

COMBAT & CASUALTY CARE

VOL III 2026
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**ADVANCING
INTERACTIVITY
IN HEALTHCARE**

COMMANDER'S CORNER



COL Mara Kreishman-Deitrick

PM, Maneuver Medical Systems
Ground-Soldier Systems

CDR, U.S. Army Med. Materiel Devlpmnt. Activity



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WHEN THE GOLDEN HOUR DIES

The inevitability of future combat casualty care in mass casualty scenarios will be dictated by large-scale combat operations. Preparing medics for this reality faces its own challenges.

By Johnathon "Nektarios" Miranda

EXCLUSIVE FEATURES



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Development Activity



HEALTH WATCH UPDATE

RDML Tracy Farrill

Director
DHA Office of Warfighter
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Falls Church, VA



LEADERSHIP PERSPECTIVE

Mr. Robert Bell

Supervisory Program Manager
Medical Simulation &
Training Program Mngt. Office
Defense Health Agency

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RECOGNITION SPOTLIGHT

Carston "Bud" Calkin, founder of Skedco, Army veteran, inventor, and a highly respected figure in rescue and tactical medicine has passed on.

By SKEDCO, Inc.



ADVANCED SIMULATION DRIVES TRAUMA READINESS

Landstuhl Regional Medical Center (LRMC), Germany, provides controlled environments designed to replicate the pressure of real world casualty response.

By Travis Jones



INDUSTRY PARTNER

SURGICAL STERILIZATION AT THE TACTICAL EDGE

A compact, ruggedized, and reliable field autoclave is enabling FDA cleared instrument sterilization closer to point of injury.

By Chris Yerger



ADVANCING MEDICAL EXPERTISE AMID THE FREEZE

The U.S. Army is refocusing specialization in cold weather warfare to combat medics in preparing them for the critical challenges of cold weather trauma care.

By USARIEM

Cover: Spc. Diana Woolfolk, left, a combat medic specialist and Capt. Emily Derosa, an aeromedical physician assistant assigned to 1st Air Cavalry Brigade check a Soldier's vitals during a casualty care training exercise at Storck Barracks, Germany, April 22, 2022. Over 20 medics and brigade doctors participated in the training to validate and evaluate systems and processes to improve readiness in the event of a mass casualty scenario; volunteers were each assigned a notional injury for the medical teams to triage and administer care. (U.S. Army Photo by Sgt. Jason Greaves)

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INSIGHTS

With summer heat come summer storms to cool and hydrate a warm, dry landscape. Just as nature restores balance so do the medical professionals who tend to their fellow protectors of our nation's freedoms in working to restore the body's balance post trauma and in promoting general good health. The Vol III 2026 edition of *Combat & Casualty Care* pays tribute to all those healthcare providers who answer the call to care for others on the battlefield and well beyond it.

From field to facility and combat medic to physician, ensuring all is done to preserve and maximize quality of life is at the core of the oath each takes in the service of human well being. A huge part of this commitment is preparedness through education and hands on application. With state-of-art medical simulator technology available in high fidelity as is employed at Landstuhl Regional Medical Center (LRMC), Germany, the gap between virtual and real world is growing ever smaller. None of this is lost on America's Defense Health Agency (DHA) which recently launched its new Medical Simulation & Training Program Management Office (MST PMO), headed by Supervisory program manager Robert Bell, with the mission to acquire, develop, integrate, field, and sustain medical simulation, training, and education capabilities across the Military Health System (MHS) continuum of care.

Of course, this continuum of care reaches well beyond the preparation of those who care for others' health to the management of day-to-day health concerns of servicemembers and their families. Tasked with enabling DHA to deliver the care and preventative services across the MHS electronic health record (EHR) system of systems architecture called MHS GENESIS, the Program Executive Office for Defense Health Management Systems (PEO DHMS) has facilitated the introduction of a new ambient listening option as part of patient EHR interactivity. This along with increased care access through diverse software integration is helping MHS GENESIS continue evolving as a world-class database for health solutions.

And without the tools to care for the health of those in the fight, those wounded in the struggle to protect our nation's interests and those of freedom loving nations might not feel their nation's will to fight for them. In an exclusive interview with COL Mara Kreishman-Deitrick, Ph.D, program manager (PM), Maneuver Medical Systems (M2S), speaks to the recent transition of PM Soldier Medical Devices (SMD) to M2S in helping the Army better target development, delivery, and sustainment of medical capabilities critical to the its lifesaving combat medics.

We cool down with this edition's spotlight on challenges associated with delivering quality medical care in the Arctic. Folks at the U.S. Army's Research Institute of Environmental Medicine (USARIEM) are ensuring medics tasked with cold weather duty can perform that duty as effectively as those they treat deserve. Oh and be sure not to miss this issue's Industry Partner focusing on surgical equipment sterilization.

As always, please feel free to email us with thoughts and suggestions. Thanks for the continued readership!

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WHEN THE GOLDEN HOUR DIES

The Army just canceled at least 34 medical training courses in order to plug a budget leak. Many of these courses taught the exact skills a peer fight will demand the instant air superiority disappears — the combat-casualty-care gap large-scale combat operations is about to expose.

By Johnathon "Nektarios" Miranda, 68W - Combat Medic · EMT Instructor · Member, Special Operations Medical Association (SOMA)



U.S. Army Soldiers, assigned to various units within the Kaiserslautern military community, participate in a combined field training exercise in Grafenwoehr, Germany. The exercise focused on prolonged field care, patient hold, and tactical combat casualty care. (Photo by Travis Jones, Landstuhl Regional Medical Center)

Every medic learns the golden hour as gospel. Get the casualty to surgical care inside sixty minutes and the odds are in your favor, usually. We treated that number like it was the law of physics, but it never was. It was a policy — and it only worked because we owned the sky.

On June 15, 2009, Secretary of Defense Robert Gates mandated that critically injured combat casualties reach surgical care by helicopter in 60 minutes or less, cutting the old two-hour standard in half. The results were not subtle. A landmark study in JAMA Surgery examined more than 21,000 casualties across Afghanistan and found median transport time fell from 90 minutes to 43. The percentage killed in action dropped from 16 to 9.9. The case fatality rate fell from 13.7 percent to 7.6. With this intel the authors estimated the policy saved 359 lives. Thanks to this policy we built the lowest case fatality rate in the history of warfare on the back of that mandate and on the air dominance that made it possible.

THE CONDITIONS THAT MADE IT WORK ARE GONE

Then we got introduced to the war in Ukraine. Point-of-injury care is routinely stretching past twelve hours. Drones hunt anything that moves; Ukrainian combatants describe the rule plainly "if it can be seen on the battlefield, it will be killed." Air medical evacuation, the single platform the entire golden-hour model was built around, becomes a target the second it lifts off. Casualty volumes are at a scale the U.S. has not absorbed since World War II.

This is the heart of large-scale combat operations, or LSCO: a peer or near-peer fight where we do not own the sky, the roads are watched, and the wounded cannot simply be flown to a Role 2 inside the hour. The Army's own analysts have said bluntly that the loss of reliable air superiority will restrict evacuation and will prevent surgical support within the golden hour for many, if not most, of the wounded. The golden hour is not compressed in

LSCO. For most casualties, it is gone.

