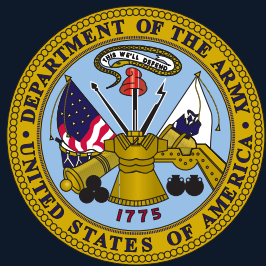


Joint Publication 4-02



Health Service Support



31 October 2006



PREFACE

1. Scope

This publication provides doctrine for the planning and execution of force health protection and health service support at the operational level, throughout the range of military operations.

2. Purpose

This publication has been prepared under the direction of the Chairman of the Joint Chiefs of Staff. It sets forth joint doctrine to govern the activities and performance of the Armed Forces of the United States in operations and provides the doctrinal basis for interagency coordination and for US military involvement in multinational operations. It provides military guidance for the exercise of authority by combatant commanders and other joint force commanders (JFCs) and prescribes joint doctrine for operations and training. It provides military guidance for use by the Armed Forces in preparing their appropriate plans. It is not the intent of this publication to restrict the authority of the JFC from organizing the force and executing the mission in a manner the JFC deems most appropriate to ensure unity of effort in the accomplishment of the overall objective.

3. Application

a. Joint doctrine established in this publication applies to the commanders of combatant commands, subunified commands, joint task forces, subordinate components of these commands, and the Services.

b. The guidance in this publication is authoritative; as such, this doctrine will be followed except when, in the judgment of the commander, exceptional circumstances dictate otherwise. If conflicts arise between the contents of this publication and the contents of Service publications, this publication will take precedence unless the Chairman of the Joint Chiefs of Staff, normally in coordination with the other members of the Joint Chiefs of Staff, has provided more current and specific guidance. Commanders of forces operating as part of a multinational (alliance or coalition) military command should follow multinational doctrine and procedures ratified by the United States. For doctrine and procedures not ratified by the United States, commanders should evaluate and follow the multinational command's doctrine and procedures, where applicable and consistent with US law, regulations, and doctrine.

For the Chairman of the Joint Chiefs of Staff:



WALTER L. SHARP
Lieutenant General, USA
Director, Joint Staff

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SUMMARY OF CHANGES
REVISION OF JOINT PUBLICATION 4-02 (FORMERLY 4-02,
DATED 30 JULY 2001, 4-02.1 DATED 6 OCTOBER 1997,
AND 4-02.2 DATED 30 DECEMBER 1996)

- **Consolidates relevant guidance found in Joint Publication (JP) 4-02, *Doctrine for Health Service Support in Joint Operations*; JP 4-02.1, *Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations*; and JP 4-02.2, *Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations*, into a single publication**
- **Provides a discussion of the relationship between health service support (HSS) capabilities and joint functions**
- **Replaces the five phases of casualty care management with the seven health service support capabilities of policy and resource acquisition capability, prevention and protection capability, first responder capability, forward resuscitative capability, theater hospitalization capability, definitive capability, and en route capability**
- **Updates the discussion of authorities and responsibilities for HSS**
- **Provides a detailed discussion of the joint force surgeon's office at the joint task force level to include duties of the office, organizing the office, and establishing battle rhythm**
- **Updates the discussion of HSS planning considerations**
- **Provides a health service logistic support planning checklist**
- **Adds a discussion of HSS in civil support operations**
- **Introduces the concept of medical civil military operations**
- **Provides expanded discussion of HSS in multinational operations**
- **Covers HSS for contingency contractor personnel**
- **Revises numerous terms and definitions used in HSS**

URGENT CHANGE 13 APRIL 2010

- **Reduces Priority 1 MEDEVAC time from two hours to one hour.**

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EXECUTIVE SUMMARY COMMANDER'S OVERVIEW

- **Covers Health Service Support**
 - **Discusses the Organization of the Joint Task Force Surgeon's Office**
 - **Describes Health Service Support Planning**
 - **Covers Health Service Support Operational Considerations**
-

Health Service Support

Health service support (HSS) sustains the mental and physical well-being of people in order to enhance performance in the accomplishment of a military mission.

Health service support (HSS) is related to three joint functions: sustainment, movement and maneuver, and protection. HSS promotes, improves, conserves, or restores health within a military system. HSS capabilities are employed across the range of military operations and include the ability to organize, train, and equip preceding deployment and enable the employment of physically fit personnel HSS. These capabilities span the operational environment from point of injury/illness to the appropriate capability of care.

Purpose

The purpose of HSS is to maintain the individual and group health needed to accomplish a military mission. The intent is to effectively and efficiently use medical capabilities and individual healthful practices to prevent and/or correct any human condition that would impair or preclude the joint force from achieving its objectives.

Joint Functions and Health Service Support Capabilities

Sustainment, protection, and movement and maneuver.

Foremost is the role of HSS in sustainment: the provision of medical support required to maintain health during prolonged operations until successful accomplishment of the joint force objectives. HSS protection involves those measures taken to prevent hazards — natural environmental, occupational, or enemy-induced — from having an adverse effect on personnel. Finally, movement and maneuver for HSS includes the planning, routing, scheduling, and control of patients and attendant medical support over lines of communications and during operations.

Within the three joint functions, HSS offers seven distinctive and overlapping care capabilities that enhance performance in a military force.

Care Capabilities

Policy and Resource Acquisition Capability. All HSS capabilities are dependent on sound policy and sufficient resource acquisition.

Prevention and Protection Capability. HSS can support the warfighter by applying prevention and protection capabilities. These capabilities are both wide-ranging and diverse and match the complexity of human health needs. These capabilities are focused on the individual, while others are directed at the family, organization, or force.

First Responder Capability. The health care capability that provides immediate medical care and stabilization to the patient in preparation for evacuation to the next HSS capability in the continuum of care.

Forward Resuscitative Care Capability. Forward resuscitative capability is characterized by the capacity to perform advanced emergency medical treatment as close to the point of injury as possible, to attain stabilization of the patient, and to achieve the most efficient use of life-and-limb saving medical treatment.

Theater Hospitalization Capability. The theater hospitalization capability offers essential care to either return the patient to duty (within the theater patient movement (PM) policy) and/or stabilization to ensure the patient can tolerate evacuation to a definitive care facility outside the theater.

Definitive Care Capability. Definitive care capability is rendered to conclusively manage a patient's condition and is usually delivered from or at facilities in the homeland, but may be delivered in facilities outside the homeland. For the Service member this care capability normally leads to rehabilitation, return to duty, or discharge from the armed forces.

En Route Care Capability. The purpose of an en route capability is the continuation of care during movement (evacuation) within the HSS continuum of care without clinically compromising the patient's condition.

Joint Task Force Surgeon Office

To assist joint force commanders at each level in supervising their force health protection responsibilities, a joint force surgeon is normally appointed for each combatant command, subunified command, and joint task force.

The joint task force surgeon's (JTFS's) office coordinates HSS and force health protection (FHP) matters for the joint task force, under the leadership and guidance of the JTFS. The JTFS's staff should be reasonably balanced in experience and rank among the Services concerned, and should be of sufficient size to effectively accomplish the following tasks: joint coordination of HSS and FHP initiatives; deployment health surveillance; HSS and FHP operations that sustains collaborative joint planning between combatant commands, Services, Department of Defense agencies, nongovernmental organizations, intergovernmental organizations, and host nation (HN) and allied participants as required; standardization and interoperability of medical capabilities and materiel; development of the HSS plan and course of action analysis; review of subordinate plans and operations; joint coordination of intratheater PM; reachback support; HSS planning and FHP operations; the collection of FHP lessons learned data; and, the implementation of programs and processes that promote and sustain a healthy and fit force, prevent injury and illness, protect the force from health threats, and deliver responsive HSS to the deployed force.

Health Service Support Planning Considerations

Timely, effective planning and coordination are essential to ensure adequate and sustainable HSS.

Proper planning permits a systematic examination of all factors in a projected operation and ensures interoperability with the campaign plan or operation plan (OPLAN). Organization of the HSS system is determined by the joint force's mission, the threat, intelligence, anticipated number of patients, duration of the operation, the theater PM policy, available lift, and hospitalization and movement requirements. The following should be considered:

Threat. The threat is a composite of ongoing or potential adversary actions; occupational, environmental, geographical, and meteorological conditions; endemic diseases that can reduce the effectiveness of the joint force through wounds, injuries, illness, and psychological stressors; and the employment of weapons of mass destruction (WMD).

Medical Intelligence. Medical intelligence is produced from the collection, evaluation, and analysis of information concerning the health threats and medical capabilities of foreign countries and non-state players that have immediate or potential impact on policies, plans, or operations.

Patient Movement. Timely PM plays an important role in the design of HSS. PM is the end result of the collaborative lift-bed planning, and involves selection of patients for movement based on consideration of medical condition, locating available beds, route planning, and the selection of movement platforms and movement control.

Patient Movement Items (PMIs). PMIs are specific medical equipment and durable supplies that must be available to support the patient. Examples of PMIs include ventilators, litters, patient monitors, and pulse oximeters.

Clinical Capabilities and Health Service Logistic Support. Specific clinical capabilities, location, health service logistic supportability, and bed requirements must be considered when planning HSS and must be detailed in the respective OPLAN.

Preventive Medicine and Health Surveillance. Risk assessment and analysis as well as preventive medicine measures must be included early in HSS planning.

Prevention of Stress Casualties. Prevention of stress casualties and control of combat and operational stress is a command and leader responsibility.

Mass Casualty (MASCAL) Situations. Procedures for handling MASCALs must be established to include casualty management resulting from WMD, combat, or other military operations.

Veterinary Service. Adequate veterinary service support is an integral part of joint FHP and it is imperative that medical planners consider veterinary support in HSS operational planning.

Dental Service. As a functional category of HSS, dental service plays a significant role in FHP for the joint force. Dental services must be included in the early stages of planning.

Host-Nation Support (HNS). HNS can be a significant force multiplier. HNS should be equivalent to US standards.

HSS for US Prisoners of War (POWs), Retained, and Detained Personnel. The geographic combatant commander establishes a theater plan on the proper handling and provision of HSS for returned US POWs and detained personnel.

HSS for Detainees. The joint force surgeon (JFS) and medical planner in conjunction with the staff judge advocate should develop detainee medical care policy recommendations for the joint force commander (JFC) in accordance with applicable laws and regulations.

Health Service Support Operational Considerations

Stability Operations

Stability operations encompass various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief. Stability operations objectives could include the restoration of services such as water, sanitation, public health, and essential medical care. The desired military end state in the health sector should be an indigenous capacity to provide vital health services.

Medical Civil-Military Operations

Medical civil-military operations are health-related activities in support of a JFC that establish, enhance, maintain, or influence relations between the joint or coalition force and HN, multinational governmental and nongovernmental civilian organizations and authorities, and the civilian populace in order to facilitate military operations, achieve US operational objectives, and positively impact the health sector.

Special Operations Forces

HSS of special operations units is characterized by an austere structure and a limited number of medical personnel with enhanced medical skills, to include emergency treatment, advanced trauma management, preventive medicine and limited veterinary and dental care. The primary focus of special operations forces HSS is to provide essential care and sustain casualties until force extraction from the operational area.

Multinational Operations

Medical staffs face numerous challenges affecting the health of multinational personnel deployed on operations. Therefore, operational HSS requires clearly defined guidance. HSS plans must be tailored to each operation and meet the demands of

geography, individual national needs, language, and communication difficulties. Every deployed multinational force should have a surgeon and/or chief medical officer who has direct access to the multinational force commander.

Chemical, Biological, Radiological, and Nuclear Operations

The JFC, at all levels, is faced with the possibility that any operation may have to be conducted in a chemical, biological, radiological, and nuclear (CBRN) environment. The threat of having to conduct operations in a CBRN environment pose unique challenges to HSS forces worldwide. The component command surgeons, working with the appointed JFS/JTFS are responsible for guiding and integrating all HSS capabilities available to the command to support mission accomplishment in an CBRN environment.

CONCLUSION

This publication provides doctrine for the planning and execution of FHP and HSS at the operational level, throughout the range of military operations.

CHAPTER I

HEALTH SERVICE SUPPORT

"The preservation of a soldier's health should be [the commander's] first and greatest care."

George Washington

1. Introduction

Health service support (HSS) sustains the mental and physical well-being of people in order to enhance performance in the accomplishment of a military mission. It is related to three joint functions: sustainment, movement and maneuver, and protection. HSS promotes, improves, conserves, or restores health within a military system (see Figure I-1). HSS capabilities are employed across the range of military operations and include the ability to organize, train, and equip preceding deployment and enable the employment of physically fit personnel HSS. These capabilities span the operational environment from point of injury/illness to the appropriate capability of care.

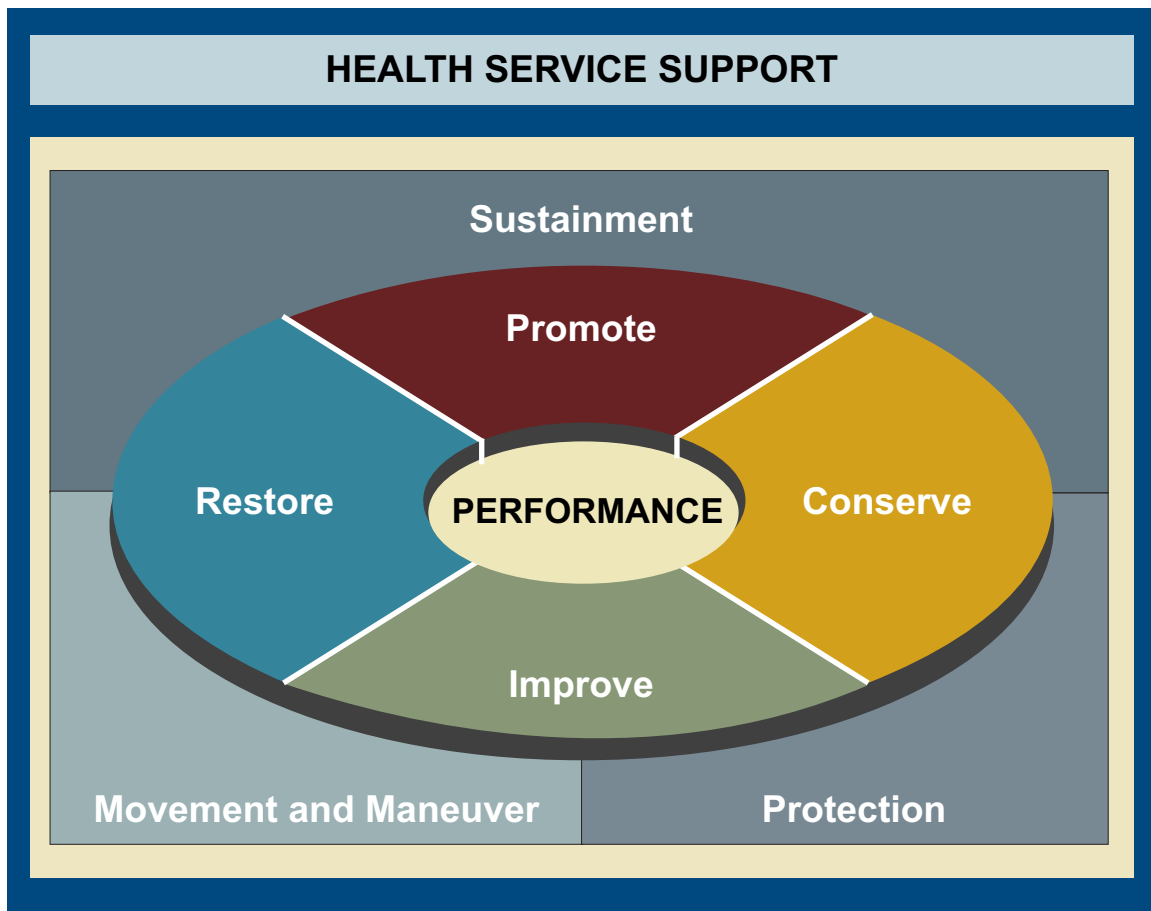


Figure I-1. Health Service Support

2. Purpose

The purpose of HSS is to maintain the individual and group health needed to accomplish a military mission. The intent is to effectively and efficiently use medical capabilities and individual healthful practices to prevent and/or correct any human condition that would impair or preclude the joint force from achieving its objectives.

