuroFlow ensures the right resources reach service members at the right time.

For more information, visit
www.neuroflow.com/government-and-military

Build Troop Readiness

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It is critical for troops to be ready for combat and be resilient when faced with challenges. NeuroFlow provides troops with self-service digital tools to support their physical and mental health while giving command and medical leadership population-level data to improve resilience programs.

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2. Maintain focus on the mission
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NEUROFLOW

LEVERAGING MEDICAL CAPABILITIES TO SUPPORT REGIONAL STABILITY AND SECURITY

BG Roger S. Giraud is a 1991 Distinguished Military Graduate of Texas A&M University. He earned a B.S. in Biomedical Science in 1991 and after an educational delay, a B.S. in Animal Science in 1993. He earned his Masters of Health Administration from Baylor University in 2004 and a Masters of Strategic Studies from the U.S. Army War College in 2015.

Previous duty assignments include Medical Platoon Leader, 1- 12 CAV, 1CD, FT Hood, TX; Executive Officer, C Company, 15th FSB, 1CD; S2/3, 15th FSB, 1CD; S4, Division Support Command, 1CD; Support Operations Maintenance Officer, 201st FSB, 1st 1ID; Commanding Officer, C Company, 201st FSB, 1ID at Camp Monteith, Kosovo, Operation Joint Guardian and Rose Barracks, Vilseck, Germany; Graduate Student, U.S. Army-Baylor University Graduate Program in Health Care Administration, FT Sam Houston, TX; Health Care Administrative Resident, 121st GH, 18th Medical Command, Seoul, Korea; Chief, Clinical Support Division, 121st GH; Operations Officer and Small Group Instructor, AMEDD Captains' Career Course, FT Sam Houston, TX; Executive Officer, 421st MMB, Wiesbaden Army Airfield and deployed to Operation Iraqi Freedom, Joint Base Balad, Iraq; Operations Staff Officer, HQDA, OTSG, Pentagon; Commanding Officer, 43rd Special Troops Battalion, 43rd Sustainment Brigade, FT Carson, CO; Assistant Chief of Staff, Logistics, CJ4/G4, International Security Assistance Force Regional Command – South/4th Infantry Division and deployed to Operation Enduring Freedom, Kandahar Airfield, Afghanistan; Chief, G35 Plans Division, USAMEDCOM and HQDA, OTSG, Falls Church, VA; Executive Officer to The Surgeon General, HQDA OTSG and CG, USAMEDCOM, Pentagon, VA; Commanding Officer, 2d Infantry Division Sustainment Brigade, Camp Humphreys, Korea; and Chief of Staff, 2nd Infantry Division/ ROK-US Combined Division; Commanding Officer, 1st Medical Brigade, Fort Hood, TX; Director of Policy and Force Integration, Deputy Chief of Staff, G-357, HQDA OTSG and USAMEDCOM, and Deputy Commanding General – Operations, USAMEDCOM. He currently serves as the Commanding General, Medical Readiness Command, Europe; Command Surgeon, US Army Europe and Africa; Director, Defense Health Network Europe, and the 21st Chief of the US Army Medical Service Corps.

Combat & Casualty Care had the privilege of sitting down with U.S. Army Brigadier General Roger Giraud of Medical Readiness Command, Europe (MRC, EUR) to discuss the challenges and opportunities that the command encounters as the lead medical readiness support organization in Europe. Our conversation highlighted the distinct operational tempo that MRC, EUR faces compared to its counterparts in the Continental United States (CONUS), as well as the unique circumstances that arise from operating in a multinational environment.

U.S. Army BG Roger Giraud

Commanding General, Medical Readiness Command, Europe
Command Surgeon, U.S. Army Europe and Africa
Director, Defense Health Network Europe

C&CC: How is Medical Readiness Command, Europe ensuring the readiness of U.S. medical forces in Europe?

BG Giraud: In my humble opinion, there is no better training ground to learn about Warfighting than in U.S. Army Europe and Africa's area of responsibility. Medical Readiness Command Europe (MRC, EUR) plays a vital role in ensuring the readiness of U.S. medical forces in Europe through a multifaceted approach. This approach includes the day-to-day work in our military medical, dental, and veterinary treatment facilities and our force health protection activities, thus ensuring our personnel are proficient in their craft. It also incorporates a wide range of training and readiness exercises and medical support to security cooperation efforts.