The contrast in the data is brutal. Ukrainian battlefield reporting suggests care delivered within the first ten minutes can cut mortality by roughly half, while delays past three hours drop survival below 60 percent. Now hold that against twelve-hour evacuation timelines. The wounded who would have lived in Helmand will die in a treeline somewhere because the helicopter never came, unless the medic on the ground can do something we spent twenty years NOT having to ask of him: keep that casualty alive for hours, sometimes days, entirely alone.

And volume changes everything. In a peer fight the wounded do not arrive one MEDEVAC at a time; they arrive in waves that would overwhelm the trauma system we built for counterinsurgency. Ukraine has adapted the only way it can decentralize care, driving surgical capability underground and far forward, and blurring the old, tidy line between Role 1 point-of-injury care and the Role 2 surgical team behind it. Out of necessity, the line medic is being asked to own more of the fight for survival than ever before. That is the soldier whose training we are now eradicating to balance a checkbook.

THE FIX HAS A NAME. SO DOES THE PROBLEM.

The Army is not blind to this. The doctrinal answer is Prolonged Casualty Care (PCC) the evolution of what the field called prolonged field care. Hold the patient. Resuscitate forward. Push blood and surgical capability toward the point of injury instead of dragging the patient rearward through contested ground. The Army's own writing now describes medics stabilizing casualties for up to 72 hours in protected collection points until a surgical team can reach them. NATO's after-action work out of Ukraine says the same thing in "colder" language: assume delayed evacuation, contested environments, and degraded logistics as the baseline, not the exception.

Here is the part that should stop every commander reading this. PCC is a fundamentally harder skill set than anything the Global War on Terror asked of a line medic and it is precisely the kind of skill you cannot improvise under fire. It has to be built in a schoolhouse, before the shooting starts.

In May, ABC News reported from internal documents and multiple U.S. officials, that the Army canceled at least 34 medical training courses in the back half of this fiscal year, out of the Army Medical Center of Excellence at Fort Sam Houston, Texas. The internal memo's stated reason was funding shortfalls and limited resources. Many of the canceled programs, ABC reported, are tied directly to frontline combat casualty care. So let me do what I told this magazine I would do: walk the trade, capability by capability, and name what we are giving away.

CAPABILITY BY CAPABILITY, HERE IS WHAT WE ARE TRADING

The casualty-care courses themselves. These pipelines produce and sustain the medic who can run a resuscitation for hours instead of minutes: manage the airway, the blood, the rewarming, the documentation, and the slow deterioration alone, in the dark, with no inbound bird. Cancel the course and you do not lose a line item. You lose the only place that competency is built before a soldier's life depends on it.

MEDEVAC command. ABC specifically reported the Army axed leadership training for officers preparing to command helicopter medical evacuation units. This move is profoundly ironic. Evacuation is becoming the single hardest medical problem in a peer fight contested air, drone threat, jammed communications and we just pulled the development of the very officers whose job is to solve it.

Far-forward blood and resuscitation. The lesson NATO keeps writing down from Ukraine is that survival now hinges on damage-control

resuscitation pushed to the point of injury: whole blood, walking blood banks, and a cold chain that does not break under fire. That is a trained competency, not a piece of equipment you draw from supply. Every course that builds it is a course we cannot afford to skip.

Care in contaminated environments. Among the cuts was training for operating in radioactive environments. Through the GWOT years that read like a box to check. Against a peer adversary with a nuclear and chemical arsenal, it reads like a capability you will desperately wish you had kept.

Behavioral health. Prolonged care is not only a physical load. Keeping a dying friend alive for twelve hours, losing him anyway, and doing it again the next day breaks people. Leadership and certification tracks for the providers who carry that load were on the list too. In a war of mass casualties and long holds, that is not a soft cut. It is a readiness cut.

"WE HAVEN'T CANCELED ANYTHING"

The Army's acting senior officer, Gen. Chris LaNeve, told lawmakers, "We haven't canceled anything," and framed any belt-tightening as the normal end-of-year drill. Respectfully, and I say this as someone who trains the people downstream of these decisions, end-of-year trimming happens at the margins, in September. These plans were on paper at the halfway mark of the fiscal year, and they reached into frontline casualty-care training. That is not the margins. That is the muscle.

The context makes it sharper, not softer. The shortfall ABC describes is somewhere between four and six billion dollars, this is driven in part by an active shooting war and a surge of real-world operations burning through the budget right now. Strip away the accounting and the trade is stark: we are cutting the training that prepares medics for the next war to help pay for the current one. That bill does not come due in a budget cycle. It comes due at a casualty collection point eighteen months from now, when a young 68W who never got the course is holding a soldier he cannot evacuate, trying to recall something he was never taught.

"I am worried that we are still largely training for the last war. We still largely do medevac drills when that likely won't be possible given new advancements in drone warfare. Additionally a lot of units like ours don't even practice combat casualty care on a regular basis and when we do it's not prolonged casualty care. I think we are starting to change our practice patterns but we need more training and urgency."

— 1LT Suzer, Medical Detachment, Los Alamitos, California

WE DON'T GET TO RELEARN THIS UNDER FIRE

Here is the uncomfortable truth my profession, cadre and my medics already know. You do not get to relearn prolonged casualty care under fire. Medicine that is not trained in peacetime gets retaught in autopsies. The golden hour delivered the lowest fatality rate in the history of war because, years earlier, somebody did the unglamorous work of building the training pipeline before the first round went downrange.

LSCO is going to take the golden hour away from us, Ukraine has already proven that much. The only open question is whether we walk into the next fight with medics who were trained for what replaces it, or whether we let a budget line make that decision for us and pay the tuition in blood. That is the gap. We still have time to close it.

Barely.

HONORING BUD CALKIN WHO CHANGED RESCUE MEDICINE FOREVER



In rescue medicine and battlefield evacuation, few inventions have had the global impact of the SKED litter. flexible, durable, and capable of operating in confined spaces, the Sked became one of the most trusted casualty evacuation systems in the world.

Behind that innovation stood Carston "Bud" Calkin — founder of Skedco, Army veteran, inventor, and a highly respected figure in rescue and tactical medicine. Bud recently passed away, leaving behind a legacy measured

beyond products or patents, but in lives saved.

Bud's service began as a combat medic, later becoming a dental laboratory specialist and instructor at the Army Medical Center and School. His assignments included Fort Sam Houston, Fort Ord, and bases in West Germany. His military service reflected technical precision, instructional leadership, and an enduring commitment to caring for others. In 1980, Bud transformed a design concept, he originally intended as a big game carrier for hunters, into a rescue stretcher capable of operating in places where traditional litters failed. In 1981, he founded Skedco with his wife Catherine working multiple jobs while building the company into a globally recognized rescue equipment manufacturer.

The SKED quickly proved itself, designed to be indestructible, the litters E-Z Glide material could be dragged, hoisted, floated, vertically lifted, and maneuvered through confined spaces while protecting casualties during transport. Sked reportedly survived being run over by a 56-ton tank in testing before being used to drag a soldier across ten miles of rugged terrain. Gradually Sked became standard equipment worldwide for military evacuation units,

firefighters, EMS providers, cave and industrial rescue teams, and other rescue professionals, with extensive use throughout Iraq and Afghanistan.

Bud never stopped innovating, he developed numerous rescue and patient immobilization systems, including the Oregon Spine Splint and flotation systems that allowed the Sked to self-right in water resulting in multiple patents. At his own expense, he traveled to many military installations around the world to personally train soldiers and rescue teams on the use of Skedco equipment. Units throughout the military honored him with flags flown in combat zones and letters of appreciation, his dedication earned him an appointment to the United States Army Medical Department Regiment by the Army Surgeon General for his outstanding support of Army Medicine.