3. Joint Functions and Health Service Support Capabilities

a. Foremost is the role of HSS in sustainment: the provision of medical support required to maintain health during prolonged operations until successful accomplishment of the joint force objectives. HSS protection involves those measures taken to prevent hazards — natural environmental, occupational, or enemy-induced — from having an adverse effect on personnel. Finally, movement and maneuver for HSS includes the planning, routing, scheduling, and control of patients and attendant medical support over lines of communications (LOCs) and during operations.

b. Within these three joint functions, HSS offers seven distinctive and overlapping care capabilities that enhance performance in a military force (see Figure I-2). These capabilities circumscribe the entirety of HSS. They include the medical resources — personnel, materiel,

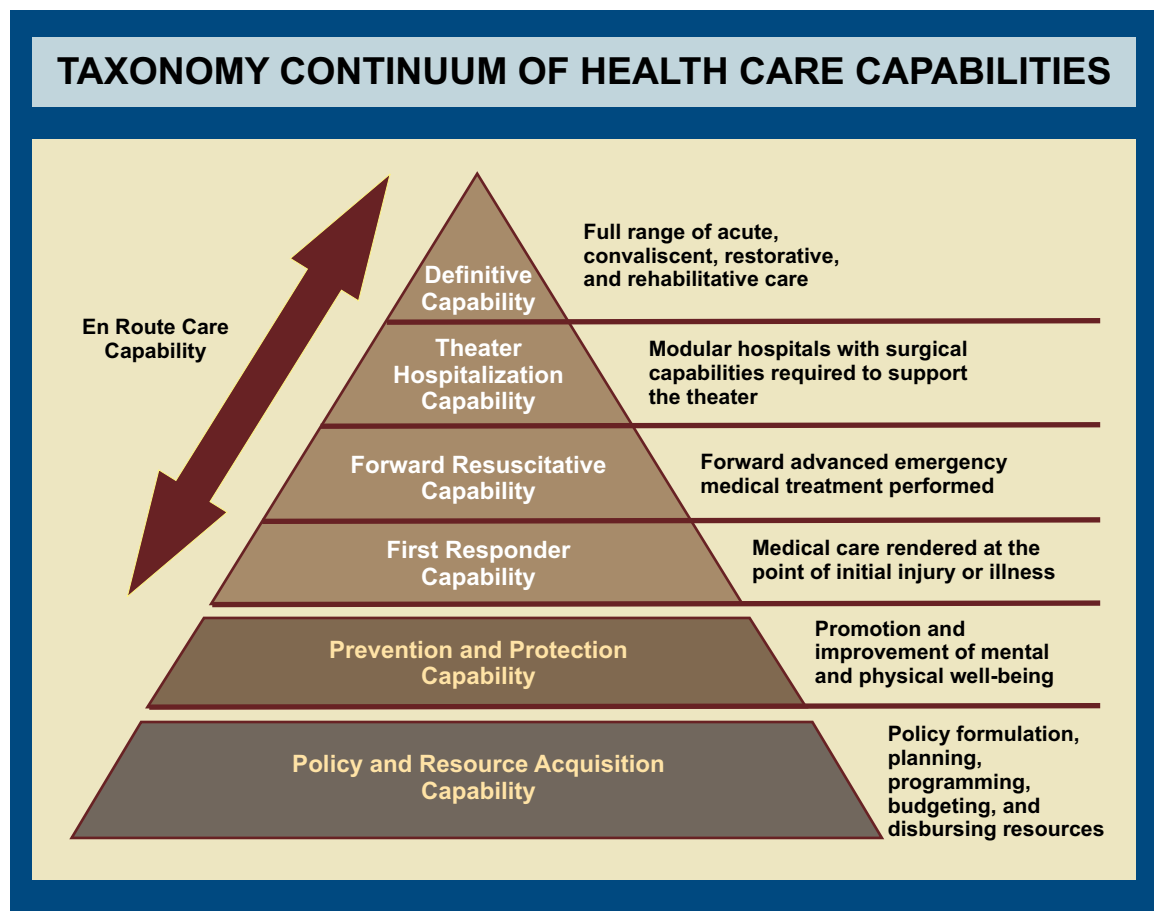


Figure I-2. Taxonomy Continuum of Health Care Capabilities

facilities, and information and the organizational enabling capacity to deliver HSS. All seven care capabilities are requisite to sustained health and are mutually supportive to that purpose. Each capability, however, has unique attributes that can be identified, improved, and applied to attain the desired well-being of the joint force.

4. Policy and Resource Acquisition Capability

All HSS capabilities are dependent on sound policy and sufficient resource acquisition. Policy provides the framework from which the HSS community derives the direction and identifies the requisite people, materiel, facilities, and information to promote, improve, conserve, or restore well-being. With policy as the guide, resource acquisition occurs through planning, programming, budgeting, and disbursement of money. This Title 10 US Code (USC) activity is foundational to the HSS community's capability to organize, train, and equip sustainment.

5. Prevention and Protection Capability

a. HSS can support the warfighter by applying prevention and protection capabilities. These capabilities are both wide-ranging and diverse and match the complexity of human health needs. These capabilities are focused on the individual, while others are directed at the family, organization, or force. Additionally, the Services will develop and enforce specific minimum standards; these standards will ensure Service members are free of diseases or medical and dental conditions that are incompatible with expeditionary military service.

b. When focusing on the joint force, the medical portion of protection is labeled force health protection (FHP). It includes all measures taken by commanders, leaders, individual Service members, and the Military Health System to promote, improve, or conserve the mental and physical well-being of Service members across the range of military operations. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards.

c. Members of the joint force have to be physically and mentally fit. This requirement demands programs that promote and improve the capacity of the personnel to perform military tasks at high levels under extreme conditions for extended periods of time. These preventive and protective capabilities include physical exercise, nutritional diets, dental hygiene and restorative treatment, combat and operational stress management, rest, recreation, and relaxation geared to the individual or organization.

d. Methods to prevent disease are best applied synergistically. Sanitation practices, waste management, pest and vector control are crucial to protection from disease. Regional spraying and the application of insect repellent to guard against hazardous flora are examples of prevention methods. Prophylactic measures can encompass human and animal immunizations, dental chemoprophylaxis and treatment, epidemiology, optometry, counseling on specific health threats, and issuance of protective clothing and equipment.

e. Key to preventive and protective care is information — the capacity to anticipate the current and future health environment — and its proper delivery to the affected human population. Derived from robust health surveillance and medical intelligence, this information addresses occupational, natural environmental, and enemy-induced threats: from industrial hazards; air and water pollution; endemic or epidemic disease; chemical, biological, radiological, nuclear, high-yield explosives, and lasers. HSS must be capable of acquiring, storing, moving, and providing information that is timely, relevant, accurate, concise, and applicable to the intended human user. In sum, this information capability is crucial to FHP.

6. First Responder Capability

a. More than any other care service, the first responder capability is defined by its time requirements. It is this health care capability that provides immediate medical care and stabilization to the patient in preparation for evacuation to the next HSS capability in the continuum of care. This capability can offer primary care outpatient services, emergent care services, medical subspecialty services, and ancillary services.

b. Primary care outpatient services often begin with the employment of basic or advanced first aid (via self-aid or buddy aid), followed by non-physician medical care, and, in some instances, physician primary care. Emergent care services offers basic pre-hospital trauma life support to include paramedic emergency care, initial resuscitative and fluid therapy, and cardiac life support. In addition to treating injuries, first responders treat patients for common acute minor illnesses.

c. Medical subspecialty and ancillary services for some first responder activities consist of basic mental health, dental and preventive medicine capabilities, as well as limited pharmacy, laboratory, and radiology capacities.

7. Forward Resuscitative Capability

a. Forward resuscitative capability is characterized by the capacity to perform advanced emergency medical treatment as close to the point of injury as possible, to attain stabilization of the patient, and to achieve the most efficient use of life-and-limb saving medical treatment. The forward resuscitative care (FRC) capability typically provides essential care for stabilization to ensure the patient can tolerate evacuation. This capability covers advanced emergency services, post surgical inpatient services, surgical subspecialty services, and ancillary services.

b. Advanced emergency services build on first responder capability by providing trauma life support, resuscitative care, emergency physician care, initial advanced burn management, and blood/fluid therapy. Available surgical services are normally comprised of trauma, general, thoracic, and orthopedic surgery capabilities. In turn, these surgical services are supported by surgical inpatient services: med-surgical nursing care, post-operative care, critical care nursing, and temporary holding services. All these capabilities are underpinned by sufficient pharmacy, laboratory, and radiology services.

8. Theater Hospitalization Capability

a. This capability delivers HSS via modular hospital configurations and/or a hospital ship required to medically sustain forces in a theater. This HSS capability involves hospitals purposely positioned to provide in-theater support. Theater hospitalization capabilities deploy as modules or multiple individual capabilities that provide incrementally increased medical services in a progressively more robust theater. The theater hospitalization capability offers essential care to either return the patient to duty (within the theater patient movement (PM) policy) and/or stabilization to ensure the patient can tolerate evacuation to a definitive care facility outside the theater.

b. In addition to the availability of substantial medical personnel skills, theater hospitalization capability has the facilities and materiel (equipment and consumable supplies) to render significant preventive and curative health care. These highly robust services encompass primary inpatient and outpatient care; emergent care; and enhanced medical, surgical, and ancillary capabilities.

c. Theater hospitalization capabilities can vary from theater to theater according to the regional infrastructure, operational area, and tempo of operation. But, a robust theater capability would contain the following services not normally resident at the lower levels in the HSS continuum of care: advanced burn management; optometry and ophthalmology; pediatric, obstetric and gynecological; dental and preventive medicine; veterinary services; internal medicine and cardiology; eye surgery, maxillofacial surgery, and neurosurgery; intensive/critical care beds and nursing; blood banking service; pathology; infectious disease; medical nutrition therapy; mental health; occupational health; medical logistics; and other medical specialties.

9. Definitive Capability

a. Definitive care capability is rendered to conclusively manage a patient's condition and is usually delivered from or at facilities in the homeland but may be delivered in facilities outside the homeland. For the Service member this care capability normally leads to rehabilitation, return to duty, or discharge from the armed forces. It includes the full range of preventive, curative, acute, convalescent, restorative, and rehabilitative medical care. And it extends to the families of members of the armed forces and Service retirees.

b. Because this definitive care capability usually resides outside the operational area, the most advanced health care can be made available and accessible to the patient — in terms of mutually supporting resources: medical personnel, materiel, facilities, and information. Definitive care includes all the capabilities embedded in the HSS, plus extraordinary preventive, restorative, and rehabilitative capabilities not existent in lesser capabilities of care. These additional capabilities give patients the maximum opportunity to enhance and sustain their performance, whether in recovery and rehabilitation, back on military duty, or as a civilian, medically retired or discharged.

10. En Route Capability

a. The purpose of an en route capability is the continuation of care during movement (evacuation) within the HSS continuum of care without clinically compromising the patient's condition. PM involves transitory medical care, patient holding, and staging capabilities during transport from the site of injury or onset of disease, through successive capabilities of medical care, to a medical treatment facility that can meet the needs of the patient. Each Service component has an organic PM capability for evacuation from point of injury to initial treatment at a health care facility.

b. En route capability can take three forms. Casualty evacuation (CASEVAC) involves the unregulated movement of casualties aboard ships, land vehicles, or aircraft. Medical evacuation (MEDEVAC) refers to dedicated medical evacuation platforms staffed and equipped to provide en route medical care using predesignated tactical or logistic aircraft, boats, ships, and other watercraft temporarily equipped and staffed with medical attendants (MAs) for en route care. Aeromedical evacuation (AE) specifically refers to United States Air Force (USAF) fixed wing movement of regulated casualties, using organic and/or contracted mobility airframes, with AE aircrew trained explicitly for this mission.

c. Today's lethal battlefield, the reduced medical footprint forward, and the "evacuate and replace" philosophy, place a high demand on the en route care capabilities of all Services. Consequently, PM capabilities are even more critical than in the past and Service medical elements



Medics from the 86th Combat Support Hospital, Camp Udairi, Kuwait, offload an injured patient transported by helicopter from a forward surgical team.

must integrate with lift operations, as well as with the associated capabilities of our Nation's allies and coalition partners.

11. Authorities and Responsibilities

a. Under the authority of the **Under Secretary of Defense for Personnel and Readiness (USD[P&R])**, the **Assistant Secretary of Defense for Health Affairs (ASD[HA])**, as the principal staff advisor for Department of Defense (DOD) health policies, programs, and activities, is responsible for HSS policy and:

(1) Programs for and resources medical and occupational health aspects of HSS within overall Defense Health Program priorities.

(2) Oversees and evaluates the effectiveness of implementation of policy and its implementing instructions.

(3) Recommends changes and/or revisions to policy and issues instructions as necessary.

(4) Monitors HSS implementation and ensures that quality assurance/quality control programs are in place.

b. The **Assistant Secretary of Defense for Reserve Affairs** monitors HSS policies for the Ready Reserve and ensures that they are consistent with HSS policies established for the Active Component.

c. The **Under Secretary of Defense for Acquisition, Technology, and Logistics**:

(1) Ensures HSS considerations are included in logistics and acquisition programs, environmental programs, Fire and Emergency Service, and Pest Management Board programs.

(2) Provides policy, oversight, and advocacy for environmental health, safety, and occupational health programs and activities, and coordinates those activities that relate to HSS with the ASD(HA).

d. The **Assistant to the Secretary of Defense for Nuclear and Chemical and Biological Defense Programs** implements policy and program oversight and direction for nuclear, chemical, and biological defense programs having an impact on HSS.

e. The **Under Secretary of Defense for Intelligence** directs that the Director of the Defense Intelligence Agency, the Service intelligence agencies, and the Armed Forces Medical Intelligence Center (AFMIC), provide operational intelligence, medical intelligence, and other information for use in assessing health threats at the strategic and operational levels.

f. The **Assistant Secretary of Defense for Networks and Information Integration/Chief Information Officer** ensures the HSS community has an effective communications system from the strategic to the tactical levels to support HSS activities.

g. The **Secretaries of the Military Departments**:

(1) Implement policy and follow implementing instructions, and report metrics in accordance with (IAW) requirements established by the ASD(HA).

(2) Program resources and develop doctrine, organization, training, material, leadership, education, personnel, and facilities to implement HSS policy.

(3) Implement effective quality assurance and quality control systems to ensure compliance with HSS policy.

(4) Evaluate and recommend changes or improvements to the HSS program.

(5) Promote healthy lifestyles, optimize safety and health of working conditions, facilitate access to health care, and conduct periodic health assessments.

(6) Monitor the physical and mental or emotional health of personnel; identify and mitigate the threats, stressors, and other risks to the health and safety of personnel; and ensure the availability and use of countermeasures.

(7) Ensure deploying personnel are medically ready for worldwide duty IAW all applicable medical standards of fitness.

(8) Provide appropriate medical support, training, equipment, and supplies to implement these policies.

(9) Inform personnel of health threats and countermeasures based upon the situations encountered.

(10) Document and report workplace injuries, illnesses, and incidents, and occupational and environmental hazards and exposures.

h. The **Chairman of the Joint Chiefs of Staff (CJCS)**:

(1) Assesses HSS and FHP as part of the overall force planning function of any force deployment decision. Periodically reassess the HSS posture of deployed forces.

(2) Monitors policy implementation and follow implementing instructions during military operations.

(3) Develops joint HSS doctrine and joint functional capabilities required to meet HSS challenges.

i. The **Joint Staff Surgeon** heads the Health Service Support Division within the Joint Staff Logistics Directorate (J-4) and through the CJCS:

(1) Assesses FHP as part of the HSS and FHP overall force planning function of any force deployment decision.

