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#### GENERAL

**ISSUE:** **Health Service Support (HSS) Plan Development**

**DISCUSSION:**

Units display an inability to develop a comprehensive Health Service Support (HSS) Plan due to the lack of synchronization of efforts by Staff, 1SGs, and MEDO during planning, preparation, and execution.

**RECOMMENDATION:**

The MEDO integrates into the staff, while simultaneously coordinating with troop 1SGs to produce a HSS plan that is feasible. The development of this plan takes into account the enemy situation and scheme of maneuver. It operates based on triggers and criteria for evacuation, CCPs, primary/alternate routes, and CASEVAC platforms. A MEDO who is embedded with the staff, gains and maintains situational awareness as combat operations develop. They are also able to shape the development of the HSS plan as phases change or follow on operations occur. This allows for quick maneuvering of medical assets in response to casualties. In order for this to be successful, the MEDO must have uninterrupted communications with the FAS/MAS as well as BDE Surgeon Cell.

**ISSUE: Casualty Evacuation**

**DISCUSSION:**

Units struggle with the facilitating of casualty evacuation. Over 95% of Died of Wounds (DOW) occur between POI and Role 1.

**RECOMMENDATION:**

The establishment of Squadron CCPs occurs between POI and the Role 1. They are located 1/3 of the distance from POI to Role 1. This allows the 1SGs to quickly move casualties to the Squadron CCP and return to the battlefield to continue to facilitate casualty evacuations. Troop CCPs are internal to the troop but provide a location for platoons to evacuate their casualties to and a collection point for the 1SGs. The Role 1 supports the Squadron CCPs by pushing 2/3 of the way toward the battlefield to collect the casualties. The distances are not a hard set rule but are dependent on the operational environment. This is where the 1SGs, Staff, and MEDO need to be in sync. CCPs are planned during COA development but with 1SG bottom up refinement. They are embedded into the scheme of maneuver and posted on sustainment graphics. As the unit pushes forward additional CCPs become activated, this is usually easiest if they are triggered by phase lines.

Units are very comfortable with embedding their ground ambulance down at the troop level. In a DA environment this takes away the ability to remain flexible and maneuver medical assets to the areas with the greatest need. When ambulances remain with the troops they are at greater risk of taking enemy contact and do not allow the Role 1 to support the CCPs. This obligates the 1SGs to evacuate from POI to the Role 1. If you have more than four casualties or multiple events, 1SGs are unable to evacuate them in the necessary time. If ground ambulances remain with the Role 1, they can maneuver them to support the CCPs. This method also prioritizes a troop or CCP based on number and type of casualties, sending them multiple ground ambulances to facilitate their casualty evacuation.

It is imperative that at all levels CASEVAC (non-medical vehicle) is part of the planning process. This means identifying the vehicles prior to movement, preparing them for arrival of casualties, and conducting battle drills on the loading and unloading of patients from these vehicles. Leaders identify CASEVAC vehicles to use for casualty evacuation back to Squadron CCPs. The Role 1 needs to prioritize patients by severity of injuries. Those most urgent may be evacuated by ground ambulances, when capabilities are overwhelmed CASEVAC vehicles augment the evacuation to the Role 1 and potentially Role 2. Units have demonstrated a reluctance to plan for these contingencies. Resulting in massive numbers of died of wounds (DOW), as they sit on casualties, awaiting the return of the ground ambulances. .The second and third order effects of utilizing CASEVAC must also be examined. 1SGs have to identify priorities. Do we haul less Classes of supply in order to facilitate casualty evacuation? If so do we increase the number of Logpacs to the troops? Do we reexamine load plans and plan for caching of supplies? The cause and effect must be taken into account when planning for CASEVAC.

**ISSUE: Maneuvering the Role 1s**

**DISCUSSION:**

The splitting of the Squadron Aid Station (SAS) into the Main Aid Station (MAS) and Forward Aid Station (FAS) is often met with reluctance. It is seen as a burden to support both Role 1s logistically as well as with security. This makes units reluctant to either split the SAS or deploy both Role 1s forward. By doctrine the Role 1 is 4k behind the FLOT; this requirement is often met with the deployment of the FAS forward. This makes responsive medical care next to impossible due to the shear breadth and complexity of the mission. The other common practice is to locate the FAS with the CTCP and the MAS with the TOC. Units are comfortable providing logistical and security support in this manner. This unfortunately renders the Role 1s non-value added. Their strength is the ability to move quickly in both their treatment and evacuation capabilities.