By conducting regular training exercises with our NATO allies, partners and theater level assets, Medical Readiness Command, Europe enables its medical personnel to master their craft and stay up to date with the latest operational procedures, medical technologies and techniques, thereby enhancing their ability to provide quality health services in a variety of environments and settings.

Additionally, the command leverages participation in several annual theater-wide readiness exercises to assess and refine the medical readiness of its units, identifying areas for improvement and

implementing corrective actions to ensure that medical forces are prepared to respond in competition, crises, or conflict.

Medical Readiness Exercises (MEDREX) and support to Security Cooperation efforts across the European and African theaters also provide valuable opportunities for medical personnel to apply their skills in dynamic and challenging settings, further solidifying their readiness. Furthermore, Medical Readiness Command, Europe fosters a culture of excellence through competitions such as the Best Medic Competition, Best Leader Competition, and the Expert Field Medical Badge (EFMB) competition, which challenge medical personnel to demonstrate their expertise and push themselves to achieve the highest standards of performance.

By adopting this comprehensive approach, Medical Readiness Command, Europe is ensuring that U.S. medical forces in Europe are equipped to provide high quality health services support and force health protection, support operational requirements, and contribute to regional stability and security, ultimately enhancing the readiness and effectiveness of U.S. military forces in the European and African theaters.

C&CC: How important are relations with NATO and Allied counterparts and what efforts are being taken by Medical Readiness Command, Europe to further those relations in Europe?

BG Giraud: Medical Readiness Command, Europe is actively fostering partnerships and strengthening relations with allied and partner nations' medical forces through a range of efforts.

One key aspect of this endeavor is participation in NATO and joint medical exercises, which enable military medical personnel from various nations to train together, share best practices, and foster interoperability.

Additionally, Medical Readiness Command, Europe is constantly cultivating partnerships with allied and partner nations through reciprocal visits, exchanges, and cooperation in training. The command hosts and participates in international medical, dental, and veterinary symposiums, which provide a platform for our professionals to share knowledge, discuss emerging trends, and address common challenges in military medicine across our theaters.

Furthermore, Medical Readiness Command, Europe engages in table-top exercises, wargames, and rehearsals of concept with Allies and Partners to enhance interoperability, develop coordinated medical response plans, and foster communication and collaboration. These collaborative efforts not only enhance the medical readiness of U.S. medical forces in Europe and Africa but also contribute to the development of a more integrated and effective collective medical support plan.

By working together with our Allies and Partners, Medical Readiness Command, Europe is helping to build trust, foster cooperation, and promote regional stability and security. The command's efforts to further partnerships and relations with our Allies and Partners medical forces are ultimately aimed at enhancing the overall readiness and effectiveness of the NATO alliance and promote a more cohesive,

More than 40 U.S. Army medical Soldiers from across Europe, and a team from the Czech Republic Army, converged on Breitenwald Range near Landstuhl, Germany Dec. 10-13 to take part in the grueling four-day 2024 Europe Best Medic Competition. The Europe Best Medic Competition is specifically designed to test the endurance, medical skills, fitness, and readiness levels of medical Soldiers. The competition consists of multiple events to include tactical combat casualty care, prolonged casualty care, a physical fitness assessment, day and night land navigation, a long-distance foot march, a combat stress shoot, and a written test. The top teams from this competition will go on to represent their respective commands at the U.S. Army Command Sergeant Major Jack Clark, Jr. Best Medic Competition to be held at Camp Bullis, TX in late January 2025. (U.S. Army)

responsive and integrated health system.

Through this convergence of efforts and planning, Medical Readiness Command, Europe plays a vital role in shaping the future of military medicine in Europe, Africa and beyond and is helping to ensure that U.S. medical forces are well-positioned to operate effectively in a rapidly changing and increasingly complex environment.

C&CC: Please talk about the joint medical force mindset or concept in the European theater (TEAM MED EUR-AF) and the importance of collaboration, teamwork and knowledge sharing among the different services.