One of the defining moments in Bud Calkin's legacy came during the 2018 Thailand cave rescue. As the world watched an international effort to rescue twelve trapped youth soccer players and their coach from the flooded Tham Luang caves. The teams utilized the Sked litter to move everyone through narrow, flooded passageways to safety, under impossible conditions.

Bud is described as technically brilliant, humble, generous and relentlessly committed to helping others. He was widely regarded as part of the fabric of the tactical medical community, deeply connected to the Special Operations medics. He attended in person or virtually every SOMA gathering prior to becoming the Special Operations Medical Association in 1987. The company proudly remains family-owned and operated in Tualatin, Oregon, where Bud and Catherine built a globally recognized business.

Bud Calkin did more than invent a rescue litter, he saved lives and changed rescue medicine forever, that legacy will continue.

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ADVANCED SIMULATION DRIVES TRAUMA READINESS

At Landstuhl Regional Medical Center (LRMC), Landstuhl, Germany, preparation does not begin when patients arrive. It begins long before, in controlled environments designed to replicate the urgency, complexity and pressure of real-world medical emergencies.

By Travis Jones, Landstuhl Regional Medical Center



Clinical staff assigned to Landstuhl Regional Medical Center participate in Battlefield Injury Progressive Training led by the Center for Nursing Science and Clinical Inquiry in collaboration with the European Medical Simulation Center, April 2026, in Landstuhl, Germany. More than 250 joint-service medical personnel completed a three-phase, high-fidelity training program using realistic patient scenarios to strengthen trauma care skills, critical thinking and team performance. The training reinforced medical readiness and prepares personnel to deliver high-quality care in support of the joint warfighter. (DoD Photo by Travis Jones)

More than 250 clinical staff at Landstuhl Regional Medical Center (LRMC), Landstuhl, Germany, participated recently in progressive, high-fidelity simulation training events aimed at strengthening both clinical performance and operational readiness across the joint medical force. Developed by the Center for Nursing Science and Clinical Inquiry (CNSCI), Walter Reed National Military Medical Center (WRNMMC), Bethesda, MD, in collaboration with LRMC's European Medical Simulation Center (EMSC), the training immersed teams in realistic scenarios that reflect the demands of military medicine.

GREATER INTERACTIVITY, NEARER REAL TIME

High-fidelity simulation uses advanced manikins and lifelike clinical environments to challenge both technical proficiency and team dynamics. In these scenarios, communication, situational awareness and decision-making are just as critical as clinical skill, particularly in environments where time is limited and conditions are constantly changing.

"At LRMC, we are not just training for the next shift, we are training for the next mission," said U.S. Army Maj. Ross Scallan, a Clinical Nurse Specialist stationed at Landstuhl. "This training ensures our medical teams are prepared to respond quickly, confidently and competently when it matters most."

Throughout the event, participants engaged in progressive, evidence-based training designed to strengthen clinical judgment, improve recognition of patient deterioration and reinforce coordinated team response. By increasing skill complexity over time, the training pushed teams to operate with greater precision and confidence under pressure.

INCREASED PREPARATION COMMONALITY

The training also supported readiness requirements by incorporating more than 25 skills from Army Individual Critical Task Lists (CTLs) and the Air Force Comprehensive Medical Readiness Program (CMRP). These standardized requirements ensure military medical personnel maintain the skills necessary to deploy, receive casualties and operate effectively in support of combat operations.

"High-fidelity simulation builds clinical and technical proficiency required in delivering safe, high-quality patient care," Scallan said. "It allows our teams to practice in realistic conditions before they are faced with real-world scenarios."

SETTING A GLOBALLY-COMPETITIVE STANDARD

As the only forward-stationed Role IV hospital in Europe, LRMC plays a critical role in supporting the Joint Force. Training of this kind ensures clinical teams are prepared to deliver care in complex and unpredictable environments, where rapid assessment and coordinated action are essential.

Participants reported increased confidence in trauma-related skills and improved ability to recognize and respond to changes in patient condition. The training also reinforced a culture centered on safety, accountability and patient-centered care.

At LRMC, readiness is developed deliberately through repetition, realism and a shared commitment to being ready before the moment arrives.

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MODERNIZING BATTLEFIELD MEDICINE FOR THE FUTURE FIGHT

As the Chartered Project Manager, Maneuver Medical Systems, COL Kreishman-Deitrick leads a 200-person workforce in five Product Management Offices to provide total life cycle management of all Army deployable medical capabilities at Roles of Care 1-3, as well as blast overpressure sensors, and garrison and deployable Holistic Health & Fitness (H2F) capabilities. Her team develops, executes, and integrates 300+ programs of record and investment activities in a portfolio including RDT&E, procurement, modernization and worldwide fielding of medical and non-medical devices, sets, kits and outfits (SKOs), and other capabilities.

COL Kreishman-Deitrick entered active duty as a 71B Medical Service Corps Biochemist after earning her PhD in 2004. Her career spans a variety of roles in the discovery and development of pharmaceuticals for military health threats, and in senior leadership roles throughout medical research, development and acquisition including CSL and Senior Nominative Command selection. She completed the Army Medical Department Fellowship at the U.S. Food and Drug Administration in 2014, and graduated from the Army War College in 2023. COL Kreishman-Deitrick is a Certified Acquisition Professional in both Program Management and Engineering and Technology Management, and is a member of the U.S. Army Acquisition Corps.



COL Mara Kreishman-Deitrick, Ph.D.

**Project Manager
Maneuver Medical Systems
Commander**

**U.S. Army Medical Materiel Development Activity
Ft. Detrick, MD**

Combat & Casualty Care had the opportunity to hear from COL Kreishman-Deitrick, PM, Maneuver Medical Systems, regarding the recent transition of the Soldier Medical Devices program manager to the maneuver medical systems space, expanding the PM's scope of responsibility to address future requirements associated with medical concerns relating to future large-scale combat operations.

C&CC: Your office transitioned from PM Soldier Medical Devices to PM Maneuver Medical Systems. What drove this evolution, and how does it better position the organization to support Army medicine?

COL KD: The transition from Soldier Medical Devices (SMD) to Maneuver Medical Systems (M2S) reflects the Army's continued commitment to modernizing battlefield medicine by delivering integrated medical and other capabilities across the full continuum of care, from prevention and pre-injury capabilities to definitive medical care and rehabilitation. While the organization's core mission, to develop and deliver deployable medical capabilities for the Warfighter, remains unchanged, the transition represents a strategic evolution in how Army Medicine develops, acquires, fields, and sustains those capabilities. As the Army's medical modernization priorities expanded, M2S evolved from three product management organizations to

five capability-focused organizations, enabling M2S to better align medical capability delivery with the operational needs of today's force.

M2S now integrates capabilities that span every Role of Care while incorporating Soldier readiness, prevention, resilience, and holistic health into a unified acquisition enterprise. Today, M2S consists of Product Manager Holistic Health & Fitness (PdM H2F), Product Manager Soldier Hospitalization (PdM SH), Product Manager Soldier Treatment & Evaluation (PdM ST&E), Product Lead Soldier Health, Prevention and Logistics (PdL SHPL), and Product Lead Operational Medicine Information Systems-Army (PdL OMIS-A). Together, these organizations provide acquisition leadership and technical expertise across capability areas that integrate physical medical devices and health and readiness equipment with the software and network capabilities needed to maximize effectiveness on the current and future battlefield.