(2) Reassesses HSS and FHP posture of deployed forces.

(3) Reviews combatant commanders' (CCDRs') joint plans, deployment orders, and other relevant documents for HSS and FHP considerations.

(4) Monitors HSS and FHP implementing instructions during military operations.

(5) Leads the development of joint HSS doctrine

j. The **CCDRs**, through the CJCS:

(1) Have overall responsibility for HSS and FHP for forces assigned or attached to their command.

(2) Establish HSS and FHP policies and programs for the protection of all forces assigned or attached to their command.

k. Appointed **joint force surgeon (JFS)** for each combatant command, subunified command, and joint task force (JTF) is a member of the joint force commander's (JFC's) personal staff, and reports directly to the JFC. The JFS:

(1) Coordinates HSS and FHP matters.

(2) Deploys health surveillance.

(3) Collaborates on joint planning between combatant commands, Services, DOD agencies, nongovernment organizations (NGOs), and host nation (HN) and allied participants as required.

(4) Promotes standardization and interoperability.

(5) Develops the HSS plan and HSS portion of the course of action (COA) analysis.

(6) Reviews subordinate plans and operations.

(7) Coordinates PM through the established joint patient movement requirements center (JPMRC).

(8) Provides reachback support to components.

(9) Advises on HSS and FHP operations and planning to include:

(a) Medical care and treatment.

(b) Forward resuscitative surgery.

(c) PM (to include en route care).

(d) Hospitalization.

(e) Dental services.

(f) Preventive medicine (to include protection of the force from natural, environmental, occupational, operational, industrial, and chemical, biological, radiological, and nuclear (CBRN) warfare health threats).

(g) Medical intelligence preparation of the operational environment (MIPOE).

(h) Veterinary services.

(i) Combat and operational stress control and mental health care services.

(j) Health service logistic support (HSLs).

(k) Medical laboratory services.

(l) Blood collection and distribution services.

(m) Command and control (C2).

(10) Collects HSS and FHP lessons learned data that provide change recommendations to current plans and policy.

(11) Implements programs and processes that promote and sustain a healthy and fit force, prevent injury and illness, protect the force from health hazards, and deliver responsive HSS to the deployed force.

(12) Assesses component commands' HSS and FHP requirements and capabilities and has the responsibility to:

(a) Advise the CCDR on all theater FHP operations (to include the establishment of minimum FHP requirements for the theater).

(b) Monitor care provided to the joint force, civilian population and other beneficiaries, and coordinate HSS with Service providers and lead agents (LAs) as needed.

(c) Assist the CCDR in formulating a recommended theater PM policy within the theater.

(d) Assist component commands in identifying HSS and FHP requirements and coordinate cross-Service support, where practical.

(e) Advise the JFC concerning the following:

1. The health of the command as reflected by disease and non battle injury (DNBI)/battle injury (BI) rates and other medical factors that could affect operations, to include medical health threat identification (ID) and protective measures for health threats, their ID and associated countermeasures.

2. Rest, rotation, and reconstitution policies and procedures.

3. Prevention and protection measures and procedures, including immunizations, field sanitation and hygiene, veterinary services support, prophylactic countermeasures, and other risk management procedures.

4. HSS operations during the joint reception, staging, onward movement, and integration (JRSOI) phase of the joint force deployment process.

(13) Informs the CCDR concerning the status of and assistance required by and provided to the civilian populace, DOD civilian employees, DOD contract personnel, detainees, NGOs, and intergovernmental organizations (IGOs).

(14) Coordinates HSS provided to or received from allies, coalitions, HN military, or other friendly nations.

(15) Supervises the activities of the joint blood program office (JBPO) and coordinate support from the Armed Services Blood Program Office (ASBPO).

(16) Obtains Service specific casualty rates, including DNBI/BI rates, to model HSS force structure and casualty flow for the joint operation.

(17) Considers support for medical civil-military operations (MCMO).

(18) In conjunction with the staff judge advocate (SJA), provides the JFC with medical rules of engagement protocols recommendations.

(19) In conjunction with the combatant command SJA, provides advice and guidance to component surgeons and JTFs on the development of policies and procedures for detainee medical care.

(20) Establish a joint theater formulary.

(21) Establish a theater policy for medical materiel standardization.

1. The **Defense Logistics Agency (DLA)** is designated the DOD Executive Agent (EA) for medical materiel for the DOD pursuant to Department of Defense Directive (DODD) 5101.9. As the EA, the DLA will be the single DOD point of contact (POC) to:

(1) Synchronize planning and execution of end-to-end medical supply chain activities.

(2) Improve the ID and coordination of contingency medical materiel requirements.

(3) Provide financial resources necessary to achieve materiel readiness and end-to-end supply chain operation.

(4) Establish acquisition programs necessary to ensure availability of medical materiel to meet combatant command requirements.

(5) Establish, monitor, and report on medical supply chain performance.

(6) Coordinate medical materiel requirements and national-level acquisition programs with other federal agencies, including the Department of Veterans Affairs, Department of Health and Human Services, the Department of Homeland Security (DHS), and Federal Emergency Management Agency (FEMA).

m. The **Defense Medical Standardization Board (DMSB)**, under the direction, authority and control of the Secretary of Defense (SecDef), with policy guidance from the Office of the Assistant Secretary of Defense for Health Affairs, serves as an executive-level body responsible for enhancing Service medical department cooperation, interoperability, and operational flexibility, while promoting efficient HSS. The DMSB is the focal point for medical standardization within DOD.

(1) Includes the clinician-driven joint selection and standardization of medical materiel in support of the highest possible in-theater essential patient care during the initial two months of an armed conflict.

(2) Ensures the Services select medical materiel for joint core assemblages enabling maximum commonality, compatibility and interchangeability across the Services.

(3) Promotes peacetime use of the same medical materiel and equipment that joint clinicians have already chosen for wartime, with the goal of enabling medical materiel

compatibility to all Services in wartime that is consistent as possible with the Services' peacetime medical materiel.

(4) Guides joint service subject matter expert (SME) panels in the process of developing and maintaining jointly recommended medical materiel, grouped in medical materiel sets, for in-theater medical care.

(5) Recommends, as needed, standardization actions as well as exceptions to standardized solutions to the ASD(HA).

(6) Provides clinical and technical expertise in support of the procurement process by recommending strategies and services best able to satisfy the unique requirements of the individual Services.

(7) Serves as the clinical focal point and agency responsible for medical materiel quality assurance issues.

(8) Provides current clinical advice to combatant commands during contingency operations on the allocation and priorities of critical medical materiel assets, with input from specialty leaders/consultants of the Services, other federal agencies, and the industrial base.

(9) Participates as an advisor at Service in-process reviews of medical materiel development programs, including milestone decision reviews, to promote joint requirements and ensure appropriate standardization of medical materiel and supporting clinical policies and procedures before transition of an item to its procurement phase.

(10) Orchestrates joint operational testing and evaluation of commercially available medical equipment and materiel.

(11) Manages the DOD/Food and Drug Administration's (FDA's) Shelf-Life Extension Program for strategically important pharmaceuticals.

n. The **United States Transportation Command (USTRANSCOM)** is the DOD's single manager for policy and standardization of procedures and information support systems for global PM.

(1) Reviews and advises on all CCDR's planning requirements for PM and patient movement items (PMIs).

(2) Establishes Global Patient Movement Joint Advisory Board to identify, review, and direct corrective actions for PM, PMIs, and the supporting automated information systems across Service boundaries.

(3) Is the program manager for PMI system.

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CHAPTER II

JOINT TASK FORCE SURGEON'S OFFICE

"A soldier's health must come before economy or any other consideration."

Napoleon I

1. Introduction

a. To assist JFC's at each level in supervising their FHP responsibilities, a JFS is normally appointed for each combatant command, subunified command, and JTF. As the principal advisor to the JFC for HSS and FHP, the JFS normally reports directly to the JFC as a member of the personal staff (see Figure II-1).

b. This chapter however, will focus on the JTF level and address the formation of a notional JTF surgeon's office.

2. Joint Task Force Surgeon's Office

a. The JTF surgeon's office coordinates HSS and FHP matters for the JTF, under the leadership and guidance of the joint task force surgeon (JTFS). The JTFS's staff should be reasonably balanced in experience and rank among the Services concerned, and should be of sufficient size to effectively accomplish the following tasks:

(1) Joint coordination of HSS and FHP initiatives.

(2) Deployment health surveillance.

(3) HSS and FHP operations that sustains collaborative joint planning between combatant commands, Services, DOD agencies, NGOs, IGOs, and HN and allied participants as required.

(4) Standardization and interoperability of medical capabilities and materiel.

(5) Development of the HSS plan and COA analysis.

(6) Review of subordinate plans and operations.

(7) Joint coordination of intratheater PM.

(8) Reachback support.

(9) HSS planning and FHP operations to include:

(a) Medical care and treatment.

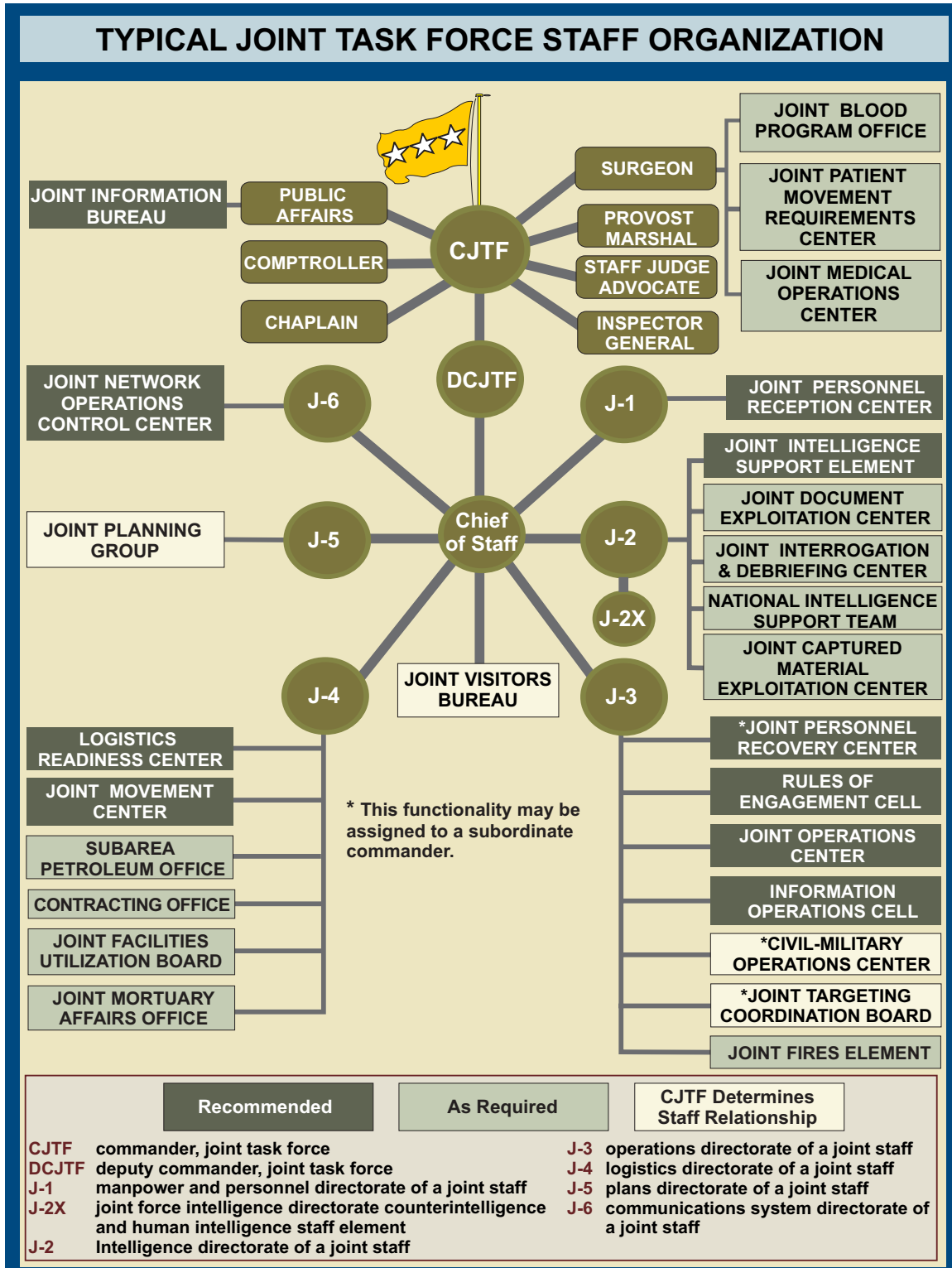


Figure II-1. Typical Joint Task Force Staff Organization

(b) FRC capabilities.

(c) PM (to include en route care).

- (d) Hospitalization (to include theater hospitalization capabilities).
- (e) Dental services.
- (f) Preventive medicine (to include force health protection against environmental, occupational, industrial, and operational health risk).
- (g) MIPOE.
- (h) Veterinary services.
- (i) Combat and operational stress control and mental health care services.
- (j) Health service logistic support.
- (k) Medical laboratory services.
- (l) Blood and blood product support.
- (m) Communications system support.
- (n) Health risk communications.
- (o) Return to duty (RTD).
- (p) Host-nation support (HNS) and/or United States Government (USG) agency support.
- (q) HSS for other than US forces.

(10) The collection of FHP lessons learned data that provides operational documentation that result in recommendations for change to current plans and policy.

(11) The implementation of programs and processes that promote and sustain a healthy and fit force, prevent injury and illness, protect the force from health threats, and deliver responsive health service support to the deployed force.

b. Working with the geographic combatant command surgeon, the JTFS assesses JTF HSS and FHP requirements and capabilities (both quantitatively and qualitatively), and provides recommendations to the commander, JTF (CJTF). The JTFS is normally a senior medical department officer from the Army, Navy, or Air Force. It is recommended they complete the JTF senior medical leader seminar. The responsibilities of the JTFS are similar to those of the geographic combatant command surgeon. **The JTFS should:**

(1) Expect to receive broad guidance and a general concept of medical operations from the geographic combatant command surgeon.

(2) Determine JTFS's office requirements, establishing and organizing the office, and preparing to deploy the section to conduct continuous (24 hour) operations.

(3) Assist CJTF with establishing specific JTF medical readiness requirements to include pre-deployment and FHP requirements; any requisite individual medical training to include safety, first aid, sanitation, health threats, and health protection measures including those related to chemical, biological, radiological, nuclear, and high-yield explosives (CBRNE) and environmental and/or industrial threats; and contingency contractors deploying with the force in the joint operations area (JOA).

(4) Advise the CJTF concerning the following:

(a) The health of the joint force such as DNBI/BI rates and other health factors that could affect JTF operations to include medical threat ID and protective measures.

(b) HSS and FHP aspects of joint operations.

(c) Rest, rotation, and reconstitution policies and procedures within the JOA.

(d) Prevention and protection measures and procedures, including immunizations, field sanitation and hygiene, veterinary services support, prophylactic countermeasures, and other risk management procedures.

(e) Health surveillance, including medical and occupational and environmental health surveillance.

(f) FHP operations during the JRSOI phase of the joint force deployment process.

(g) The treatment and evacuation of US and multinational forces (MNFs) personnel within the JOA.

(5) Establish priorities for actions within the JTFS's staff and identify HSS issues that are significant information reporting requirements.

(6) Determine requirements to establish, as a minimum an area joint blood program office (AJBPO) and a JPMRC. If a JPMRC is not established to provide management for both regulating and patient evacuation, direct liaison must be established with the theater patient movement requirements center (TPMRC) or the Global Patient Movement Requirements Center (GPMRC) and Service PM components.

(7) Ensure that JTF HSS and FHP planning:

(a) Identifies and provides appropriate HSS resources and infrastructure that supports the CJTF's concept of operations (CONOPS) at the operational and tactical levels.

(b) Provides the CJTF a healthy and fit force, prevent casualties, and manage and effectively care for casualties and the total delivery of responsive HSS to the deployed force.