BG Giraud: The mindset in the European and African theater is rooted in the concept of Team MED EUR-AF. To be clear, Team MED EUR-AF is not a standing organization. It is a mindset of collective purpose that drives shared understanding and unity of effort amongst all medical organizations and entities in this theater, regardless of service. It sets expectations for collaboration, teamwork and knowledge sharing that encompass the entirety of supporting the joint force and defines how we, as a collective entity, operate in competition, crisis, and in conflict.

In the competition phase, Team MED EUR-AF operates in a continuous environment of collaboration and teamwork to enable shared understanding and deliver high quality health services at the point of need. By continual collaboration and teamwork among the Combatant Commands, the Defense Health Agency, the services, and our Allies and Partners, we accomplish two things: (1.) we deliver high quality health services to our beneficiaries and the Joint Force at the point of need, and (2.) we set conditions to effectively transition to crisis or conflict.

When faced with crisis or conflict, the collective purpose of Team MED EUR-AF enables a more rapid and effective transition as it enables the services to surge capabilities, adapt to evolving battlefield conditions, and provide more timely and effective care to those in need. The strength of the unity of effort among all elements of Team MED EUR-AF lies in the ability to facilitate collaboration, knowledge sharing and technical expertise among the Combatant Commands, Defense Health Agency and the services, ensuring a unified and effective approach to combat casualty care.

Ultimately, the convergence of our medical enterprise teammates serves as a cornerstone of military medical readiness across the Europe and Africa theaters, underscoring the importance of unity of effort and cooperation among the services in convergence of our medical plans and delivery of health services at the point of need.

C&CC: Why is tactical combat casualty care and readiness of the medical force so important in terms of large-scale combat operations (LSCO)?

BG Giraud: The delivery of military combat casualty care is a critical component of large-scale combat operations, as it directly impacts

the survival and recovery of wounded service members. It provides a sense of confidence to our Soldiers and their families knowing that they will be cared for if they are injured or ill. We are a symbol of strength for our supported forces.

In the context of high-intensity conflict, the ability of combat medics to provide prolonged life-saving care is paramount, as medical evacuation by ground and air assets may be delayed due to various factors such as terrain, weather, or enemy activity. For the wounded, ill or injured, we are a symbol of hope.

Our combat medics and other medical personnel must be trained and equipped to provide extended care, often in austere and resource-constrained environments, to stabilize and sustain casualties until they can be evacuated to higher levels of medical care.

This requirement for prolonged care necessitates that combat medics possess advanced skills and knowledge in trauma care, including the ability to manage complex injuries, control hemorrhage, and maintain airways.

Furthermore, combat medics must be able to adapt to evolving battlefield conditions, making rapid decisions to prioritize care, allocate limited resources, and coordinate with other medical assets to ensure seamless continuity of care.

The importance of combat casualty care cannot be overstated, as it directly affects the morale and effectiveness of our combat units, as well as the overall success of U.S. military operations.

By providing high-quality, prolonged care, our combat medics play a vital role in saving lives, reducing morbidity and mortality, and enabling wounded service members to return to duty or receive definitive care.

Early care and rehabilitation in large scale operations provides the best chance for us to keep our service members in the fight while maximizing our ability to conserve the fighting strength and win.

Ultimately, the ability of our combat medics to provide life-saving care in the most challenging environments is a testament to their skill, dedication, and commitment to preserving the lives of their fellow service members and is essential to the success of large-scale U.S. combat operations.

TRANSFORMING MILITARY MEDICAL DEVELOPMENT FOR THE FUTURE FIGHT

In October 2024, the U.S. Army Medical Materiel Development Activity (USAMMDA) changed command, and the first Project Manager was chartered for the new Soldier Medical Devices Project Management Office (SMD PMO) within the Army's Program Executive Office (PEO) Soldier. The rest of USAMMDA has been combined with elements of the U.S. Army Medical Research and Development Command to constitute a new organization, Operational Medical Systems, under the Defense Health Agency.