Headquartered at Fort Detrick, Maryland, M2S is working alongside Army organizations, Joint partners, industry, and academia. M2S serves as a bridge between emerging technology and operational requirements. The new name reflects a broader mission centered on ensuring Army maneuver formations and the Army medical force have the equipment, technology, and systems needed to care for Soldiers across the care continuum and across the battle space.

C&CC: What are the most significant challenges facing Army medical modernization today, and how is M2S addressing them through its portfolio of programs?

COL KD: Modern military operations demand medical systems that are increasingly mobile, interoperable, and adaptable. Medical personnel must be able to document patient care securely, establish treatment capability in austere environments, rapidly integrate emerging technologies, and ensure commanders have the medical information they need for agile, real-time decision-making. Meeting those demands requires close collaboration among capability developers, acquisition professionals, operational users, and industry partners.

M2S addresses these challenges through a diverse portfolio that spans operational health information technology, deployable treatment, evacuation and hospitalization systems, medical infrastructure, and Soldier health and readiness enablers. Across every portfolio, the organization emphasizes user-centered design, continuous collaboration with stakeholders, and acquisition strategies that reduce development timelines while maintaining rigorous testing and evaluation. This approach enables M2S to deliver capabilities that are operationally relevant, technologically current, and responsive to the evolving needs of Army Medicine.

C&CC: How is PdL OMIS-A modernizing battlefield medical documentation and improving continuity of care across operational environments?

COL KD: OMIS-A is modernizing the Army's operational health information

technology by providing deployed medical personnel with secure digital documentation capabilities that improve continuity of care while reducing dependence on paper records. From combat medics documenting care at the point of injury to providers operating in Army medical formations, OMIS-A is helping create a more connected operational medical environment by ensuring data flows all the way back to Role 4 and the health record, as well as to critical command and control (C2) systems.

Working closely with the Joint Operational Medicine Information Systems (JOMIS) program office, OMIS-A supports the testing and integration of applications such as Battlefield Assisted Trauma Distributed Observation Kit-Joint (BATDOK-J) for point-of-injury documentation and the Operational Medicine Care Delivery Platform (OpMed CDP) for documentation at higher roles of care. Together, these systems strengthen medical situational awareness while enabling patient information to move more efficiently across the continuum of care.

Another OMIS-A capability, PHOENIXMed (Patient Health, Operational Electronic Network Information Exchange Medical), exemplifies responsiveness to Warfighter needs. Developed using Agile software development principles, OMIS-A developed PHOENIXMed to bridge critical health IT gaps in the European theater. Successfully fielded to forward units in Europe in 2025, the browser-based platform operates through the Army cloud and eliminates many of the infrastructure requirements associated with legacy systems. By replacing paper SF 600 documentation with secure electronic records, PHOENIXMed improves efficiency, enhances documentation accuracy, and provides deployed medical personnel with a workable solution tailored for Role 1 and Role 2 care.



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Maneuver Medical Systems display at the 2026 Medical Warfighting Forum at the Medical Center of Excellence. (M2S Photo)

C&CC: How is PdM SH modernizing Role 3 hospitalization capabilities to better support deployed medical forces?

COL KD: PdM SH is responsible for delivering the Army's Role 3 Hospital Center capabilities through the development, procurement, fielding, modernization, and sustainment of deployable medical systems. These capabilities expand upon Role 2 support by providing advanced clinical services that include resuscitation, damage control surgery, postoperative care, intensive care, diagnostic imaging, pharmacy support, and other specialized medical capabilities required to sustain combat operations.

PdM SH manages this mission through three complementary teams. The OR/ICU and Ancillary Medical Devices Team equips deployable surgical suites, intensive care units, ophthalmology capabilities, and supporting clinical systems. The Medical Infrastructure Support Team (MIST) provides the shelters, environmental controls, power generation, and utility integration that enable these hospitals to operate effectively in expeditionary environments. MIST is also leading development of the Multimodal Medical Container (M3C), a modernization initiative designed to enhance Forward Resuscitative Surgical Detachment capabilities while supporting future evacuation operations. Completing the portfolio, the Role 3 Sets, Kits, and Outfits (SKO) Team standardizes the medical assemblies and equipment configurations required to rapidly establish hospital capability wherever operational forces require it.

Together, these efforts ensure deployed medical forces have modern, scalable, and mission-ready hospitalization capabilities that can deliver world-class care under challenging operational conditions.

C&CC: The Rapid Army Portable/Tactical Oxygen Resource (RAPTOR) Battlefield Oxygen initiative has advanced rapidly. What acquisition strategies helped make that possible, and what lessons could benefit future medical modernization efforts?

COL KD: Managed by PdL SHPL, RAPTOR supports the Army's priority effort to provide portable battlefield oxygen generation while demonstrating that acquisition speed and disciplined program management can work hand in hand.

Working collaboratively with the Army's Soldier Enhancement Program (SEP), contract partners, and additional Army stakeholders, SHPL rapidly secured funding, coordinated evaluation planning, synchronized testing activities, and advanced program execution well ahead of traditional acquisition timelines. Approval of SEP funding enabled the program to accelerate by approximately one year, while early coordination with the



Combat medics evaluate medical trauma sensor (MTS) prototypes during the SWORD 2026 exercise in Poland. PM M2S is partnered with the Defense Innovation Unit and the Army's Global Tactical Edge Acquisition Directorate to accelerate MTS prototype development and delivery. (M2S Photo)

U.S. Army Medical Test and Evaluation Activity positioned operational assessments to begin without unnecessary delay. Parallel collaboration with Special Operations Command also encourages continued innovation through competitive development, ultimately strengthening the capability delivered to operational forces.

RAPTOR highlights how proactive partnerships, streamlined decision-making, and responsible fiscal stewardship can significantly improve acquisition outcomes while ensuring emerging medical technologies continue to meet the Army's operational requirements.

C&CC: Looking ahead, what emerging technologies or capability areas will have the greatest impact on battlefield medicine, and what role will M2S play in delivering those capabilities to the force?

COL KD: As Army Medicine prepares for future operational environments, M2S is focused on capabilities that ensure survivability, and enable readiness, prevention, and the entire medical care continuum. Digital health technologies, expeditionary hospitalization systems, manned and unmanned patient movement and monitoring, and streamlined acquisition practices are all helping shape the next generation of military medical capability.

Equally important is integration of medical capability with the next generation systems and capabilities being fielded to our maneuver formations. Medical capability is not an add-on, but an integral part of the systems of capabilities with which our formations fight and win. M2S ensures this stays a priority through our integration within Capability Program Executive (CPE) Ground – Soldier Systems and Portfolio Acquisition Executive (PAE) Maneuver Ground, and through partnerships across the Army's PAE ecosystem. Whether improving digital continuity of care through OMIS-A, enhancing deployable hospitalization through PdM SH, accelerating lifesaving technologies such as RAPTOR, or delivering any of the other critical capabilities in the portfolio, M2S remains focused on equipping Army formations with innovative, mission-ready solutions that preserve combat power and support Soldiers whenever and wherever they are called to serve.

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SURGICAL STERILIZATION AT THE TACTICAL EDGE

A compact, ruggedized, and reliable field autoclave is enabling FDA cleared instrument sterilization closer to point of injury, and the United States Marine Corps is taking notice.