(c) Provides essential care of the injured and ill in the JOA and their rapid evacuation to definitive medical care.

(d) Provides for prescription refills of maintenance medications within the JOA.

(e) Identifies joint deficiencies and risks, and develops joint alternative COAs to address shortfalls.

(f) Conducts HSS operations in a uniform manner that promotes collaborative planning between JTF components, DOD and other USG agencies, and appropriate NGOs and IGOs, HN and allied participants, and builds on collaborative strengths.

(g) Considers as functional HSS categories for JTF planning: PM, blood program, hospitalization, FRC capabilities, HSS for other than US forces, RTD, medical logistics, FHP, and preventive medicine, dental services, veterinary services, combat and operational stress control, medical communications system and intelligence, and HNS or other US Federal agency support.

(h) Considers support for MCMO.

(8) Ensure membership and required medical liaison relationships to appropriate JTF boards, centers, cells, groups, and teams.

(9) In conjunction with the JTF SJA, provide the CJTF with medical engagement protocol recommendations.

(10) Assist component commands in identifying HSS and FHP requirements and assign cross-Service support where practical; conduct liaison with each component surgeon to ensure HSS and FHP support is provided and maintained.

(11) Establish the JTF operational area FHP, HSS and PM plan, and ensure efficient and effective interface of the theater and strategic AE systems through the JPMRC.

(12) Monitor medical regulating and PM activities of the JPMRC and ensure procedures are established to provide patient in-transit visibility information to the manpower and personnel directorate of a joint staff (J-1).

(13) Assist the CJTF in formulating a recommended PM policy within the JOA and monitor evacuation requirements.

(14) Evaluate and characterize the occupational and environmental health threats in JOA and make recommendations for countermeasures to control or reduce occupational and environmental health, and safety threats that may impact personnel health or mission objectives.

(15) Advise the CJTF on the medical analysis of the COAs and the medical estimate based on the integration of all health and safety risk assessments.

(16) Integrate health risks with other operational risks using risk management principles to reduce the impact on JTF missions and personnel during joint operations.

(17) Communicate risks on health and safety including protective countermeasures and other topics such as use of chemoprophylaxes, sanitation, and first aid to JTF personnel in the JOA (to include all military personnel, essential DOD civilian, and contractor personnel who directly support deployed forces).

(18) Establish HSS and FHP procedures for operations in a CBRN environment to include recommending the theater PM policy of contaminated patients.

(19) Provide MIPOE to the JTF intelligence directorate of a joint staff (J-2) for inclusion in the joint intelligence preparation of the operational environment (JIPOE).

(20) Provide preventive medicine support and information on cultural issues relevant to interactions with HN medical systems; and participate in the selection of bed-down locations.

(21) Provide guidance for development of medical annexes to joint plans, HSS estimates, and patient estimates based on casualty planning factors.

(22) Coordinate with all other medical support activities in the JOA that may play a role in the mission to ensure unity of effort. These may include NGOs, IGOs, multinational medical units, HN medical assets, and other USG agencies and activities/interest in the public health sector.

(23) Coordinate all FHP and deployment health surveillance and readiness pre-deployment, deployment, employment, and redeployment activities and tasks.

(24) Be aware of the presence of special operations forces (SOF) within the JOA and provide HSS and FHP as required.

(25) Ensure appropriate medical care is provided for civilians, contractors, allied military personnel, and detainees per mission requirements, established medical engagement protocols, DOD policy, contractual obligations, or applicable national agreements.

(26) Plan for providing support in the prevention and treatment of stress.

(27) Monitor mass casualty (MASCAL) plans for the JOA.

- (28) Plan for support to personnel recovery operations.
- (29) Coordinate disaster relief/humanitarian assistance (HA) augmentation, and provide HSS support to civil affairs (CA) forces as required.
- (30) Recommend the task organization of HSS units to satisfy all JTF mission requirements; and monitor the availability of, and recommend the reassignment and utilization of HSS assets in the JOA.
- (31) Determine, in conjunction with the JTF SJA and the chain of command, the eligibility for medical care in JTF medical treatment facilities (MTFs).
- (32) Maintain situational awareness by coordinating HSS information with the geographic combatant command surgeon, component surgeons, JTF HSS units, allied and coalition surgeons, and other agency medical support personnel as required.
- (33) Coordinate HSS consultation services for the JTF to include telemedicine as required.
- (34) Evaluate and interpret medical statistical data.
- (35) Recommend policies, and determine requirements and priorities for HSS logistics to include blood and blood products, medical supply and resupply, and medical equipment maintenance and repair services.
- (36) Ensure that medical records are established and maintained on patients that are treated at JTF MTFs.
- (37) Ensure a dental capability is established as required by the mission.
- (38) Ensure a pharmacy capability is established as required by the mission.
- (39) Ensure a viable veterinary program is established as required by mission requirements.
- (40) Ensure a medical laboratory capability is established for the ID and confirmation of the use of suspect biological and chemical weapons agents against JTF forces as required by mission requirements.
- (41) Ensure individual informed consent is established prior to the administration of investigational new drugs used as a countermeasure for endemic diseases in the JOA or to protect JTF forces against possible CBRN weapons.

(42) Ensure communications equipment compatibility, standardization of radio frequencies, reports formats, treatment protocols, and requirements for equipment with allied, coalition, and multinational HSS units, and other USG agencies when appropriate.

(43) Ensure the development and distribution of a standardized operational and medical terminology reference guide to facilitate the synchronization of HSS efforts, and minimize misinterpretation with multinational HSS units.

(44) Promote and improve the health of the joint force through programs on injury prevention, dental health, good nutrition, tobacco use prevention and cessation, physical fitness and weight control, responsible sexual behavior, stress management, suicide prevention, alcohol and drug abuse prevention, and other health initiatives.

(45) Capture and apply operational and medical lessons learned.

(46) Attend CJTF and chief of staff (COS) director's planning meetings and briefings, as required.

(47) Ensure that the appropriate functions of HSS and FHP are integrated into the JTF battle rhythm.

(48) Ensure that medical modeling and simulation tools are used to tailor medical force structure to tactical missions during the deployment when available, and employ software to maintain a medical common operational picture (COP) as an overlay to the warfighter COP.

(49) In conjunction with the JTF operations directorate (J-3) and J-4, ensure that HSS, either as a responsibility of the contractor or the CJTF is fully delineated in operation plans (OPLANs), operation orders (OPORDs), and contracts to assure appropriate medical staffing for contractors deploying with the force (CDF) in the JOA.

(50) Establish a theater health surveillance capability to monitor disease and environmental hazards, carry out significant event epidemiological investigations, coordinate activities of in-theater laboratory and support assets, provide related-support to units, assist with documenting in medical records environmental and occupational monitoring results and exposure diagnoses, and communicating health risks.

(51) In conjunction with the JTF SJA and geographic combatant command JFS, develop JTF policies and procedures for detainee medical care to include:

(a) Ensuring that the medical annex of OPLANs, OPORDs, and contingency plans includes procedures for the treatment of all detainees. Medical support should specifically include: emergency and essential care that provides for restoration of functional health and all sanitary aspects of food service including provisions for potable water, pest management, and entomological support, preventive medicine (to include immunizations as directed and established by applicable policies), professional medical services and medical supply; reviewing,

recommending, and coordinating the use and assignment of medically trained detainees and medical material; and establishing policy for the medical repatriation of detainees.

(b) Tasking subordinate MTFs/units to support detainee operations and provide medical care that focuses upon emergency surgery and essential postoperative management to prevent probable death or loss of limb or body functions; essential care that provides for the restoration of functional health; higher medical care as required (including dental and optometry); isolation areas (for contagious disease) if necessary, and routine sick call at the JTF strategic detention facility.

(c) Ensuring that the appropriate health care providers are available to address the health care needs of female detainees.

(d) Ensuring the provision of separate hygiene facilities and supplies in any facilities in which female detainees are accommodated.

(e) Ensuring the provision for an initial medical screening of detainees that includes an examination and documentation of the detainee's physical condition upon initiation of detention, and the examining of detainees for contagious diseases (to include chest radiograph and tuberculin skin test).

(f) Ensuring that medical screening of detainees is conducted monthly, to monitor the general state of health, nutrition and cleanliness of detainees, and to detect contagious diseases. Monthly screenings should include documentation of the weight of each detainee.

(g) Ensuring that preventive medicine inspections are conducted at the JTF detention facility.

(h) Ensuring the establishment of a medical record for each detainee and that copies of that record shall accompany the detainee whenever they are transferred to another facility or released.

(i) Recommending to the CJTF an immunization policy for detainees as dictated by disease health threat.

(j) Ensuring that detainee repatriation and release procedures include a full physical prior to release or transfer, instructions for the use of prescribed medications, a supply of medications, and that all appropriate medical and dental records accompany the detainee.

(k) Ensuring that health care providers charged with any form of assistance with the detainee interrogation process, to include interpretation of medical records and information, are prohibited from any aspect of detainee health care.

(l) Developing plans for prisoners on a hunger strike or who refuse treatment.

(m) Ensuring that detainees evacuated to a JTF MTF for treatment is escorted by an armed guard as designated by the CJTF. The guard must remain with the patient while in the MEDEVAC and treatment chain.

(n) Ensuring that experimental research is not conducted on detainees.

(o) Ensuring that physical security is provided by nonmedical personnel as designated by the CJTF.

(p) Establishing procedures to obtain signed permission for all surgical or invasive procedures performed on detainees.

3. Organizing the Joint Task Force Surgeon's Office

a. The JTFS's office must be adequately staffed and task organized to support the mission of the JTF and possess the requisite expertise to effectively manage the functional areas shown in Figure II-2. Some considerations for determining the functions required by the staff include:

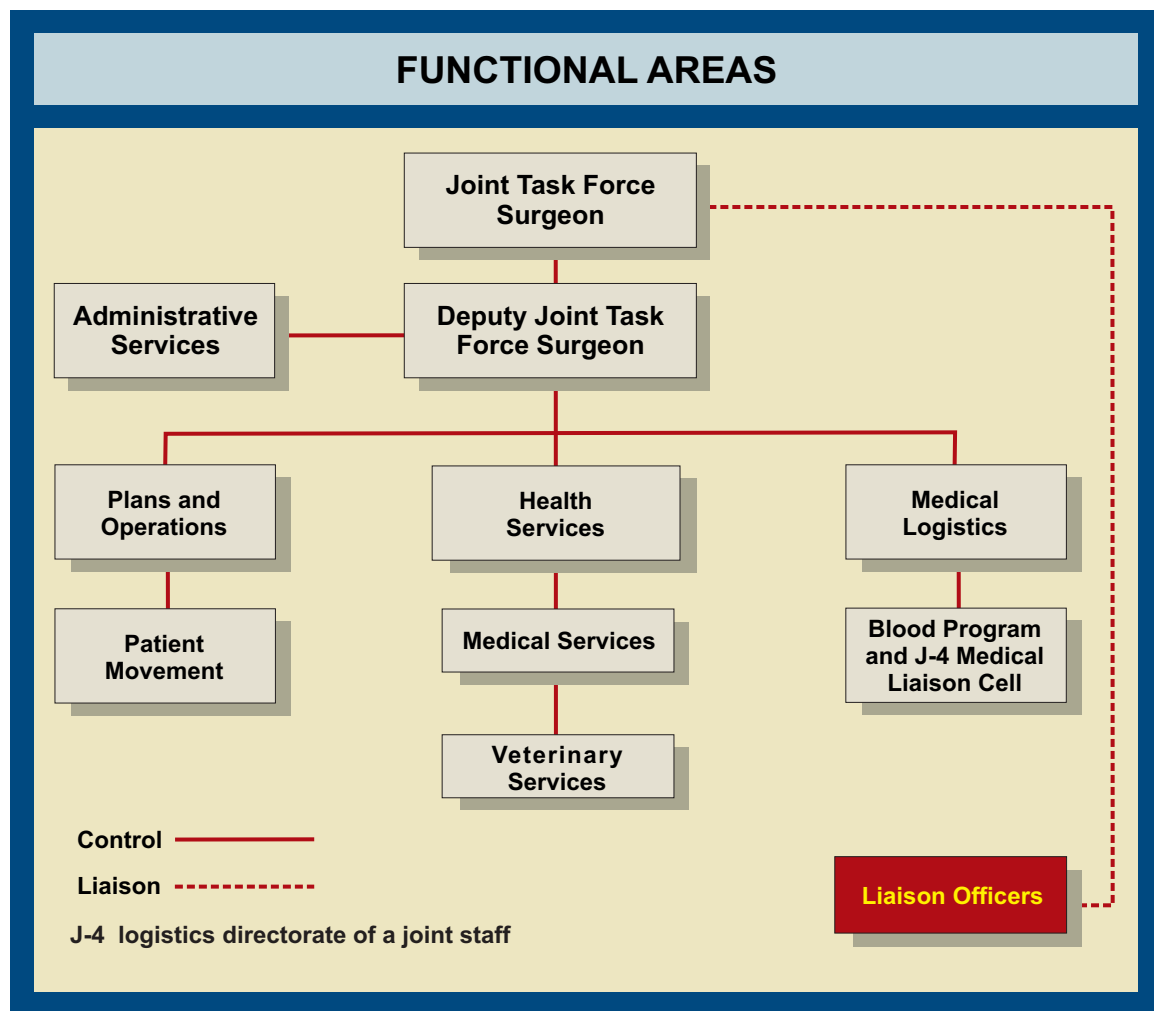


Figure II-2. Functional Areas

- (1) The mission of the JTF.
- (2) HSS forces assigned.
- (3) The amount of time required to plan and form the staff.
- (4) The anticipated health threat (including CBRN exposures).
- (5) Specialists required.
- (6) Size of the workspace (on a ship, in tents, in a building).
- (7) Environmental factors (tropical, mountainous, desert, arctic).
- (8) HN/multinational support.

b. Some of the positions the JTFS may require to staff the JTFS's office are provided below. Some of the functions of these positions can be combined as necessary and appropriate. Typical staff positions include:

- (1) Deputy surgeon.
- (2) Medical operations officer.
- (3) Senior medical operations noncommissioned officer (NCO)/chief petty officer (CPO).
- (4) Medical plans officer.
- (5) Environmental science officer (ESO)/environmental health officer (EHO).
- (6) Industrial hygiene officer (IHO)/bioenvironmental engineer (BEE)/sanitary engineer.
- (7) Medical intelligence officer.
- (8) Area joint blood program officer.
- (9) PM (evacuation) officer.
- (10) Medical logistics officer.
- (11) Preventive medicine officer/public health officer/public health nurse.
- (12) Veterinary services officer.

(13) Liaison officers (LNOs) (to include multinational liaison, IGO/NGO LNOs, and HN LNOs).

(14) International health officer.