By OPMED Strategic Communications Office

U.S. Army Reserve medics from the 396th Combat Support Hospital, headquartered at Fairchild Air Force Base, Washington, perform a litter carry during a promotional photo shoot for Army Reserve marketing and recruiting at Fort Hunter Liggett, California. (U.S. Army Reserve photo by Master Sgt. Michel Sauret)

After 40 years developing and delivering medical solutions, the U.S. Army Medical Materiel Development Activity (USAMMDA), Ft. Detrick, MD, continues its organizational transformation as directed by the National Defense Authorization Act. This organizational transition builds on the solid foundation established by USAMMDA, the Department of Defense's lead medical developer since 1985. It also paves the way for future medical development and modernization across the U.S. military by establishing two new separate organizations with a shared Army heritage: Soldier Medical Devices (SMD), which remains within the Department of the Army, and Operational Medical (OPMED) Systems, which is now part of the Defense Health Agency (DHA). While OPMED will focus on medical development for the entire DoD and across all roles of care of the Military Health System (MHS), SMD will develop and field integrated medical solutions for the Army and Joint Force, focusing on forward deployed medical capabilities that meet the requirements of 2030, 2040, and beyond.

DEVELOPING SOLUTIONS FOR FRONTLINE MEDICAL PROVIDERS

Transforming Army and DoD medical development was years in the making. For decades, USAMMDA was home to development and fielding of medical devices, treatments, vaccines, prophylactics, and technologies for the U.S. military. Developing and delivering medical devices for frontline medical providers is intricate, complex, and time intensive. The legacy processes and procedures for equipping Soldiers, Sailors, Airmen, and Marines were established during a time when the U.S. and its international partners were preparing for conventional Cold War threats.

However, during the past 20 years, which saw the advent of the U.S. War on Terror, diffusion of military and guerilla threats extending beyond the Iron Curtain, and near-peer military competitors operating in the Indo-Pacific, European and Arctic regions of the globe, the

U.S. Army medics with the 1st Armored Brigade Combat Team prepare for a combat casualty treatment demonstration during the medical experimentation portion of Project Convergence Capstone 4 (PC-C4), Fort Irwin, CA. Medical developers from across the U.S. Army joined forces to test the latest Department of Defense medical technology and treatment programs as part of PC-C4 at the U.S. Army's National Training Center. (U.S. Army photo by T. T. Parish)

medical development mission of the U.S. Army has evolved to meet the challenges of future conflicts. As with all complex enterprises, transformation – to address contemporary challenges and prepare for the future – is imperative to both mission focus and operational relevance.

ENHANCING JOINT FORCE MEDICAL READINESS

Operational Medical Systems, part of the DHA, is the Department of Defense's premier medical development and acquisition enterprise. OPMED enables medical providers in the Army, Navy, Air Force, and Special Forces communities to provide lifesaving and life-prolonging care at and near the front lines. The team collaborates with stakeholders in the DoD, academia, and industry to help prepare America's Joint Force for future conflicts across the globe, including the Indo-Pacific and Arctic regions. OPMED develops and delivers world-class medical capabilities for combatant commanders directing Large-Scale Combat Operations (LSCO) in austere environments to save lives and return injured service members to the fight.

USAMMDA's transformation, and the establishment of SMD PMO and OPMED, can be best understood as the end of one era and the beginning of another. This article is the first in a series describing the mission and functions of the two new organizations. Please check out the next issue of *Combat & Casualty Care* for a more in-depth look at both Operational Medical Systems and Soldier Medical Devices.

FIELD MEDIC BEHAVIORAL HEALTH SUPPORT

In January 2025, the Walter Reed Army Institute of Research (WRAIR) joined forces with the 65th Medical Brigade at Camp Humphreys, South Korea, to conduct a train-the-trainer course on Behavioral Health Guidelines for Medic Assessment and Response (BH GEAR). Designed to equip medics and unit helpers—many without prior behavioral health training—with essential skills for assessing and addressing mental health issues, the course marks a significant step toward bolstering mental health support within military units.

Led by Dr. Katie Nugent, a behavioral health epidemiologist at WRAIR's Military Psychiatry branch, the three-and-a-half-day program was supported by an expert team that included Dr. Josh Wilk, Ms. Kristina Clarke-Walper, Maj. Jose Nunuz, Capt. George Mesias, and Ms. Mary Sampson. The training provided a comprehensive, hands-on experience that prepared participants not only to implement BH GEAR within their own units but also to train others, thereby creating a multiplier effect.