By Chris Yerger, Founder, Fort Defiance Industries (FDI)



FDI VP of Engineering, David Michalik, leads field sterilization training with U.S. Navy Sailors of 3rd Marine Logistics Group at Camp Kinser, Okinawa, Japan. (U.S. Marine Corps Photo by Lance Cpl. Matthew Borruso)

On May 18-20, 2026, at Camp Kinser, Okinawa, Sailors from across the 3rd Marine Logistics Group spent three days learning to operate and maintain a new field surgical instrument sterilizer. The trainees became proficient with a device poised to close a longstanding capability gap.

PERSISTENT FIELD PROBLEM

For the U.S. Marine Corps, instrument sterilization has emerged as a priority for advancing the capabilities of far-forward surgery. "The USMC faces a persistent logistical challenge in providing high-capacity, reliable medical sterilization at the tactical edge, particularly within the context of Expeditionary Advanced Base Operations (EABO) and contested logistics where legacy systems are often too resource-intensive or fragile for far-forward deployment," explains Chandler Swartzendruber, Engineer on the Expeditionary Medical Systems team within Portfolio Acquisition Executive Marine Corps (PAE MC).

SOLUTION BUILT FOR EXTREMES

The FRONT-LINE Field Sterilizer, or FL135, was engineered around the much-needed requirement for more capacity and reliability. The FL135 is a dynamic air-removal steam sterilizer designed specifically for field environments and is engineered for the harsh conditions that sideline sterilizers normally used in commercial hospitals or dental practices. It has been validated to MIL-STD-810G for vibration on trucks and helicopters, a 30-inch drop, blowing dust, driving/freezing rain, humidity, and it operates at altitudes up to 10,000 feet. Even during Arctic storage testing at -65°F, the FL135 was able to reacclimate and run validated sterilization cycles — conditions in which other devices normally fail.

LEANER LOGISTICS

What appeals to logisticians is the compact operational footprint. The FL135 sterilizes up to 25 pounds of instruments, uses only four ounces of

water per cycle, and recycles its own condensate for up to 50 cycles before a water change-out. The chamber fits full-length rigid containers with outside dimensions of 23.1" x 12.4" x 6.1", and with two cycles, can sterilize an entire Bookwalter retractor set. The FL135 runs on 120 or 230-240 VAC at 15 amps, already common for existing military power distribution systems. An Immediate Use cycle with 25lbs of instruments runs about 35 minutes. With no heavy vacuum pump, there is one less component to fail, and zero Bowie-Dick testing burden to sustain. Swartzendruber explains the benefit clearly: the FL135 "could enable forward medical elements to sustain continuous surgical operations in austere environments without overburdening Class I and Class VIII supply chains."

CLOSER TO THE POINT OF INJURY

By "delivering a ruggedized, easily transportable system that pushes sterilization capabilities closer to the point of injury," as Swartzendruber puts it, the FL135 allows a surgical team to confidently reprocess its own instruments where the casualties are, rather than rationing sterile sets or evacuating to reprocess. The system, Mr. Swartzendruber noted, is currently under evaluation by PAE MC for inclusion in the Health Service Support Authorized Medical Allowance Lists (AMALs) Family of Systems — the formal path to fielding it across the entire force.

ALREADY WITHIN REACH

For military units that want it now, the FL135 is FDA cleared [510(k) K243801] and carries National Stock Number 6530-01-732-4515. It is available for purchase through the Defense Logistics Agency's Electronic Catalog (ECAT) under contract SPE2DH-22-D-0016. Because a fielded capability is only as good as the Soldiers, Sailors, Airmen, and Marines who operate and maintain the capability, FDI offers in-person, hands-on training, and a comprehensive on-demand video library to ensure all users are fully equipped.

REVOLUTIONIZING MILITARY HEALTHCARE: MHS GENESIS CONTINUES TO EVOLVE WITH AMBIENT LISTENING INTEGRATION

By Defense Health Agency



Rhonda Sanders, a physician assistant at Kenner Army Health Clinic, speaks with a patient during an appointment at Fort Lee, Virginia. Ambient Listening, a tool within MHS GENESIS, helps providers remain engaged in conversations with patients while automatically documenting relevant information in the electronic health record. (Photo by Shanita Dorsey, Kenner Army Health Clinic)

The Military Health System is undergoing a monumental transformation, shifting how care is delivered, documented, and experienced by both patients and providers. At the heart of this modernization is MHS GENESIS, the Department of Defense's federal electronic health record (EHR). Providing a single, secure, and highly integrated health record for service members, veterans, and their families, MHS GENESIS currently supports more than 9.5 million beneficiaries and approximately 194,000 provisioned users globally. As the platform enters its next phase of evolution, the Defense Health Agency is strategically integrating cutting-edge artificial intelligence, most notably through the rollout of new ambient listening technology, to further reduce administrative burdens and enhance the patient-provider connection.

THE EVOLUTION AND STATUS OF MHS GENESIS

MHS GENESIS represents a massive leap forward from legacy EHR systems, which often required custom-built functions and lacked seamless interoperability. By offering a unified inpatient and outpatient platform, MHS GENESIS connects medical and dental information across any military hospital or clinic, regardless of the military branch.

The journey to modernize the military's EHR began in February 2017 with a limited fielding at four initial operational capability sites in the Pacific Northwest. Following rigorous assessments and improvements to deployment and training processes, incremental deployment began in September 2019. Despite the challenges posed by the COVID-19 pandemic, the rollout continued steadily. The flexibility of MHS GENESIS was proven during this time; COVID-19 specific configuration changes were implemented within hours, compared to the nearly four weeks it may have taken legacy systems.

By June 2023, DHA completed the stateside deployment of MHS GENESIS, swiftly following up with all overseas hospitals and clinics by September 2023. A notable achievement of the deployment timeline occurred in March 2024 at the joint DOD and Department of Veterans Affairs Captain James A. Lovell Federal Health Care Center in Chicago, Illinois, the first of more joint sites to come. Lovell marked the end of the DOD's seven-year deployment and established a critical blueprint for how the DOD and VA can seamlessly share resources, facilities, and clinicians without information technology acting as a barrier.

Looking toward the future, the MHS GENESIS platform is continuously receiving enhancements based on end-user feedback. Future updates will focus on optimizing data, standardizing and automating clinical processes, and developing targeted user resources while exploring new technologies to further reduce administrative workloads.

Recent upgrades have already introduced patient portal enhancements like prescription refills and secure messaging, as well as scheduled virtual visits at certain sites. Additional future strategic plans for patient portal enhancements aim to improve the user experience, and secure access via the new DOD-wide authentication system, MyAuth (replacing DS Logon) should take place this year.

THE NEW ERA OF AMBIENT LISTENING TECHNOLOGY

Fulfilling the promise to explore new technologies, DHA has introduced a groundbreaking capability to military medicine: ambient listening technology. Known formally as the Clinical AI Agent, this tool records and analyzes conversations between patients and providers during medical appointments, automatically capturing clinical notes and automating

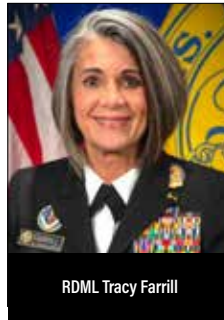
administrative tasks for medical staff.