(15) Administrative staff.

c. The JTFS's office may be organized in many different ways. One example is shown in Figure II-3 and is used for illustrative purposes only. The mission of the functional areas and duties of the staff include:

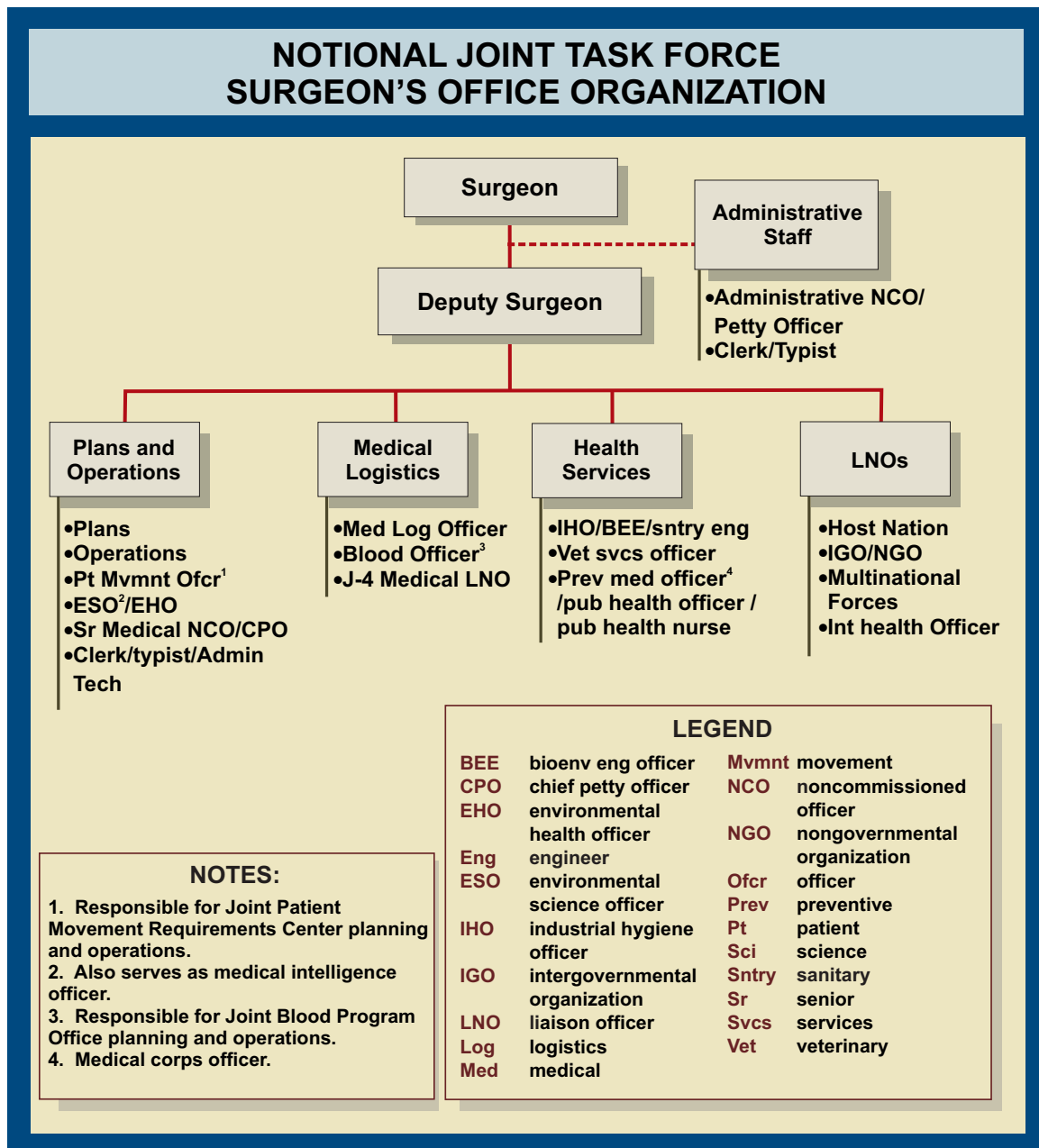


Figure II-3. Notional Joint Task Force Surgeon's Office Organization

(1) The **deputy joint task force surgeon (DJTFS)** is normally a senior medical planner from the Army, Navy, or Air Force. It is recommended they complete the joint medical planner's course and the JTF senior medical leader seminar. The role of the DJTFS is often seen as one of filling in the "gaps" when the staff requires specific detailed guidance, facilitating JTFS's staff actions that support the CJTF, serving as the JTFS in the absence of the incumbent, and providing and reinforcing the JTFS's guidance and intent. Specific responsibilities of the DJTFS may include:

(a) Assisting the JTFS with:

1. Determining office manning, equipment, and transportation requirements.
 2. Developing guidelines for types of medical supplies needed, supply procedures, stockage levels, sizes and location of medical supply installations, and medical equipment maintenance support.
 3. Assigning responsibilities to individual sections or individuals as appropriate, to include the assignment of liaisons to the JTF J-4, civil-military operations center (CMOC) as required, joint civil-military coordination board as required, humanitarian assistance survey team (HAST) as required; joint interagency coordination group and membership duties to the joint planning group (JPG) and other JTF organizations as required.
 4. Maintaining oversight on the implementation of JTFS's policies/procedures.
 5. Supervising augmentation medical teams, as required.
 6. Ensuring that the appropriate training is conducted for JTFS's staff .
 7. Maintaining a master policy file and monitoring the JTFS's office standard operating procedures (SOP).
 8. Monitoring JTFS's staff actions and functions to ensure compliance of assigned taskings (to include common administrative tasks).
- (b) Supervising the plans and operations section of the JTFS's office and the development of HSS and FHP plans.
- (c) Keeping the JTFS informed on the status of HSS and FHP throughout the JTF by monitoring the status of patient beds, evacuation requirements, joint blood program, medical logistics, veterinary support and food safety service programs, dental services, and deployment health surveillance and preventive medicine programs.
- (d) Forming, organizing, and supervising appropriate JTFS medical boards, offices, and cells as required.

- (e) Supervising the development of Annex Q, “Medical Services,” of the OPLAN.
- (f) Compiling reports reflecting the overall medical readiness of the JTF.
- (g) Performing JTFS duties when directed.
- (h) Establishing the JTFS’s staff daily operations cycle or “battle rhythm.”
- (i) Coordinating and managing the JTFS’s office daily battle update assessment meeting.
- (j) Coordinating with the JTF COS to ensure that the appropriate functions of HSS and FHP are integrated into the JTF battle rhythm.
- (k) Serving as chief, joint medical operations center (JMOC) as required.
- (l) Serving as member, JPG, and joint medical working group (JMWG) as required.

(2) **The plans and operations section** is the focal point for all HSS operational matters within the JTFS’s office. Its primary functions are to plan and develop the HSS infrastructure to protect the health of JTF forces; mitigate the effects of illness and injury within the JOA, and serve as the hub for achieving HSS situational awareness by establishing a JMOC for information management and the facilitation of HSS synchronization. Staffing may include medical operations/plans officers, PM (evacuation) officer, ESO or EHO, and senior medical operations NCO or CPO.

- (a) The medical operations/plans officers should:
 - 1. Develop HSS plans.
 - 2. Ensure that appropriate health care is provided for civilians, allied/coalition military personnel, enemy prisoners of war (EPWs), and detainees, per applicable agreements.
 - 3. Supervise integration and use of medical augmentation teams.
 - 4. Develop the MASCAL treatment and evacuation plan.
 - 5. Coordinate the provision of medical intelligence to the JTF.
 - 6. Coordinate disaster relief and foreign humanitarian assistance (FHA) medical augmentation, as required.
 - 7. Coordinate establishment of a layered medical communications network among component medical units with the JTF communications system directorate (J-6), with consideration for interoperability with multinational HSS partners.

8. Establish medical communication requirements with the JTF J-6.
9. Input medical estimates into simulation models when conditions allow.
10. Plan for telemedicine support capabilities that are not currently organic to component medical units.
11. Determine tactical and strategic information requirements and POCs.
12. Serve as a member of the JPG and JMWG as required.
13. Serve as chief or member of JMOC as required.
14. Be prepared to serve as a member of the advanced echelon (ADVON) team and HAST as required.
15. Coordinate support requirements with the J-4 and component logistic planners as well as the HSS planners to ensure synchronization of support requirements of general supply and services as well as medical supplies.

(b) The PM (evacuation) officer should:

1. In coordination with the GPMRC, organize and operate the JPMRC.
2. Provide oversight of the JPMRC in their role of directing the medical regulating and PM activities within the JOA, coordinate the movement of patients, and track hospitalization in the JOA.
3. Maintain visibility of joint and multinational MTFs, TPMRC, component commands, GPMRC, and transportation agencies to facilitate patient flow and optimum use of hospitalization and evacuation assets.
4. Designate treatment facilities within the JOA to receive patients based upon medical regulating report.
5. Coordinate with TPMRC/GPMRC to obtain continental United States (CONUS) bed designations for patients who will not be returned to duty within the theater PM policy.
6. Serve as patient administration liaison to patient administration departments/sections of component and coalition MTFs.
7. Obtain reports from component and coalition MTFs to consolidate requests for movement of patients out of the JOA.

8. Advise the JTFS on a daily basis of specialty bed availability throughout the JOA, and on capabilities and limitations of supporting PM resources.

9. Maintain a database of beds available by type within the JOA and cross match patients to the MTF with the capability and capacity for the type of care required.

10. Assist the JTFS with the development and dissemination of theater PM procedures and guidance.

11. Serve as the JPMRC in the JOA until one is established.

12. In concert with the JTF J-4 and TPMRC, develop procedures to transfer patients from the US medical regulating system into the HN's MEDEVAC or hospitalization system as required.

13. Monitor multinational and component MTF bed availability.

14. Maintain visibility of individual patients within the JOA from initial hospital admission to disposition.

15. Ensure a functional USTRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES) for tracking patients in the evacuation system.

16. Develop procedures with the JTF J-1 for mutual exchange of information.

17. Serve as a member of JMOC and JMWG.

(c) The **ESO/EHO** should:

1. Prepare preventive medicine and medical intelligence/threat estimate and annexes of JTF OPLANs/OPORDs, ensuring that medical intelligence requirements are included in the appropriate annexes.

2. Provide the JTFS with recommendations on policies, force structure, and priorities for use of preventive medicine resources.

3. Plan, monitor, and supervise preventive medicine operations, to include:

a. Air, water, and soil sampling strategies.

b. Waste control and management.

c. Prevention and control of DNBIs.

d. Vector control and management.

e. Distribution and/or administration of force health protection prescriptive products, chemoprophylaxis, barrier creams, and immunizations.

f. Health surveillance to include medical and occupational and environmental health (OEH) surveillance.

g. Food and potable water services.

4. Maintain the preventive medicine staff journal and ensure that incoming and outgoing messages, correspondence, and significant activities are logged, and receive preventive medicine reports, highlighting significant trends.

5. Monitor preventive medicine personnel, units, and equipment within the JOA.

6. Maintain preventive medicine overlay by coordinating with the force health protection section, preventive medicine detachments, and special teams.

7. Advise the JTFS on a daily basis of preventive medicine activities throughout the JOA.

8. Provide the JTFS with recommendations on policies regarding the sanitation of all aspects of food service from procurement and transportation to disposal.

9. Serve as the medical intelligence officer.

10. Coordinate with the JTF J-2 to provide MIPOE input to the JIPOE.

11. Provide the JTFS and subordinate HSS units with situational awareness regarding the health threat of exposures to CBRN agents and OEH threats.

12. Serve as a member of JMOC.

13. Be prepared to serve as a member of JMWG, ADVON team, and HAST as required.

14. Assist in the development and delivery of health risk communications messages to Service members and commanders.

(d) The medical operations/plans NCO/CPO should:

1. Assist plans and medical operations officers with collection and evaluation of medical reports, and development and coordination of appropriate actions.

2. Establish equipment/maps for current and future operational planning.

3. Maintain the daily staff journal and ensure all incoming and outgoing messages and correspondence, significant events and actions are logged.

4. Maintain all plans and operations maps/overlays/supplies. Prepare briefing slides as required.

5. Coordinate with specific Service component for medical support/augmentation as required.

6. Serve as member of JMOC.

(3) **The medical logistic section** is the central point for HSS logistics within JTFS's office. Its primary function is to plan, develop, and coordinate the medical logistic infrastructure and support for the JTF. Staffing may include a joint medical logistics officer (JMLO), an area joint blood program officer, and a JTF J-4 medical liaison officer.

(a) The JMLO should:

1. Prepare medical logistic estimates and the logistic portion of Annex Q to JTF OPLANs.

2. Review and evaluate medical reports to determine the availability of Class (CL) VIII, and determine if action is required.

3. Develop and coordinate recommendations as necessary and present to the JTFS for approval.

4. Prepare and coordinate draft messages/correspondence and present to the JTFS for approval and release.

5. Maintain contact with each component surgeons' logistics section.

6. Assist JMOC with logistics issues, and with other issues/actions as required.

7. Interface with the theater lead agent for medical materiel (TLAMM) and/or the theater medical logistic management center (TMLMC) and JTF J-4 medical liaison as required.

8. Coordinate transportation for medical units, personnel, supplies, and equipment with the JTF J-4 medical liaison; if a JTF J-4 medical liaison is not available, coordinate with the joint deployment distribution operations center (DDOC) and JTF J-4.

9. Monitor availability and operational readiness of critical CL VIII (major end item) equipment as determined by JTFS.

10. Assist JTF HSS units with maintenance and repair of medical equipment as required.

11. Monitor status and availability of medical CBRN equipment.

12. Serve as supply officer for the JTFS's office and acquire material/equipment through the supply system or local purchase as required.

13. In coordination with the ESO/EHO, medical plans and operations section, and JTF J-4, identify available sites within the JOA to set up joint treatment facilities.

14. Maintain liaison and communications with the EA and LA for medical logistics, and the geographic combatant command medical logistics officer.

15. In coordination with the JTF J-4, maintain a listing of foreign sources of supply for consideration to reduce strategic lift, improve the range of items available, and shorten order fulfillment times; and coordinate contracts required for HN medical support.

16. Be aware of Service CL VIII capabilities, limitations, tactics, techniques, procedures, personnel, and equipment sets.

17. Implement policies and procedures for the removal of medical wastes with the JTF J-4.

18. Identify and monitor required medical and dental supplies and sourcing, stockage levels, distribution, resupply, and maintenance.

19. Facilitate joint use of health care services and facilities.

20. Serve as a member of JMOC.

21. Serve as a member of the JMWG.

22. Review any applicable performance-based agreements (PBAs) which effect medical logistics operations.

(b) The **JBPO** should:

1. Manage the joint blood program for the JTF.

2. Coordinate, monitor, and ensure component blood programs, blood product requirements, and capabilities within the JOA are managed and maintained IAW FDA guidelines/requirements.

3. Form, organize, and operate the AJBPO.
4. Brief the current JTF blood status as required.
5. Prepare CONOPS and the joint blood program portion of Annex Q to JTF plans and OPORDs.
6. Advise the JTFS regarding management, policies, and procedures for handling blood and blood products.
7. Coordinate blood distribution for and between component Services within the JOA.
8. Monitor JTF blood status through the daily blood report (BLDREP).
9. Establish procedures and publish instructions for disposal or destruction of excess and outdated blood.
10. Maintain liaison with the blood supply units (BSUs), blood transshipment centers/transportable blood transshipment centers (BTCs/TBTCs) and the JBPO at the combatant command surgeon's office for reporting and coordination purposes.
11. Plan the handling, storage, and distribution of blood components within JOA.
12. Consolidate and forward requirements for resupply of blood products to the JBPO based on JTFS's guidance.
13. Serve as single manager for blood products in the JOA.
14. Assess need for AJBPO.
15. Assist the JTFS with the development and dissemination of JOA blood management policies, procedures, and guidance.
16. Compile area BLDREPs and forward as appropriate.
17. Be prepared to serve as a member of JMWG as required.

(c) The JTF J-4 medical liaison should:

1. Serve as a conduit from the JTFS to the JTF J-4 in support of HSS requirements as they relate to logistics, to include: contracting, engineering, transportation, medical supplies, and personnel services.

2. Represent the interests and requirements of the JTFS during JTF J-4 logistical requirements deliberations.
3. Maintain liaison and communication with the JTF J-4.
4. Collaborate with the JTF J-4 in defining requirements for medical materiel within the JOA.
5. Coordinate and integrate CL VIII requirements into the joint operation planning and execution processes.
6. Be aware of policies associated with PMIs, including biomedical maintenance considerations, asset accounting, exchange procedures, and other issues.
7. Be aware of Service CL VIII capabilities, limitations, tactics, techniques, and procedures, including organization, personnel, and equipment sets.
8. Advise the JTFS on all CL VIII planning and Joint Operation Planning and Execution System (JOPES) requirements.
9. Provide medical logistic support requirements input to the HSS logistics support estimate and plan.
10. Work with the JTF J-4 transportation operations officer and medical representative in the DDOC to plan and coordinate transportation resources to support HSS priorities and CONOPS.
11. Provide input to the JTF J-4 sustainment plans officer regarding medical sustainment requirements; ensure distinctions between critical, routine, and special handling medications and supplies are identified and properly processed.
12. Advise the JTFS on the conduct and execution of HSS logistics.
13. Evaluate current HSS logistic operations.
14. Maintain liaison with JMOC, Service components, commands, activities, and agencies supporting the joint force including the EA and LA.
15. Monitor the status/location of HSS units as they move into, within, and out of the JOA.
16. Coordinate health service logistic activities with the geographic combatant command and Service component materiel/resource managers.