Recent data underscores that medics often feel less confident when discussing mental health compared to physical health. To address this, BH GEAR was developed to enhance medics' knowledge and confidence in identifying and managing mental health concerns, ensuring they have the practical tools needed to support their units effectively.

More info: WRAIR.mil

DYNAMIC MRI TO ADVANCE TBI RESEARCH

Dynamic magnetic resonance imaging (MRI) technology is being used to advance traumatic brain injury (TBI) research. (DHA)

According to the CDC, approximately 5.3 million people in the United States live with a traumatic brain injury-related disability. TBIs often result from a violent jolt or impact to the head, commonly caused by vehicle accidents, falls, sports injuries, and combat trauma. These injuries can lead to long-term complications, neurological damage, or even death.

During a TBI, rapid skull acceleration deforms brain tissue, and the severity depends on factors such as impact force and injury type. Dr. Dzung Pham, professor and vice chair for research in the Department of Radiology and Bioengineering at the Uniformed Services University School of Medicine, is studying how skull acceleration leads to TBI damage.

Pham's lab has developed specialized MRI-compatible devices that mimic mild head accelerations without causing injury. These tools allow researchers to observe brain movement in real-time using advanced neuroimaging techniques. These newer techniques are critical since many TBI patients experience persistent symptoms even when standard MRIs show no abnormalities. Because TBI treatment options are limited, researchers aim to uncover the mechanisms behind brain injuries. Key factors such as impact magnitude, frequency, and affected brain regions remain poorly understood. By analyzing brain deformation during acceleration, Pham's lab identifies areas at higher risk of injury. This data is also used to refine computational models that simulate TBI scenarios, helping predict concussion risks and improve protective gear like helmets.

More info: DHA.mil

ENABLING MEDICAL FORCE TRANSFORMATION IN SUPPORT OF FUTURE FIELD READINESS

Command Sergeant Major Victor Laragione is a native of Corpus Christi, Texas. He attended Advanced Individual Training at Fort Sam Houston, Texas, graduating as a Combat Medic. Command Sergeant Major Laragione comes to the MEDCoE from the U.S. Army Medical Research and Development Command where he served as the Command Sergeant Major since August 2020. Other notable assignments include: Medic and Squad Leader in the 261st Area Support Medical Battalion, Fort Bragg, N.C.; Emergency Room Shift Leader at the Medical Element Sato Cano Air Base, Honduras; Clinic NCOIC at Keller Army Community Hospital, West Point, N.Y.; Clinic NCOIC and Training Room NCO at Landstuhl Regional Medical Center (LRMC), Germany; RAKKASANS Medical Platoon Sergeant at 3/187th Infantry Battalion and 1/33rd Cavalry Regiment, Fort Campbell, Ky.; OC/T and Operations Sergeant at 1/289th Training Support Battalion (AC/RC), Houston, Texas; Clinical Operations and Company 1SG at LRMC, Germany; Company 1SG at 47th Combat Support Hospital, Joint Base Lewis-McChord, Wash.; Senior Enlisted Advisor at the Public Health Command – Pacific, Camp Zama, Japan; Command Sergeant Major at the Troop Command, LRMC, Germany; and the Command Sergeant Major at the Madigan Army Medical Center, Joint Base Lewis-McChord, Wash. He deployed to Blue Factory, Bosnia-Herzegovina in support of Operation Joint Forge and to Iraq in support of Operation Iraqi Freedom. He is a Class 65 graduate of the United States Army Sergeants Major Academy, Fort Bliss, Texas.

Command Sergeant Major Victor Laragione

U.S. Army Medical Center of Excellence
Joint Base San Antonio- Ft. Sam Houston, TX

Combat & Casualty Care had the pleasure of speaking with Vic Laragione, Sergeant Major (CSM), U.S. Army Medical Command Center of Excellence (MEDCoE), regarding his role and experience as a combat field medic and how today's applications will address tomorrow's battlefield needs.