**RECOMMENDATION:**

A way to employ the Role 1s to the greatest strategic advantage is to push both forward. While under continuous contact, keeping the FAS ready to receive casualties as the MAS pushes forward to maintain that close proximity allows for uninterrupted Role 1 support. You can continuously push the MAS or FAS forward while one remains available, creating a “leap frog” appearance. Another means of employment, depending on terrain, is to deploy both forward in support of their respective troops. This generally occurs when the Squadron mission involves separate corridors with terrain acting as a barrier between troops. Another benefit for splitting the FAS and MAS as well as pushing them forward is the reduction of evacuation times and avoiding the overwhelming of resources. If utilized in their intended capacity, DOW casualties would be greatly reduced.

**REFERENCES**

**ATP 4-02.3** *Army Health System Support to Maneuver Forces*

**ATP 4-02.5,** *Casualty Care*

**ATP 4-25.13,**  *Casualty Evacuation*

**FM 4-02,**  *Army Health System*

**ISSUE: Medical Training**

**DISCUSSION:**

Medical training for the Line Medics is commonly non-existent or not to the degree that the treatment and evacuation medics receive. The difference in their abilities is patently obvious. Medics in general are often not individually vetted by the provider and given their left and right limits.

**RECOMMENDATION:**

The medical platoon needs to develop and implement a tough and realistic training program for all medics assigned to the platoon, to include the line medics. Line medics belong to the Medical PLT/HHT CDR and they need to be afforded the same training opportunities that the other medics receive. A comprehensive provider training program needs to occur that establishes the capabilities and scope of each medic in the Squadron. This “credentialing” can be certified quarterly by a provider and be tailored to the specific medic. It is that medical platoon leadership’s responsibility, to ensure the most qualified and capable of medics are sent in support of those troops. The implementation of this training plan needs to be coordinated through the HHT CDR/1SG to ensure necessary emphasis and coordination’s are made. In addition it is leader’s responsibility to ensure that medics are being used as force multipliers. If a medic holds an additional duty position that would prohibit them in acting as a medic in a emergency than they are no longer medics.

**REFERENCES**

**FM 4-02.4**, *Medical Platoon Leaders Handbook*

**ISSUE: Medical Communications for Combat Casualty Care (MC4)**

**DISCUSSION**

The platoon’s struggle with the establishment and implementation of MC4 systems The MC4 systems boost our capabilities and insure we meet the requirement of tracking patients through the approved medical tracking system that is accessed through the MC4 system. This capability allows the platoon to directly order their Class VIII items, and track update statuses. The medical platoon lost the opportunity to conduct classes with those that were not familiar with the system and order all Class VIII through the DCAM system. This would of allowed the unit to track due outs with expected supplies. The platoon needs to train all Medics on the use of the MC4 system to include the Palm Pilots and the proper procedures for uploading patient encounters in the field to the stand alone system in the SAS as this is an Army requirement and ensures continuity of patient care.

##### RECOMMENDATION

MC4 is the approved AMEDD Medical Documentation and CL VIII Ordering System. This is the system that will be used in theater to order medical supplies and ensure appropriate patient documentation. Continue to get repetitions with the ancillary programs in the MC4 system. It is possible to establish and utilize MC4 in garrison operations. This would ensure that the necessary level of comfort in their utilization is established. This will also introduce the Squadron leadership to the resources that are required to insure functionality of the system (i.e. internet connectivity). It will also provide a foundation for standard operating procedures in relation to ordering CL VIII from the Medical Company.

##### REFERENCES

**FM 4-02.4**, *Medical Platoon Leaders Handbook*

**Gateway to Medical Information for Deployed Forces,** <https://www.mc4.army.mil/>

**Internet Access to References**

CALL products require access through .mil computers and an identity check at <http://call.army.mil/>. You must follow links to the “DoD Personnel Area”.

Most doctrinal publications are available at the Army Training Information Architecture - Migrated (ATIA-M) site <http://www.train.army.mil/>. Login and then follow links to the ADLSC search. Access to certain references requires an Army Knowledge Online account and password.