Between October and December 2025, DHA conducted a successful limited release of the technology across four pilot sites: Madigan Army Medical Center, Naval Medical Center Camp Lejeune, Naval Medical Center Portsmouth, and Wilford Hall Ambulatory Surgical Center. Following rave reviews from the approximately 400 participating providers, DHA rapidly phased the technology into military hospitals and clinics worldwide throughout June 2026.

"The deployment and adoption of ambient listening technology align with the most recent guidance from the White House Office of Management and Budget directing federal agencies to accelerate AI adoption, and the Department of War AI strategy," said Saniah Fatemi, a program manager supporting DHA's rollout efforts. "By rapidly deploying ambient listening at enterprise scale, DHA is executing its mandate to modernize care delivery, strengthen medical readiness, and operationalize high-quality AI technology in support of the warfighter."

In practice, the technology is remarkably intuitive. After obtaining verbal consent from the patient, a provider simply starts the recording. They can then conduct a normal, engaging encounter without needing to stare at a computer screen or frantically type notes. Once the appointment concludes, the provider reviews and signs the AI-generated clinical note, which is then seamlessly integrated into the patient's permanent MHS GENESIS record.

"The integration of ambient listening into MHS GENESIS is vital to strengthening joint warfighting capabilities, allowing their health story to follow them while serving and beyond," said U.S. Public Health Service



RDML Tracy Farrill

Rear Adm. Tracy Farrill, director of DHA's Office of Warfighter Health Advantage, and the MHS Digital Functional Champion. "By leveraging technologies like ambient listening, we are investing in data-driven solutions and unifying our clinical care, fostering dynamic collaboration from the point of injury through rehabilitation.

The impact on both sides of the stethoscope has been profound. Administrative tasks are widely recognized as a primary factor driving provider burnout. Lt. Col. Matthew Royall, deputy branch chief of ambulatory informatics at DHA, noted reducing this burden has far-reaching consequences for provider retention and work-life balance. Providers have reported a significant decrease in the time required to complete clinical notes, allowing them to allocate more time directly to patient care.

For patients, the technology fosters a much more engaging and personal healthcare experience. Beneficiaries reported feeling a deeper connection with their providers due to sustained eye-to-eye contact and a natural dialogue that isn't interrupted by screen-time.

Ultimately, the integration of ambient listening into MHS GENESIS is a strategic investment in warfighter readiness.

"Getting the appropriate diagnoses, correctly documenting the treatment plan is a mutual benefit, not only better outcomes for the patient, but better-quality data," Royall explained

By unifying clinical care through data-driven AI solutions, DHA is ensuring its providers are supported, its patients are heard, and its highly mobile warfighters are ready for whatever lies ahead.



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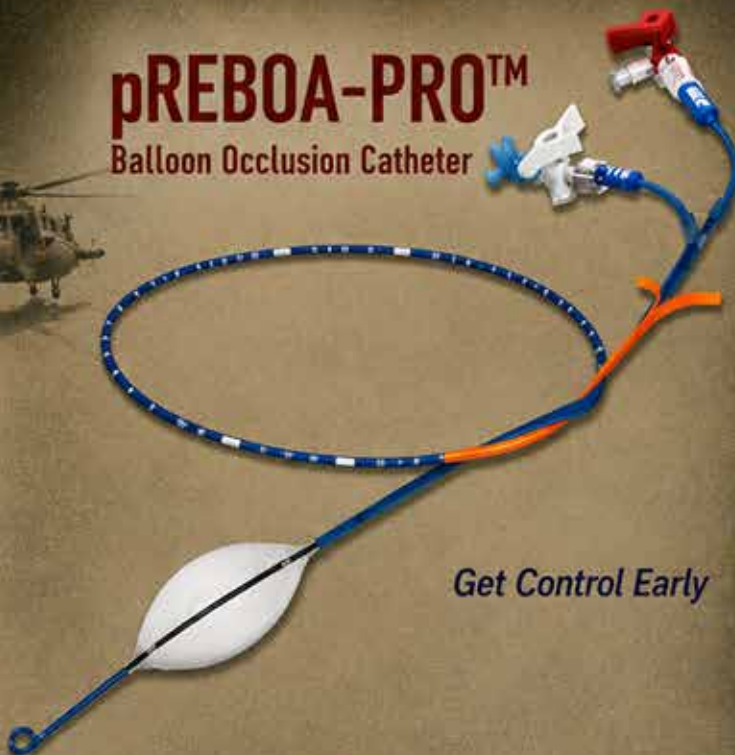
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The battlefield has changed, and military medicine must evolve with it. Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA), particularly next-generation partial occlusion technology like pREBOA-PRO™, is redefining how surgical teams manage non-compressible torso hemorrhage — one of the leading causes of preventable death in combat. Unlike traditional hemorrhage control methods that rely on rapid evacuation timelines, REBOA provides a minimally invasive method to stabilize critically injured warfighters by maintaining blood flow to the heart and brain while controlling life-threatening bleeding below the balloon. This capability is especially critical in future conflicts where evacuation may be delayed, surgical assets dispersed, and prolonged field care the operational reality.

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On behalf of Bud Calkin, CEO, Skedco, and Jim Meadows, CEO, Panakeia

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ADVANCING MEDICAL EXPERTISE AMID THE FREEZE

The Arctic is a harsh environment, and troops deployed there face a set of unforgiving challenges unique to this setting. Given the potential for future conflicts to take place in extreme cold environments, the U.S. Army reactivation of the 11th Airborne Division in June 2022 for specialization in cold weather warfare is presenting an opportunity to combat medics who have completed either the Cold Weather Orientation Course (CWOC) or Cold Weather Leaders Course (CWLC).

By USARIEM Strategic Communications



U.S. Airmen from across the 673d Medical Group evacuate a simulated trauma victim while rendering tactical combat casualty care (TCCC) during the Arctic Warrior Challenge 2022 at Joint Base Elmendorf-Richardson, AK, April 2023. The Arctic Warrior Challenge was a scenario-based field training exercise designed to hone the 673d Medical Group Airmen's TCCC skills, improve operational readiness, and foster unit cohesion. TCCC outlines prehospital combat medicine devised to provide lifesaving care to injured combatants, to limit the risk of further casualties, and to help achieve mission success. (U.S. Air Force photo by Alejandro Peña)

The practice of medicine is particularly affected by cold weather, which impairs a medic's dexterity, causes medical supplies to freeze, and creates an urgent need to warm casualties. To prepare medics for Cold Weather Injuries (CWI), the Medical Simulation Training Centers (MSTC) at Joint Base Elmendorf-Richardson and Fort Wainwright (Anchorage and Fairbanks, respectively) offer an Arctic Medicine Course. This week-long course is oriented not only to recognizing and treating CWI but also to understanding how cold weather affects the medic's ability to perform Tactical Combat Casualty Care (TCCC).

UNIQUE PREPARATION FOR UNIQUE POINT OF INJURY

In 2023, the Army's Soldier Center Simulation and Training Technology Center (STTC), Orlando, FL, proposed a Small Business Innovative Research (SBIR) topic centered on developing modeling and simulation training systems to aid military medical first responders in recognizing and treating CWI.

The Defense Health Agency approved the topic. After completing Phase I, three firms were selected for two-year Phase II efforts. The three efforts complement each other in forming a training "system of systems".