C&CC: What scope does your role encompass as the Command Sergeant Major (CSM) for the U.S. Army Medical Center of Excellence (MEDCoE), and what are your current focus areas?

CSM Laragione: As the Command Sergeant Major, my role is to advise the MEDCoE Commanding General, support the development of both current and future generations, and help transform our medical force to meet the evolving needs of operating environments. While many may view MEDCoE primarily as a schoolhouse, our responsibilities go far beyond that. We are tasked with synchronizing and integrating doctrine, organization, training, materiel, leadership, personnel, facilities, and policies (DOTMLPFP) to ensure that Army Medicine enables the Joint Force to win our nation's wars.

One key focus area is the modernization of the combat medic. We are conducting a proof of principle aimed at enhancing medic capabilities. The 90 students enrolled in this program will not only complete the core 68W combat medic curriculum but also develop advanced problem-solving skills to manage casualties when evacuation is delayed. They will be trained to provide interventions over extended periods when the critical "golden hour" is not available.

I've identified that many of our medical NCOs have lost the specific skills required for their MOS. Often, this is due to being task-organized into different roles, administrative duties, or lack of opportunity to maintain their skills based on operational requirements. My goal is to re-focus NCOs on maintaining MOS proficiency and becoming subject matter experts in their fields. We've initiated a rewrite of DA PAM 600-25, aligned the Army Technician's Badge with the 68 CMF, and are supporting TRADOC's pilot MOS competency testing at NCOPDS to support this effort.

Another critical focus is modernizing content delivery methods in our education and training platforms. Given the current generation's familiarity with digital tools and virtual environments, we are adapting

CSM Laragione was chosen to represent the Army for the Noncommissioned Offices Association's Senior Enlisted Panel. Senior leaders from each branch of the uniformed services discussed the current state of their branch, transformation efforts at an unclassified level, and fielded questions from the hundreds of attendees in attendance. (U.S. Army MEDCoE)

our instructional approaches. Our trainees are increasingly accustomed to digital resources over traditional textbooks and PowerPoint lectures. To meet this shift, we are modernizing classrooms, leveraging virtual learning platforms, and adjusting our training to ensure our students are best equipped to treat patients and save lives.

Developing agile leaders is also a key priority. We are aligning with TRADOC to ensure NCOPDS training is relevant and meets the needs of the force. We've introduced the Medic Master Trainer Course to empower senior enlisted leaders in developing and safeguarding training plans. At MEDCoE, our Drill Sergeants are trained in Arbinger tools to build the trust necessary to guide trainees and peers effectively. We also prepare our Soldiers for competitions and support their professional development through courses, development sessions, and events like the Army Medicine Sergeants Major Summits, which bring Sergeants Major from all components together to foster unity and collaboration.

C&CC: From a 68W combat medic training perspective, how have you seen an evolution in preparation to meet the challenges of future Large Scale Combat Operations (LSCO) and Multi-Domain Operations (MDO)?

CSM Laragione: We are continuously evolving to improve the training and education of our medics. The current 16-week Advanced Individual Training has served the force well over the past 24 years, but recent lessons from the conflict in Ukraine have highlighted the need to enhance the baseline skills of our medics. In response, we've made significant updates to the curriculum, adding essential skills such as autologous blood transfusions, prolonged casualty care, and training on disease non-battle injuries.

While we've already incorporated technology and simulation training to create more realistic combat and medical scenarios, we recognize the need for ongoing improvement. Through the Enhanced Combat Medic Proof of Principle initiative, we are exploring the addition of an extra four weeks of training to address gaps in the current curriculum. This expanded training will cover topics like Prolonged Casualty Care, Disease Non-Battle Injuries (DNBI), burns, thoracic trauma, triage, pharmacology, and medication administration. We also plan to introduce Advanced Life Support, Behavioral Health, toxicology, as well as neurological and endocrine disorders.

By enhancing our medics' training in these critical areas, we aim to develop their clinical judgment skills, making them better equipped to deliver optimal care in contested environments. This will allow them to expedite the return of Soldiers to duty and save lives on the battlefield. Our commitment to continuous improvement and readiness ensures that our combat medics are prepared to meet the evolving demands of future conflicts and provide the highest standard of medical care.