17. Maintain thorough knowledge and understanding of JTF OPLANs, OPORDs, and component and supporting forces concepts of operations/support.

18. Assist the JTF J-4 with conducting HN/allied liaison to assess capabilities and availability of critical HSS resources.

19. Assist the JTFS and JTF J-4 with recommending sizes and locations of health service logistic organization and installations required, types of medical supplies needed, supply procedures to be followed, stock levels to be maintained, and medical equipment maintenance procedures.

20. Ensure the accuracy and clarity of health service logistic status reports, information, and statistical data for presentation to the CJTF.

21. Plan and coordinate medical maintenance support, redeployment, and reconstitution of assets in theater.

22. Coordinate support of medical material from foreign sources and support provided by HN and coalition partners as required.

23. Serve as a member of the JMWG.

24. Review any applicable PBAs which effect medical operations.

(4) **The force health protection section** is responsible for ensuring a vigorous and comprehensive joint force health protection program within the JTF. Its primary function is to assist the JTFS and component surgeons with establishing policies and procedures to deliver a healthy and fit force, prevent casualties, and maintain the health of the JTF while deployed. Staffing may include an IHO/BEE sanitary engineer, veterinary services officer, or public health officer/public health nurse.

(a) The IHO/BEE should:

1. Assist JTFS in employing risk management principles for managing health risks to enhance mission effectiveness during joint operations.

2. Obtain and maintain medical intelligence and identify and assess health threats.

3. Evaluate and characterize OEH threats and recommend control measures to eliminate or reduce the risks in JOA. Ensure the completion preliminary food/water vulnerability assessments, initial health risk assessments, and preliminary hazard assessments for basing locations. Communicate the health risks and impact on the mission to the JTFS.

4. Collaborate with geographic combatant command surgeon's force health protection officer to assist the JTFS with establishing pre-deployment and post-deployment guidance.
5. Using risk management principles, evaluate the health threat controls being used in the operational environment to ensure they are adequately controlling the risks. Provide an analysis to JTFS.
6. Provide the JTFS with recommendations on policies, force structure, and priorities of effort for sanitation, entomological, and sanitary engineering resources.
7. Assist the ESO/EHO in monitoring preventive medicine and environmental operations.
8. Provide technical consultative support on medical issues related to CBRN casualty care, to include development of plans for MASCAL operations.
9. Establish and foster liaison relationships to include, but not limited to: the JTF J-2, J-3, AFMIC, Centers for Disease Control and Prevention (CDC), Defense Threat Reduction Agency, US Marine Corps Chemical Biological Incident Response Force, US Army Research, Development, and Engineering Command, Armed Forces Radiobiological Institute, US Army Medical Research Institute of Infectious Disease, and the US Army Medical Research Institute for Chemical Defense, and NGOs, IGOs, USG agencies, civilian, and multinational personnel as required to facilitate support to civil-military operations (CMO).
10. Collaborate with geographic combatant command surgeon's FHP officer and CBRN medical experts to provide the JTFS with procedures for HSS operations in a CBRN environment.
11. Serve as the JTFS's FHP officer.
12. Communicate health risks and countermeasures for the JOA to deploying personnel and to redeploying personnel and their health care providers.
13. Develop occupational and environmental monitoring data summaries and ensure that any environmental or CBRN exposures to JTF personnel are appropriately documented in their medical records.
14. Be prepared to serve as a member of JMOC, JMWG, ADVON team, and HAST as required.
15. Incorporate a deployment health surveillance plan and readiness requirements and a theater medical surveillance capability into Annex Q.

16. Establish procedures to submit OEH surveillance data and reports to the JTF and the US Army Center for Health Promotion and Preventive Medicine (USACHPPM).

(b) The veterinary services officer should:

1. Prepare the concept of veterinary operations to the FHP portion of Annex Q to JTF OPLANs/OPORDs.

2. Provide the JTFS with recommendations on veterinary operations to include policies, force structure, and priorities for use of veterinary resources.

3. Provide the JTFS with advice and procedural recommendations for the control of existing or anticipated animal and zoonotic diseases that may be of significance for human disease prevention, for food production interests, or as bioterrorism threats.

4. Plan, monitor, and supervise veterinary operations, to include the inspection of food and food sources, control of animal and zoonotic diseases of military significance, food quality control system for source establishments supporting the theater, standards and levels of veterinary care and treatment of military animals to include medical and surgery support as required, treatment of animals other than military-owned animals as required, import laws and regulations of foreign countries, food recall procedures for all subsistence items in the JOA, and the care of military working dogs (MWDs).

5. Maintain liaison with veterinarians of higher headquarters (HQ), those of US, multinational, and foreign government agencies, the JTF J-4 medical liaison, the JTF J-4 contracting officer, and JTF food service officer.

6. Provide the JTFS with recommendations on policies regarding the sanitation of all aspects of food service from procurement and transportation to disposal.

7. Advise the JTFS on foreign animal diseases that may affect redeployment of military equipment back to CONUS or allied nations and coordinate with the appropriate governmental agencies as required.

8. Investigate claims concerning injury or death of indigenous animals resulting from military operations as appropriate.

9. Provide guidance on decontamination procedures for US-owned equipment retrograding to CONUS and allied nations to prevent the transmission of animal diseases.

10. Conduct staff visits and inspections of JTF component veterinary facilities and units.

11. Serve as a member of JMOC.

12. Be prepared to serve as a member of the JMWG, ADVON team, and HAST as required.

(c) The preventive medicine officer/public health officer should:

1. Provide the JTFS with medical knowledge management and the evaluation and interpretation of medical statistical data.

2. Triage and screen medical indicators of exposure through baseline level changes.

3. Provide population health support to the JTF.

4. Assist the JTF FHP officer with designing and developing pre-deployment and post-deployment guidance.

5. Provide available health risk assessment information to redeploying units and their health care providers.

6. Assist the JTF FHP officer with establishing procedures for reporting DNBI, reportable medical events, OEH surveillance data, and documenting all JTF personnel exposure to CBRN elements.

7. Be prepared to provide education and counseling to a targeted civilian populace regarding health maintenance and promotion, and disease prevention during HA and CMO.

8. Be prepared to collaborate with other JTF HSS personnel and assess the physical, psychosocial and health care status of a targeted civilian populace (to include displaced civilians) and develop a health maintenance and wellness plan of care during HA and CMO.

9. Be prepared to serve as a member of JMOC, JMWG, ADVON team, and HAST as required.

(5) **The JTFS administrative staff** provides administrative, planning, individual training, and personnel support services to the JTFS and staff. The administrative staff may comprise of an administrative NCO or CPO and a clerk typist. **The administrative staff** should:

(a) Provide word processing, graphics, and automated services and computer support for briefings and situation reports.

(b) Establish equipment and supplies for the surgeon's office.

(c) Establish a filing system and a message-processing section.

- (d) Ensure the receipt and distribution of required reports as directed by the JTFS.
- (e) Coordinate interface and liaison support to the JTF special staffs and JTF directorates as required by the JTFS.
- (f) Assist with the input of medical estimates into simulation models when conditions allow.
- (g) Receive and review all messages and correspondence leaving the JTFS's office on computer disk or hard copy; check spelling, format, and print final copy.
- (h) Coordinate and verify message traffic format with the JTF J-6 message center.
- (i) Be prepared to serve as a driver or alternate as required.
- (j) Be prepared to serve as a mail clerk or alternate as required.
- (k) Ensure that classified messages are placed only on designated computers.
- (l) Supervise daily staff journal operations and ensure all incoming and outgoing messages, correspondence, and significant events and actions are logged appropriately.
- (m) Be prepared to support the JMOC.

(6) **LNO section's** primary functions are to monitor, coordinate, advise, and facilitate multinational HSS contributions. Medical LNOs provide the JTFS with the capability of monitoring and synchronizing current and future multinational HSS operations; foster effective coordination between coalition HSS staffs, and advise the JTFS regarding the optimal utilization of coalition HSS capabilities. Staffing may include an international health specialist (IHS), HN HSS LNO, MNF HSS LNO, USG LNO, and/or an IGO/NGO LNO.

(a) **The IHS** provides effective HSS liaison support by combining cultural and linguistic proficiency with regional medical expertise, and fosters partnerships with military, civilian, and multinational and USG personnel. As the medical LNO on the JTFS staff, the **IHS** should:

1. Monitor and evaluate the health care infrastructure and medical resources within the JOA.
2. Advise the JTFS on civilian and interagency HSS capabilities and limitations within the JOA.
3. Establish communications and a partnership with local HSS resources in the JOA.



Members of the 86th Combat Support Hospital provide emergency medical care in a climate-controlled temper tent at Camp Udairi, in northern Kuwait.

4. Be prepared to provide technical expertise and assistance in identifying and assessing foreign national public and private health systems, sanitation systems, health services, personnel, resources, and facilities.

5. Establish and foster working relationships with key NGOs, IGOs, USG agencies and multinational medical forces.

6. Be prepared to exchange advice and assistance with foreign nationals, IGO, NGO, and USG and multinational agencies in preventing, controlling, and treating diseases through education, immunizations, and sanitation support.

7. Be prepared to assist with, and when necessary conduct assessments and area studies of public health system needs as required.

8. Be prepared to facilitate communications with foreign national government and private health resources for CMO, and in support of government administration.

9. Assist with mission planning on military medical interaction with civilians and medical units.

10. Be prepared to provide expertise in political, economic, and social factors support to medical planning by identifying potential opportunities for medical CMO, HA,

humanitarian and civic assistance (HCA), humanitarian assistance program-excess property (HAP-EP), and other related programs.

11. Assist with transition operations to relinquish military run medical operations back to civilian authorities.

12. Be prepared to serve as a liaison to the CMOC.

13. Be prepared to serve as a member of JMOC, JMWG, ADVON team, and HAST as required

(b) HN and MNF HSS LNOs should:

1. Monitor, coordinate, advise, and assist the JTFS as required.

2. Advise the JTFS on the HSS capabilities/limitation of their Service or country.

3. Establish communications with their command.

4. Possess language or translation capability.

5. Have connectivity with their HQ, and provide continuous coordination and ensure cooperation between units.

6. Be informed of the operational status of their unit.

7. Facilitate the submission of required reports from their unit to the JTFS as required.

8. Advise the JTFS regarding the optimal utilization of their Service or country's HSS capabilities.

9. Attend JTFS's daily battle update assessment meeting and be familiar with and prepared to brief unit plans, movement plans and when required, movement times to critical locations.

10. Be prepared to serve as a member of JMOC.

4. Joint Task Force Surgeon's Office Battle Rhythm

a. The JTFS's office daily operations cycle or "battle rhythm" is developed by the DJTFS and is normally maintained in the JMOC. The purpose of the JTFS's office battle rhythm is to provide the JTFS's staff with a daily schedule of events necessary to support the JTF HSS mission. The JTFS's office battle rhythm reflects the times of the day for recurring events of



Evacuating a patient from an Army medical evacuation helicopter.

interest to the JTFS staff and is employed as a tool for ensuring information is available, so that the staff can predict when key elements of mutual influence for the CJTF, geographic combatant command surgeon and JTF components are required. All JTFS staff sections provide input to the DJTFS in the development of the JTFS office battle rhythm. They are responsible for participating in the various JTF briefings and meetings as indicated in the battle rhythm; and ensuring that key information products and reports are obtained, transmitted to the CJTF and higher HQ, and posted and maintained on the JTFS's homepage. Changes to the JTFS's office battle rhythm are typically announced during the JTFS's daily update brief. Once the office battle rhythm is approved, the JMOC chief or the JMOC battle captain ensures the JTFS's office battle rhythm is posted to the JTFS's web page (see Figure II-4).

b. The following are some recommendations the JTFS should consider when providing guidance regarding the JTFS's office battle rhythm:

(1) Start with the CJTF's battle rhythm. The JTFS's office battle rhythm must conform to the CJTF's.

(2) Identify those events and activities that occur on a recurring basis.

(3) Provide desires concerning staff updates and meetings that the JTFS will normally attend. Information should include:

(a) Any requirements for staff updates prior to meetings with the CJTF, COS, geographic combatant command surgeon, or component surgeons.

SAMPLE JOINT TASK FORCE SURGEON'S OFFICE BATTLE RHYTHM	
0300z	Joint medical operations center (JMOC) shift change (Shift Change Brief)
0400z	Reports due to the Joint Task Force (JTF) Surgeon: Blood Report, Medical Situation Report (SITREP), Medical Logistics Report, Medical Regulating Report, Weekly Disease and Nonbattle Injury (DNBI) Report, etc.
0600z	Staff inputs due for Morning Updates
0800z	CJTF Morning Update (Joint Operations Center Conference Room)
0830z	Joint Planning Group (JPG) Meeting
0930z	Commander's Planning Guidance and/or Operations Synchronization Meeting
1000z	JTF Surgeon's Daily Battle Update Brief
1030z	Joint Personnel Status Report (J-1)
1100z	Daily CJTF SITREP input due
1200z	Chief of Staff Update (Staff Meeting)
1200z	Logistics Coordination Board (J-4 Conference Room)
1330z	Joint Medical Working Group (Health Service Support Planners Meeting)
1400z	Combatant Command Surgeon Conference Call Update
1500z	JMOC shift change (Shift Change Brief)
1530z	Staff inputs for Evening Updates
1600z	JTF Surgeon's Conference Call with Component Surgeons/Health Service Support Units
1700z	CJTF Evening Update (JOC Conference Room)
1900z	Web Page Updates Posted
2400z	CJTF SITREP released

Figure II-4. Sample Joint Task Force Surgeon's Office Battle Rhythm

(b) Times for meetings with CJTF, COS, geographic combatant command surgeon and component surgeons (video teleconferencing [VTC], telephone, other).

(c) Frequency and potential meeting times of JTFS's office staff updates (e.g., informal morning update and a more formal evening update).

(d) Nature of the updates (e.g., types of information to be presented can drive the time required to conduct the updates).

(4) Integrate appropriate functions of HSS and FHP into the JTF battle rhythm.

5. Boards, Centers, Groups, Teams, and Cells

a. The JTFS may establish boards, centers, offices, and cells or may be asked to provide medical liaison relationships and membership to internal JTF organizations to coordinate HSS issues. These boards, centers, offices, cells, and internal JTF organizations may include and are not limited to: JPMRC, AJBPO, JMOC, JMWG, JPG, J-4 medical liaison cell, CMOC, ADVON team, and HAST.

b. The establishment of boards, centers, offices, cells, groups, and teams are described as follows:

(1) JPMRC

(a) The JPMRC provides the theater PM requirements capability for a JTF. It may be a “stand alone” entity operating within a JOA or subordinate to, and may receive direction from the GPMRC, located at Scott Air Force Base, Illinois, or the supporting patient movement requirements center (PMRC). The JPMRC performs integrated PM tasks for units assigned to the JTF or within the task force’s JOA and may coordinate through the TPMRC to request and schedule strategic AE support, or work directly with the GPMRC as required. JPMRC membership is coordinated between the geographic combatant command surgeon and the GPMRC. Since PM requires intratheater and intertheater lift, it is critical that the JPMRC communicate requirements to the JTFS J-4 LNO to ensure seamless patient flow.