While the development for these projects is being conducted by three Florida-based small businesses, the two efforts involving manikins require testing in a true Arctic environment. The STTC is working closely with the Fort Wainwright MSTC to ensure user testing is performed at an appropriate location. While the manikins have been placed in freezers for initial testing, Fort Wainwright affords the opportunity to expose the systems to the relevant austere environment and integrate into current instruction.

Researchers from the STTC and manikin developers attended the Arctic Medicine Course in late January and early February 2026, to see how the course was conducted and to perform some initial testing in the cold and snow. During the first week, the first day of the course saw a low of -25oF, the lowest temperature of the two weeks; the low the remainder of the week was always below 0oF with the high seldom above 10oF. The second week

was somewhat warmer, although temperatures stayed well below freezing. One to two feet of snow covered everything outside, making total or partial immersion quite easy.

ROBUST SIMULATION TO ADDRESS TOUGH REALITIES

While testing in a relevant environment is always important, it becomes even more critical when that environment is well below 0oF and blanketed with snow. Hardening a human patient simulator focuses on several areas:

- Ensuring simulated skin does not become brittle and crack
- Ensuring on-board liquids (e.g., simulated blood) do not freeze
- Comparing battery life in the cold to battery life in a temperate climate
- Ensuring internal electronics, tubing, joints, etc., operate in the cold
- Ensuring the interior stays dry when the manikin is immersed in snow

The first small business information research (SBIR) effort is web-based familiarization training for extreme CWIs. The system allows medics to engage in interactive, self-paced modules that cover critical topics like hypothermia, frostbite, and other cold-related injuries, anytime and anywhere. There will be a variety of skill levels to choose from, and the training will scale to the individual user's prior knowledge or training, ensuring a tailored training experience that maximizes engagement. This innovative approach not only enhances individual competence but also ensures that everyone is in tune with the same doctrine and learning materials based on their skill level. The training will reflect the latest research and best practices, ensuring medics are well-prepared to make informed decisions in high-pressure situations. Medics can access the course material from their home station for initial training and review it later for skill refreshment, all on their own schedule and without the need for travel.

Research teams viewed critical training exercises employed to help guide manikin performance criteria. These exercises included cold weather immersion followed by tourniquet treatment or other dexterity reduced medical treatment, medical evacuation (MEDEVAC) loading/unloading procedures, cold weather specific injury treatment and care (frostbite, hypothermia, mental distress, etc.), and a culminating exercise targeting casualty evacuation in rough terrain.

The second SBIR effort employs advanced mixed reality capability to bridge the gap between classroom and field training. Using an Augmented Reality headset, CWIs can be superimposed on a physical human patient simulator, allowing trainees to visualize the progression of injuries like frostbite and hypothermia in real-time. It also allows instructors the ability to change type and severity of an injury, providing a level of realism impossible to achieve with a static manikin or moulage. The manikin is also being hardened for use in the cold, providing for both an indoor introduction to CWI and an outdoor manikin that exposes students to the reality of treating CWI in the cold.

The hardened manikin research team performed some initial environmental testing of the prototype torso and electronics to see how the system would respond when exposed to the elements for prolonged periods of time. The team evaluated internal insulation, material performance, and the impact of heating elements to core temperature. The controller and electronics performed as expected and were not damaged by the elements or condensation buildup inside of the torso. Since this effort involves designing a manikin from scratch, this foundational testing focused on core component viability rather than full-system scenarios.

STREAMLINING SIMULATED TO REAL-WORLD TRANSITION

Field tests were then conducted with mixed reality involving hardened commercial manikins. Leveraging a mature commercial platform allowed for a more complete prototype, which was integrated directly into the Arctic Medicine course for multiple outdoor scenarios. Both students and instructors remarked favorably on the manikin's ability to operate in sub-zero weather, a capability lacking with the existing inventory of patient simulators. Furthermore, the mixed reality component worked well outside in the bright and snowy conditions.

The final effort is focused on developing an extreme cold weather medical training system capable of surviving the harsh environment. This ruggedized manikin system is being built from the ground up and will support standard medical procedures typically conducted in extreme cold weather environments. The project is also developing cold weather moulage overlays that enable existing medical manikins to display signs of cold weather injury like frostbite. Together, these deliverables provide a flexible solution, enabling both high-fidelity field exercises with the new manikin and cost-effective upgrades to existing equipment.

Following the successful demonstrations in a relevant Arctic environment, the project is well-positioned for its next phase. Further development and testing will enhance the capabilities of these technologies, delivering an increasingly realistic and effective training experience. With anticipated Congressional support for the SBIR program, the STTC is optimistic about securing post-Phase II funding. This, combined with growing interest in extreme weather training, will be critical in transitioning these technologies into a comprehensive training solution for the nation's forces.



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DELIVERING MEDICAL READINESS AT THE SPEED OF NEED

Robert E. Bell III is the Supervisory Program Manager for the Medical Simulation and Training Program Management Office (MST PMO) within the Defense Health Agency. A former U.S. Army Field Artillery Officer, he has over 28 years of senior management experience from both government and industry. Throughout his career, Mr. Bell has observed firsthand how operational medicine can be a combat multiplier, and he brings that knowledge to his team's mission.

In his current role, Mr. Bell leads cross-functional teams to deliver solutions that enhance warfighter medical readiness, provider proficiency, and patient safety. Before taking the helm of the MST PMO, he served as Deputy Program Manager for the Clinical Support PMO, overseeing programs valued at over \$74 million and fielding critical systems to enhance the health of service members. Mr. Bell holds a Master of Science in Information Management and is a certified Project Management Professional (PMP).

In a recent Q&A with Combat and Casualty Care, Mr. Bell spoke to the work of the MST PMO and how it contributes to warfighter readiness by improving medical proficiency through simulation and training excellence.

C&CC: What are some of the primary missions of the MST PMO?

Mr. Bell: Our mission is to improve beneficiary healthcare, medical readiness, and warfighter lethality by delivering simulation, modeling, and digital solutions. MST PMO is the full lifecycle acquisition management expert in this domain. In most cases, we can take a specific or derived capability requirement through development, testing, fielding, sustainment, modernization, and (eventually) retirement.

C&CC: How do those missions drive the wider missions of research, development, and acquisition within the Defense Health Agency?

Mr. Bell: Every initiative in our current portfolio, and any future programs, needs to move the needle in relation to one of the four DHA Lines of Effort. Taking an even broader view, the Department of War is moving forward with acquisition reform. The Adaptive Acquisition Framework involves new models for acquisition to deliver to the warfighter more quickly without sacrificing quality, while tailoring [programs] to the particulars of the requirement and the domain in which they will be used. We are embracing these, principally with the Software Acquisition Pathway and the middle tier of acquisition.

Separately, but under this same objective, DOW is revising the Federal Acquisition Regulation and opening more opportunities for non-FAR based acquisition approaches. This is an area where MST PMO excels and has been doing so for years. We have built a strong record of success using Other Transaction Authorities and look forward to using other non-traditional contracting approaches like Commercial Solutions Openings and Small Business Innovation Research. We intend to continue our legacy as leaders in these areas, and that includes helping other organizations who do not have the same track record.



Robert E. Bell III
Supervisory Program Manager
Medical Simulation and Training
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C&CC: How does MST PMO work with internal and external stakeholders to define mission objectives and shape strategies to meet the needs of warfighters?