C&CC: What other medical specialties train at the MEDCoE, and how has their training adapted for the challenges of LSCO and MDO?

CSM Laragione: MEDCoE offers 257 courses across a wide range of medical specialties, including 22 enlisted medical occupational specialties, 96 officer areas of concentration, as well as officer and enlisted Professional Military Education and graduate education.

In response to the challenges of Large Scale Combat Operations (LSCO) and Multi-Domain Operations (MDO), we have adapted many medical training programs. These updates now emphasize the operational environments in which medical personnel will work, preparing them for unique challenges. Using lessons learned, the curriculum has been updated to incorporate tactical skills relevant

CSM Laragione fields questions from SFC Conlon and SSG Dillon Cooper from the Medical NCO Academy during the 2024 MEDCoE Best Medic Competition. (U.S. Army MEDCoE)

to LSCO and MDO, such as casualty and nonstandard evacuation procedures, prolonged care considerations, and triage in mass casualty situations. We are also integrating drone battle drills into our field training exercises to address the threats drones present, as seen in recent conflicts. Additionally, recognizing the demanding nature of LSCO, many programs now include training on resilience, mental health awareness, and self-care. We are also exploring how best to introduce discussions on moral injury.

C&CC: What advice would you give to medical NCOs and Soldiers to be ready and trained for the next conflict?

CSM Laragione: I would advise medical NCOs and Soldiers to focus on these key areas:

Stay Informed and Relevant: NCOs should make it a priority to stay current with Army doctrine and publications that guide our operational frameworks. Understanding the regulations and doctrine that shape how the Army operates and fights is critical for effective leadership.

Maintain MOS Proficiency: NCOs must strive to be subject matter experts in their field. Continuously honing their skills and knowledge through education and consistent practice ensures they can effectively train their Soldiers and execute their wartime missions with confidence.

Uphold Standards and Discipline: Maintaining high standards and discipline is essential for unit cohesion and readiness. By fostering a culture of discipline through effective training, NCOs strengthen mental toughness, teamwork, and communication—key elements for mission success, especially during high operational tempo or in challenging environments.

Prioritize Holistic Fitness: In line with Army FM 7-22, Holistic Health and Fitness, NCOs should emphasize physical fitness, but also focus on the mental, spiritual, and sleep aspects of readiness. By maintaining personal fitness and promoting the well-being of their Soldiers, NCOs help ensure overall unit resilience and readiness.

Invest in Professional Development: NCOs should actively seek opportunities for learning and skill enhancement, while also supporting the professional growth of their subordinates. Investing in professional development not only improves individual capabilities but strengthens the team as a whole, preparing everyone for future challenges.

CALENDAR OF EVENTS

MAR 24 - 15
Deployed Medical & Healthcare Delivery Conference
London, UK
Defenceiq.com/events-deployedmedicalforum

MAR 25 - 27
Global Force Symposium
Huntsville, AL
Meetings.ausa.org/globalforce

APR 6 - 9
Sea Air Space
National Harbor, MD
Seaairspace.org

APR 28 – MAY 2
The Military Health System Conference
Cleveland, OH
Mhsconference.com

APR 29 - MAY 1
Modern Day Marine
Washington, DC
Marinemilitaryexpos.com

MAY 5 - 8
SOF WEEK
Tampa, FL
Sofweek.org

MAY 13 – 15
LANPAC
Honolulu, HI
Ausa.org/lanpac/2025

MAY 5 - 9
SOMA
Raleigh, NC
Specialoperationsmedicine.org/SOMA

JUN 16 - 17
AIM Health R&D Summit
San Antonio, TX
Velocitytx.org/startup-programs/funding/aim-conference/

JUL 3-4
Combat Medical Care Conference
Ulm/Blaubeuren, Germany
Cmc-conference.de

AUG 12 – 14
GVSETS and Modernization Update
NOVI, MI
NDIA.mich.org

OCT 13 - 15
AUSA Annual Meeting
Washington, DC
Ausa.org/annual

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[1] *Risk factors for onset of hypothermia in trauma victims: The HypoTraum Trial Lapostolle et al.Critical Care 2012, 16:R142*

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