(b) Joint Patient Movement Requirements Coordination. The purpose of JPMRC coordination is to functionally integrate medical regulation responsibilities (the proper medical treatment facility specialty bed), transportation movement requirements (best mode of transportation, such as airframes/ships/land), mission requirements determination (the right medical crew members and medical equipment), coordination, and related activities supporting JTF PM requirements. The JPMRC provides TPMRC type, automated information system (AIS) support and operations for a JTF. Normally, supporting activities will be established to support JTF PM operations within the designated JTF JOA. When operating within an area that already has an established TPMRC, the TPMRC will maintain overall responsibility for theater PM operations, but the JPMRC is responsible for PM operations within the JOA and coordinates with the TPMRC for intratheater PM and the GPMRC for intertheater PM. Information affecting overall theater operations will be reported to the respective TPMRC per procedures established in the specific OPORD. Elements potentially supporting JTF integrated PM operations are:

1. JTF PM LNOs established, as required, when the JPMRC is not collocated with or in close proximity to the JTF surgeon and staff. The JTF PM LNOs:

a. Coordinate PM issues with and obtain required PM information updates from the JPMRC.

b. Provide the JTFS and staff with information regarding PM activities, issues, capabilities, and workload.

c. In coordination with the JPMRC and supporting TPMRC, obtain JTF staff coordination and approval on PM issues, as required.

2. Deployable joint patient movement teams (JPMTs) provided by USTRANSCOM, or other appropriate combatant commands, provide PM expertise and support the integration of PM operations and information. Although USTRANSCOM has the DOD mission to provide these resources, support may also be provided by other combatant commands if a particular expertise is needed (e.g., an individual from the host TPMRC to provide a unique theater perspective not available in USTRANSCOM-provided elements). Deployable JPMTs:

a. Establish or augment a JPMRC.

b. Augment a TPMRC.

c. Deploy to intertheater or out of operational area interface points to support patient reporting and collection of required PM information.

d. Provide data to the supported TPMRC.

For more information on the PMRCs see Appendix A, "Patient Movement."

(2) AJBPO

(a) AJBPO. The geographic combatant command surgeon may direct the establishment of an AJBPO to provide regional blood management in the theater. The AJBPO may be established upon activation of a JTF as outlined in the respective OPLAN or OPORD.

(b) The functions of an AJBPO are similar to a JBPO, but in a limited geographical area. The AJBPO:

1. Coordinates blood requirements and distribution of blood and blood products to support all the BSUs and MTFs in the AJBPO area regardless of Service component. This includes defining the distribution system for blood and blood products at all levels from the supporting BTC or BSU down to the MTF.

2. Evaluates blood donor centers (BDCs), blood products depots (BPDs), BTCs, BSUs, and MTF transfusion services within the operational area to ensure the requirements of the JBPO are supported or addressed in the geographic combatant command and/or JTF OPLAN/OPORD.

3. The AJBPO core membership includes:

a. Blood bank or clinical laboratory officer.

b. Laboratory technician.

c. Administrative NCO/CPO.

4. The AJBPO supporting membership may include:

a. Administrative NCO/CPO.

b. Laboratory technician.

See Appendix D, "Blood Management," for more information on the ASBPO.

(3) JMOC

(a) In order to facilitate and provide responsive health services to the CJTF, medical resources must be effectively organized and synchronized to support joint operations.

(b) The JMOC is organized with essential JTFS staff to plan, coordinate, and harmonize the JTF's HSS and FHP operations. The major functions of the JMOC are to:

1. Provide a central location for medical planning and operations.
2. Monitor current and future operations and conduct required support planning.
3. Determine medical sustainment requirements.
4. Apprise the JTFS and CJTF on the status of HSS to the JTF.
5. Coordinate support requirements with the supported combatant command surgeon.
6. Maintain visibility of medical unit locations, capabilities, logistic status, and overall HSS system readiness.
7. Coordinate with the JTF staff in all areas to include J-1 thru J-6, CA, and legal.
8. Manage and maintain situation reports regarding JTF HSS operations.
9. Characterize disease and environmental threats within the JOA.
10. Develop medical concepts and countermeasures to mitigate disease and environmental threats.
11. Ensure FHP within the JOA.

(c) Staffing of the JMOC is situational dependent, but would normally include the following positions:

1. Operations officer (chief).
2. Plans officer.
3. Senior medical plans NCO/CPO.
4. Medical operations NCOs/CPOs.
5. ESO/EHO (also functions as medical intelligence officer).
6. Sanitary engineer/BEE/IHO.
7. JMLO.
8. HN liaison(s.)
9. IGO/NGO and USG liaison(s).
10. MNFs liaison(s).
11. Administrative staff (clerk/typists and NCO/CPO support as required).

(d) Note: The JMOC does not replace the AJBPO or the JPMRC. These offices remain operational as defined by applicable directives, instructions, and doctrinal manuals. Resource staffing for the JMOC is accomplished with members assigned to the functional areas of the JTFS's staff.

(4) JMWG

(a) The JMWG provides a forum for medical planners to validate, coordinate, and synchronize issues identified through the logistic coordination board of the standing joint force HQ or the JTF JPG, and from other JTF boards and centers as appropriate. Once established, the JMWG functions are integrated into the JTFS's staff battle rhythm.

(b) JMWG core membership includes:

1. Geographic combatant command medical planner.
2. JTF medical planner.
3. JTF PM officer.

4. JTF JMLO.

5. JTF J-4 medical LNO.

6. JTF component medical planners.

(c) JMWG supporting membership includes:

1. DJTFS.

2. JTF IHO/BEE/sanitary engineer.

3. JTF ESO/EHO.

4. JTF area joint blood program officer.

5. JTF international health officer.

6. Veterinary services officer.

7. Preventative medicine/public health officer/public health nurse.

(5) JTF J-4 Medical Liaison Cell

(a) The JTF J-4 medical liaison cell functions as a coordinating cell for health service logistic planning and operations, and serves as a conduit from the JTFS's staff to the JTF J-4 in support of HSS sustainment requirements as they relate to logistics to include: contracting, engineering, transportation, medical supplies, and personnel services.

(b) JTF J-4 medical liaison cell core membership includes:

1. Medical liaison cell leader (normally a medical logistics officer).

2. Medical liaison cell NCO/CPO.

(6) JPG

(a) The JPG is the JTF's planning organization consisting of designated representatives of the JTF HQ principal and special staff sections, JTF components, and other supporting organizations as deemed necessary by the CJTF. The JPG is a task-organized team formed to conduct integrated planning for a specific mission. The role of the JPG is to support the commander's decision-making process. Its primary responsibilities include, but are not limited to, crisis action planning (to include

COA development), JTF OPORD development, and planning for future operations (e.g., transitioning, termination, follow-on).

(b) The medical member to the JPG should:

1. Integrate JTF HSS and FHP effort as a medical representative on the JTF JPG.

2. Evaluate and assess HSS for various COAs scenarios developed during JPG planning sessions.

3. Develop HSS plans in support of various OPLANs and OPORDs.

4. Identify joint HSS resources to meet medical support requirements for crisis and contingency operations.

5. Establish the JMWG.

(7) CMOC

(a) The CMOC is an ad hoc organization, normally established by the geographic combatant commander (GCC) or subordinate JFC, to assist in the coordination of activities of engaged military forces, and other USG agencies, NGOs, and IGOs. There is no established structure, and its size and composition are situation dependent. The JTFS may be asked to provide medical liaison to the CMOC.

(b) The medical liaison to the CMOC should be prepared to:

1. Advise the JTFS regarding the optimal use of JTF HSS assets during CMO.

2. Advise the JTFS on civilian health care infrastructure, medical resources and interagency HSS requirements, capabilities, and limitations within the JOA.

3. Provide the JTFS with recommendations to develop policies regarding the use of military medical supplies for the treatment of displaced civilians.

4. Be prepared to provide sanitation and medical requirements for displaced civilian camps and assembly areas per Annex Q of the OPLAN when requested by appropriate authority.

5. Maintain connectivity with the JTFS and JMOC, and provide continuous coordination and ensure cooperation between CMOC and the JTFS's office.

6. Establish and foster working relationships with key NGOs, IGOs, and multinational medical forces.

7. Coordinate and assist with the prevention, control, and treatment of endemic or epidemic disease within the civilian population that affects military operations.

8. Coordinate with the JTFS for HSS required in displaced civilian assembly areas and camps.

9. Be prepared to provide technical expertise and assistance in identifying and assessing foreign national public and private health care systems, resources, facilities, and sanitation systems.

10. Be prepared to assist with and, when necessary, conduct assessments and area studies of public health systems as required.

11. Assist with mission planning on military medical interaction with civilians and medical units.

12. Assist with transition operations to hand off military run medical operations back to civilian authorities.

13. Determine the capabilities and effectiveness of health and sanitation systems and the impact of those systems on CMO.

14. Coordinate the use of foreign national government and private health resources for CMO, and in support of government administration.

15. Be prepared to provide advice and assistance in establishing technical requirements for public health services and resources to support government administration (e.g., clinics, hospitals, pharmacies, food preparation and storage, ambulance transportation, medical personnel, and education).

16. Provide advice and coordination in rehabilitating, establishing, delivering and maintaining government public health systems and agencies during CMO.

(8) ADVON Team

(a) An ADVON team is often established to provide a minimum capability for C2 during the buildup of the JTF. This team can assist in clarifying the JTF mission, determine force requirements to accomplish the mission, establish a sequence for force deployment, evaluate HNS, and determine if there are ongoing operations being conducted by other than military forces. Medical personnel assigned to augment the ADVON team provide FHP support, assess HN medical systems (to include information on cultural issues relevant to interactions with HN medical systems), participate

in the selection of bed-down locations for the JTF, validate the preliminary hazard assessment, and conduct an environmental health site assessment, as needed.

(b) Medical membership to the ADVON team may consist of the following JTFS staff:

1. Core membership:

a. ESO/EHO; and/or IHO/BEE.

b. JTF medical planner.

2. Supporting membership:

a. JTF international health officer.

b. Veterinary services officer.

c. Preventative medicine officer/public health officer.

(9) HAST

(a) The HAST is designed to deploy to a crisis country and immediately affect liaison with US embassy officials and any other USG agencies who may already be present in or have deployed to the crisis country. The primary mission objective of the HAST is to conduct a military assessment of the situation and obtain, develop and communicate critical information to assist the GCC and CJTF in the decision-making process, in order to effect timely allocation of military resources.

(b) The HAST may consist of any of the following JTFS staff:

1. ESO or EHO.

2. IHO/BEE/sanitary engineer.

3. International health officer.

4. Veterinary services officer.

5. Preventive medicine officer or public health officer.

6. Joint Task Force Surgeon Reachback

a. To make the best use of all available medical technologies and resources, the JTFS may extend beyond the JTF's organic HSS capabilities to identify and bring to bear resources not immediately available in the JOA. Reachback allows for HSS infrastructure support services

that sustain forward-deployed medical forces to transfer products and ideas as they are required in the JOA. It also provides a channel to contact SMEs when a technical issue exceeds the JTF's medical SME's capability.

b. The JTFS reachback capability network includes the GCC staff, supporting and other combatant command SMEs, Service SMEs, other US government agencies, designated multinational partners, academic and industrial sources, and both technical linkages and personal relationships developed through training and habitual associations. The JTFS should consider the following when employing reachback:

(1) Reachback can be accomplished through various means to include: secure/un-secure E-mail, telephone, web sites, and video conferencing.

(2) Reachback resources have other primary missions and may not be specifically staffed to support continuous reachback.

(3) Reachback can also result from a request for assistance.

(4) Reachback should be conducted using established JTFS's protocols and SOPs.

(5) VTC reachback capability requires the JTF J-6 to plan and integrate VTC reachback support into its communications system support plans and structure, and provide the required/ dedicated bandwidth to the JTFS staff.

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CHAPTER III

HEALTH SERVICE SUPPORT PLANNING

“The great thing in all military service is health.”

Admiral Lord Nelson

1. Health Service Support Planning Considerations

a. Timely, effective planning and coordination are essential to ensure adequate and sustainable HSS in a theater. Proper planning permits a systematic examination of all factors in a projected operation and ensures interoperability with the campaign plan or OPLAN (see Chairman of the Joint Chiefs of Staff Manual (CJCSM) 3122.03B, *Joint Operation Planning and Execution System (JOPES) Volume II, Planning Formats*. Organization of the HSS system is determined by the joint force’s mission, the threat, intelligence, anticipated number of patients, duration of the operation, the theater PM policy, available lift, and hospitalization and movement requirements (see Figure III-1).

(1) **Threat.** The threat is a composite of ongoing or potential adversary actions; occupational, environmental, geographical, and meteorological conditions; endemic diseases that can reduce the effectiveness of the joint force through wounds, injuries, illness, and psychological stressors; and the employment of weapons of mass destruction (WMD).

(2) **Medical Intelligence.** Medical intelligence is produced from the collection, evaluation, and analysis of information concerning the health threats and medical capabilities of foreign countries and non-state players that have immediate or potential impact on policies, plans, or operations.

(a) Medical intelligence merges the capabilities of the medical and intelligence communities to gain a better understanding of potential threats and to identify mitigation and response options to minimize potential impacts. Through proactive analysis and increased situational awareness, medical intelligence is an essential component in understanding the threat environment and formulating policy and response options. Medical intelligence data is critical in enabling the JFS and medical planner to provide the JFC with information to attain situational understanding of health threats; enable the development of HSS and FHP policies and strategies that mitigate natural and intentional incidents; provide knowledge superiority for the deterrence, prevention, mitigation, and destruction of CBRN threats and aggression; and redefine the battlespace from a medical perspective by employing strategic and preventative medical response planning.

(b) The JFS and medical planner must consider the entire scope of the threat to effective HSS and FHP, and make allowances for MIPOE. MIPOE is a component of the JIPOE process, and it assists JFSs and medical planners in analyzing enemy, environmental, and medical threats in the JOA. It includes data not only on medical and disease threats in the JOA, but also intelligence information on enemy capabilities, the terrain; weather; the local medical infrastructure; potential humanitarian and refugee situations; transportation issues; political, religious, and cultural beliefs; and social issues.



Figure III-1. Health Service Support Planning Considerations

(3) **Patient Movement.** Timely PM plays an important role in the design of HSS. PM is the end result of the collaborative lift-bed planning, and involves selection of patients for movement based on consideration of medical condition, locating available beds, route planning, and the selection of movement platforms and movement control. The HSS planner should consider using all means of PM.

(4) **PMI.** PMIs are specific medical equipment and durable supplies that must be available to support the patient. Examples of PMIs include ventilators, litters, patient monitors, and pulse oximeters. The purpose of the PMI system (see Figure III-2) is to support patients in-transit, to exchange in-kind PMIs without degrading medical capabilities, and to provide prompt recycling of PMIs. The originating MTF is responsible for notifying the PMRC if the patient needs any special medical equipment for transport. The MTF cannot necessarily provide PMIs for patients.