Mr. Bell: An old boss of mine used to be fond of the phrase "stick to the knitting." Essentially, he was saying to focus on the fundamentals. In my 20 years of experience with the Military Health System moving programs forward, a critical success factor is always establishing strong relationships between a PMO program lead and the "functional champion" for the program. A lot comes down to that relationship and way of doing business established between the Program Manager and the functional champion.

We are looking forward to working with DHA's Office of Warfighter Health Advantage to ensure our programs optimize warrior needs. We will continue to deliver warfighter advantage by utilizing the middle tier of acquisition. This will allow us to put a prototype into warfighter hands months (if not years) earlier in the process and identify the "knowable unknowns" sooner, as well as the pain points within Military Departments. The process buys the PM time, long before a deployment decision, to get these elements added to the backlog so they can be prioritized and addressed appropriately in the development cycle.



The Medical Simulation and Training Program Management Office team gathers for a photo, Naval Support Activity Orlando, Florida, July 14, 2026. (Defense Health Agency Photo by T. T. Parish/Released)

C&CC: What are the primary focus areas for MST PMO during this time of widespread transition and evolution within the military medical development enterprise? How do you stay relevant to the wider DOW mission?

Mr. Bell: We have a six-point strategic plan that we keep in the forefront of everything we do:

1. Deliver Warfighter medical readiness; 2. Deliver medical warrior currency; 3. Provide stewardship excellence; 4. Commit to team and customer excellence; 5. Operate with operational discipline; and 6. Endeavor to modernization and improved support plans.

I think we stay relevant in a few ways. Our technical selection boards are critical to everything we do. Without selecting the right industry partner, you are going to face an uphill battle. We favor best value award basis over lowest price technically acceptable (LPTA) for this reason. Bringing the right vendor partner alongside is key.

Additionally, we must push beyond our comfort zone to commit to product management excellence. Delivering the right high-quality product on time is so important to maintaining relevance. Having the right processes and resources in place to sustain the product and willingness to modernize the product along the way is the last facet. Surprisingly, I still see multiple small to mid-size programs fail because of complacency. In the fast-moving world of digital products, you can deploy a great product today that, without modernization, will be obsolete in three years without careful planning.

Lastly, our office is known for simulation, but the demand signal for it appears to have decreased somewhat. We are adept lifecycle managers, regardless of whether the program involves a simulator component – so I think a willingness to broaden some of our portfolio composition will go a long way to ensuring we remain relevant as a PMO. I think we will be asked to do more in the digital solutions and software space than has been the case in the past and I think there is an eagerness to get after the most urgent DHA/MHS mission needs, regardless of the nature of the program.

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Healthcare providers practice an emergency delivery using the Complicated Obstetrical Emergency Simulation System 2 (COES2). Integrated and acquired by the Medical Simulation and Training Program Management Office through an industry partnership, these simulators are being deployed to over 40 Medical Treatment Facilities globally. (Courtesy photo by Gilberto Vallejo, MST PMO/Released)

C&CC: Tell us about some of your partnerships with industry and academia.

Mr. Bell: I've mentioned the importance of selecting the right industry partner from the outset of a program. The MST PMO has also done some local level "reverse industry" events to solicit industry solutions, to the extent possible, that can be incorporated into our plans and objectives.

We have an industry, government, and academic consortium concept here in my area [of Florida] called Team Orlando. The primary goal of Team Orlando is to improve the combat readiness, safety, and decision-making capabilities of the joint warfighter and federal first responder through advanced technology. Rather than each military branch developing their own training simulators in silos, Team Orlando allows them to do the following:

- **Co-Locate** – Almost all these commands are physically situated next to each other in the Central Florida Research Park adjacent to the University of Central Florida
- **Collaborate** – Share technological breakthroughs, reducing duplication of effort and saving taxpayers billions of dollars
- **Innovate** – Rapidly pivot commercial technologies such as virtual reality, augmented reality, artificial intelligence, and digital twins into military use cases

I think there are opportunities for my office to enhance collaboration with this group, and I believe it would be beneficial to the DHA and MHS.

C&CC: Why is it important for the DOW to have the functions MST PMO provides?

Mr. Bell: What excites me most about our work is our unique ability to improve medical proficiency through simulation and training excellence. Skill decay is a

very real challenge across various duty stations, and our training solutions are a gamechanger for keeping vital medical skills sharp and ready.

Looking ahead to preparedness for Large-Scale Combat Operations (LSCO) against near-peer adversaries, we can no longer rely on the standard "Golden Hour" for medical evacuations. Role 1 and Role 2 medical care will inevitably demand more advanced skills to sustain patients during Prolonged Field Care (PFC). I am confident that our office can provide the advanced training solutions necessary to maintain these vital medical capabilities in the field.

C&CC: What is MST PMO's solutions-based approach to implementing organizational changes to better meet the needs of the DHA and DOW?

Mr. Bell: I think this re-organization is unique compared with DHA's history of organizational change. At the Component Acquisition Executive (CAE) level, this one is being driven by acquisition reform and the need for greater efficiency as a combat support agency, getting on more agile "wartime footing." People seem to be onboard with the prospect of less bureaucracy and greater authority being pushed to lower levels of the organization.

Communication is a personal challenge for me, and I try to live up to the Bridges Transition Model, which talks about the "law of 7" with communication. People need to hear the same message 7 times in 7 different ways before they embrace it, so I am trying to do my part in that respect. Lastly, my office has volunteered some of our staff to help with working groups endeavoring to refine operating processes across the enterprise.

C&CC: What are some of the current and near future objectives for the MST PMO as we head into 2027 and beyond?

Mr. Bell: I've already hinted at some of our objectives in talking about our strategic plan, but to name some more tangible milestones: We need to



Anatomical eye models used for lateral canthotomy training are displayed inside a shipping container during a site visit by Medical Simulation and Training Program Management Office leadership and subject matter experts. The visit took place at an industry partner's facility that focuses on product conceptualization, design, and development in Winter Park, Florida, July 14, 2026. (Defense Health Agency Photo by Cameron E. Parks/Released)

achieve Minimum Viable Product (MVP) for our Role 4 Modeling tool; award our newest program, Training Risk Assurance Compliance and Evaluation (TRACE), a system to lower risk and support compliance associated with whole blood transfusions; and transition to sustainment phase for our DHA Texting Solution (DHATS) and Virtual Education Center (VEC) programs.

We also need to continue our efforts with our Complicated Obstetrical Emergency Simulation System 2 (COES2) deployments to high priority sites. We have four more high priority low volume fieldings planned before the end of the fiscal year. Finally, there is a new effort called Advanced Joint Operational Medical Simulation (AJOMS) in which we are partners with J-7 and Joint Trauma Registry. We are excited about this program and are still finalizing the requirements before it can be awarded.

C&CC: How do you foster a team-oriented approach to mission accomplishment for the MST PMO?

Mr. Bell: While the rest of the world seems to be moving towards more individualism and isolation, we still like to do things as a team...face-to-face as much as possible. We like to celebrate personal and work achievements together, and we meet face-to-face with virtually every member of our team twice a month in staff meetings.

Although our MST PMO team is made up of both government civilians and contractors, we operate with a "one-team, one-fight" mindset. When you walk through our office, it is very difficult to determine who is a civilian and who is a contractor because we work side-by-side with similar intensity and focus. This seamless collaboration is exactly how we drive success. We are entirely aligned toward a single, vital objective: supporting our Service members in uniform and ensuring they have the world-class training solutions required to remain at the top of their game.

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