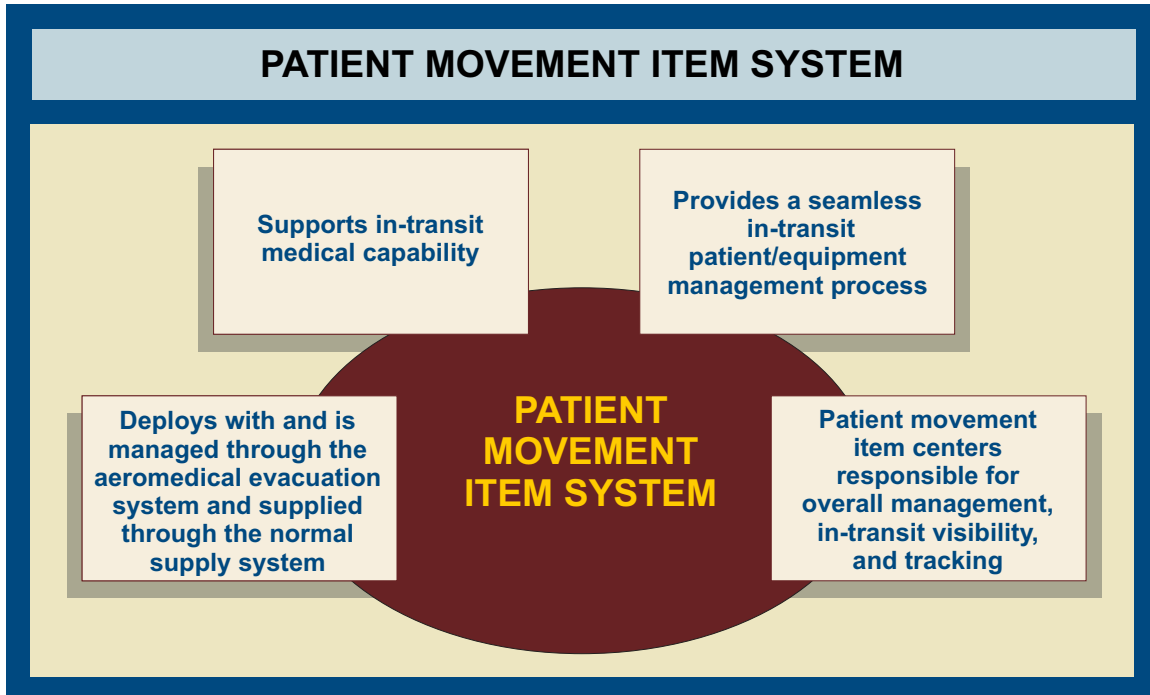


Figure III-2. Patient Movement Item System

PMIs accompany a patient throughout the chain of movement, from the originating MTF to the destination MTF, whether it is an intratheater or intertheater transfer. Planners must ensure that PMIs are available at the correct location and ready for use and PMI centers are established (establishment of theater PMI centers and cells is the responsibility of the US Air Force). PMI centers are established to support worldwide theater requirements. PMI centers will be located at aerial ports of embarkation and/or debarkation to match AE support plans. PMI centers and cells will receive, refurbish (i.e., technical inspection, calibration, repair, and replenishment of expendable supplies to maintain a 3-day level of supplies), redistribute, and return PMIs collected from MTFs. PMI centers can be augmented with personnel and equipment from the other Services; liaison personnel may also be assigned. At the time an MTF initiates a PM request requiring PMIs, the PMI center and/or cell will initiate action for the exchange of in-kind PMIs.

(5) **Clinical Capabilities and HSLS.** Specific clinical capabilities, location, health service logistic supportability, and bed requirements must be considered when planning HSS and must be detailed in the respective OPLAN. HSS planners must consider the following.

- (a) Sufficient personnel with the clinical capabilities necessary to provide care for the expected number and types of patients in the theater.
- (b) Specific clinical capability, relative mobility, logistic supportability, and the necessity to ensure a logical expansion of capabilities in theater.
- (c) Critical time and distance factors that impact on morbidity and mortality rates.
- (d) Health service logistic issues, including:

1. Standardization.
2. Use of a theater single integrated medical logistics manager (SIMLM).
3. Items requiring special handling.
4. Transportation.
5. Type and quantity of medical supplies needed.
6. Supply procedures and sustainment requirements.
7. Medical equipment maintenance and support requirements.
8. Disposition of medical waste IAW health and environmental considerations.
9. Optical fabrication.

(e) Blood supply and distribution.

(6) **Preventive Medicine and Health Surveillance.** Risk assessment and analysis as well as preventive medicine measures must be included early in HSS planning. The deployment health surveillance program is initiated and the means to counter the health threats in the operational area are



Navy personnel offloading a patient from an Army medical evacuation helicopter to a US Navy ship.

identified to the greatest extent possible, before the forces arrive. Specific preventive medicine procedures are generally the responsibility of the component commands. The JFS advises the CCDR on specific preventative medicine procedures to be implemented, typically accomplished through the component commands.

(a) Preventive medicine is the anticipation, communication, prediction, identification, prevention, education, risk assessment, and control of communicable diseases, illnesses, and exposure to endemic, occupational, and environmental threats. These threats include nonbattle injuries (NBIs), environmental and occupational exposures, combat stress responses, WMD, and other threats to the health and readiness of military personnel. Communicable diseases include anthropod-, vector-, food-, waste, and waterborne diseases. Preventive medicine measures include field sanitation, medical surveillance, pest and vector control, disease risk assessment, environmental and occupational monitoring and health surveillance, medical countermeasures, health threat controls for waste (human, hazardous, and medical) disposal, food safety inspection, and potable water surveillance.

(b) Deployment health surveillance includes identifying the population at risk (PAR); identifying and assessing their potentially hazardous exposures (e.g., medical, occupational and environmental, psychological, CBRN); using health risk communications practices to communicate the risk; employing specific countermeasures to eliminate or mitigate exposures; and utilizing medical surveillance procedures to monitor and report DNBI/BI rates and other measures of health outcomes to higher authority in a timely manner. Theater medical surveillance is essential for early identification of health threats within the operational area in order to prevent, neutralize, minimize, or eliminate them. The health surveillance program must cover all periods from predeployment, deployment, redeployment, to post-deployment. This information must be included in the health services support annex (see Appendix K, JOPES Annex Q) to the joint OPLAN and/or OPOD supporting the operation. A comprehensive deployment health surveillance program includes preventive and epidemiological procedures and health risk communication practices to ensure that commanders are kept informed on the health of the force, health threats, occupational and environmental threats, stressors, risks, and necessary preventive medicine and stress control measures before, during, and after deployment.

1. Protocols are required for vaccines, chemoprophylaxis, barrier creams, and pretreatments which are recommended for deployed forces and which are not approved for general use or are not approved for the purpose for which they are being administered under the FDA's guidelines. If the vaccine or medication is to be administered without a member's prior consent, the SecDef must generally obtain a waiver of informed consent requirements IAW title 10, USC, section 1107(f). This will require extensive documentation, which should be electronically archived for future reference and retrieval.

2. Establishment of a central repository for all specimens and samples, to include suspected biological warfare and chemical warfare agents and data, must be coordinated with the ASD(HA).

(7) **Prevention of Stress Casualties.** Prevention of stress casualties and control of combat and operational stress is a command and leader responsibility. HSS and other personnel at all levels play important supporting roles. A coordinated program must be planned for the prevention, treatment, and RTD of combat stress reaction casualties. Active education, training, and prevention programs assist with controlling stress and preparing unit leaders and HSS personnel to identify and manage stress reactions in units.

(8) **Mass Casualty Situations.** Procedures for handling MASCALs must be established to include casualty management resulting from WMD, combat, or other military operations. Particular emphasis is placed on the flexibility of HSS units to respond to sudden changes in the casualty situation. Successful management of a MASCAL situation is a complex task where success relies as much on well-practiced logistics and communications as it does on skilled medical treatment. The JFS must ensure that the communications, transportation, triage and emergency management, PM, and HSLs management aspects of the MASCAL plan are thoroughly rehearsed. Additionally, JFSs must ensure that chaplains are present to support wounded or injured personnel as well as staff members both during and after the situation.

(9) **Veterinary Service**

(a) Adequate veterinary service support is an integral part of joint FHP and it is imperative that medical planners consider veterinary support in HSS operational planning. The US Army is the DOD EA for veterinary support for the Services, and in some instances, support is provided to allies and/or coalition partners and HN agencies. Army Veterinary Corps, Navy Preventive Medicine, and Air Force Public Health provide food inspection services, assuring food wholesomeness, safety, and security. Army veterinary units are task-organized and tailored in order to support government owned animal health care, veterinary preventive medicine, and food safety and security programs. The potential of food-borne disease, the threat of contamination of subsistence, the need to assess the zoonotic endemic disease threats, and the need to provide health care to MWDs all require an early veterinary presence throughout the entire operational area of all joint and multinational operations.

(b) When deployed in military operations, veterinary support and preventive medicine capabilities reduce the vulnerability of US and MNFs to DNBI. Veterinary personnel work closely with Army, Air Force, and Navy preventive medicine units to provide coordinated FHP support. Veterinary food inspection is necessary to ensure food safety, quality assurance, and adequate food hygiene. Services provided by veterinary units include sanitary surveillance of food source and storage facilities, and surveillance of foodstuffs to ensure a safe and wholesome food supply. Procurement of fresh foods, bottled water, ice, and beverages is supported by veterinary personnel through sanitation audits performed on local food establishments in the operational area. The veterinary unit, through the CJTF, is responsible for the publication of a directory of approved food sources for the JOA.

(c) Comprehensive veterinary medical and surgical programs are required to maintain the health of government owned animals. By providing complete medical and surgical care to all MWDs supported in the JOA, the Army Veterinary Service assists in ensuring the



C-130 providing intratheater aeromedical evacuation of personnel.

effectiveness of the MWD as a force multiplier. A majority of biological weapon agents are zoonotic and therefore, quick recognition in the animal population may detect a significant hazard to human health. By monitoring and evaluating endemic animal diseases of military importance and environmental zoonotic disease hazards to both animals and humans, veterinary units assist in maintaining a health and fit force in the JOA.

(d) As a component of HSS, veterinary service has an essential role in formulating FHP for the joint force. Early HSS and FHP planning considerations for veterinary service support should include the CONOPS, type and duration of operation, estimated strength of the joint force and other organizations requiring veterinary support, means of shipping CLI supplies and the anticipated stockage levels for the JOA, estimated JTF MWD strength, proposed use and location of government-owned and/or indigenous animals, the size and type of civic-military action programs to support the local population and animals, and the anticipated CBRN threats in the JOA.

(10) **Dental Service.** As a functional category of HSS, dental service plays a significant role in FHP for the joint force. Dental services must be included in the early stages of planning. Dental resources and capabilities must be planned for the treatment, restoration, and maintenance of oral health.

(a) **Dental Services.** Dental readiness and dental health should be IAW policy requirements and available resources.

1. A healthy and fit force and provides the commander with an optimally fit Service member capable of withstanding the physical and mental rigors associated with combat and other military operations. In-garrison and operational dental care ensures a dental ready force.

2. Dental care is preventive in nature, thereby ensuring protections.

3. Dental's secondary mission is to augment medical assets during MASCAL situations. Proper planning and training is essential to mission success.

(b) **Dental Service Planning** — must include the consideration of two categories of dental services in joint and multinational operations. One category of dental care is provided within the operational area and another category of dental services is provided in the support base.

(c) The planning process includes an evaluation of the size and anticipated duration of the operation, along with categories of dental care required to support the operation.

1. Category I — Operational Care

a. **Emergency Care.** Care given for the relief of oral pain; diagnosis and treatment of infections; control of life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulties); and treatment of trauma to teeth, jaws (maxilla/mandible), and associated facial structures is considered emergency care. It is the most austere type of care and is available to deployed Service members. Common examples of emergency treatments are airway management, hemorrhage control, stabilization of maxillofacial injuries (fracture stabilization, soft tissue injury/laceration repair), simple extractions, management of maxillofacial infection (antibiotics, incision, and drainage), interim pulpal therapy (pulpectomy), pain medication, and temporary restorations.

b. **Essential Non-Emergency Care.** Care necessary to intercept potential emergencies to prevent lost duty time and preserve fighting strength is considered essential non-emergency care. Personnel in Dental CL 3 (untreated oral disease with potential to cause an emergency within 12 months) should be provided this level of care as the tactical situation permits. Common examples of essential non-emergency care are basic restorations, extractions, definitive pulpal therapy (pulpectomy, obturation), treatment of periodontal conditions, and simple prosthetic repairs. Essential non-emergency care is also intended to maintain the overall oral fitness of personnel at a level consistent with combat readiness. Most dental disease is chronic and recurring. Unit dental readiness and health will deteriorate from the day of deployment if essential dental care is not provided by deployed dental support. JTF dental units should provide essential non-emergency care to those in Dental CL 2 (untreated oral disease not anticipated to cause an emergency within 12 months) as the tactical situation and availability of dental resources permit.

2. **Category II — Comprehensive Care.** Dental treatment to restore and/or maintain optimal oral health, function, and esthetics is comprehensive dental care. This

category of care is usually reserved for HSS plans that anticipate an extended period of reception and training in theater and is also included as a component of the theater hospitalization capability. The scope of facilities needed to provide this level of dental support could equal that of theater hospitalization capability medical facilities.

(11) **Host-Nation Support.** HNS can be a significant force multiplier. HNS should be equivalent to US standards. The JFS must assess HN medical capabilities and make recommendations to the JFC on their use for deployed US forces. Descriptions of HN medical capabilities should be sought from sources such as the Armed Forces Medical Intelligence Center (<http://mic.afmic.detrack.army.mil/> or analogous classified site), US embassy health unit personnel in-country, base support plan surveys, and recent exercise or operation after-action reports. In many operations, HN blood supplies do not meet US standards of care. The JFS should make arrangements to store and use blood products from US-approved sources even if HN MTFs are planned to support the deployed force. HNS may reduce the lift requirements necessary to deploy HSS to the JOA.

(12) **HSS for US Prisoners of War (POWs) and Detained Personnel.** The GCC establishes a theater plan on the proper handling and provision of HSS for returned US POWs and detained personnel.

(13) **HSS for Detainees.** The JFS and medical planner in conjunction with the SJA should develop detainee medical care policy recommendations for the JFC IAW applicable laws and regulations. The JFS and medical planner should ensure that the approved detainee medical care policies are published in the medical annex of OPLANs and OPORDs, and appropriate concept plans (CONPLANs) and fragmentary orders (FRAGORDs). Additionally, when developing HSS plans for supporting detainee operations, the JFS and medical planner should consider at a minimum, that the medical annex of OPLANs and OPORDs includes procedures to the extent practicable, for the treatment of detainees that are guided by professional judgments and standards similar to those that would be applied to personnel of the Armed Forces of United States. Additional considerations should include but are not limited to: appropriate intervention procedures for prisoners on hunger strikes or who refuse treatment; appropriate procedures that manages an outbreak of contagious disease within the detainee population; the provision for an initial medical screening of detainees; interpreters that are available to translate patient complaints to attending medical personnel; and an immunization policy for detainees as dictated by the disease health threat.

(14) **HSS in Multinational Operations.** US military operations are often conducted with the armed forces of other nations in pursuit of common objectives. Each multinational operation is unique, and key considerations involved in planning and conducting multinational operations vary with the international situation and perspectives, motives, and values of the organization's members. JFSs and medical planners should be cognizant of the following regarding multinational operations:

(a) **Cultural Differences.** Medical personnel should remain mindful of the fact that each force has a unique cultural identity. The JFS and medical planner should identify key staff positions

with language and regional expertise requirements and ensure adequate interpreters or translators and area specialists are appropriately planned for and available to support HSS operations.

(b) **Liaison.** The JFS and medical planner should establish multinational medical LNO requirements early in the planning process.

(c) **Medical Intelligence.** Members of the MNF may operate separate intelligence systems in support of their own policy and military forces. These national systems may vary widely in sophistication and focus, and may not have capabilities similar to the US to collect and process medical intelligence. The JFS and medical planner should collaborate with the J-2 to provide appropriate information early in the planning process, so the JFC can determine what information can be shared with multinational forces.

(15) **HSS in JRSOI.** JRSOI encompasses all of the activities needed to receive a unit's equipment and personnel at aerial ports of debarkation (APODs) and seaports of debarkation (SPODs). The JFS and medical planner's scope of responsibilities during JRSOI activities typically begins prior to the reception of units at the APODs and SPODs. HSS planning for JRSOI should include an assessment of HN medical facilities and services for potential HNS, predeployment planning activities for FHP, and planning for medical capabilities to sustain HSS operations during the four phases of JRSOI. The JFS and medical planner should also ensure JRSOI HSS and FHP requirements are appropriately detailed in the appropriate OPLAN and OPORDs.

(16) **HSS for CDF.** The JFS and medical planner should ensure that HSS, either as a responsibility of the contractor or the JFC, is fully delineated in OPLANs, OPORDs and contracts to assure appropriate HSS in the JOA for CDF. Additionally, the JFS and medical planner should ensure specific theater medical readiness requirements to include predeployment and FHP requirements and requisite individual medical training to include safety, first aid, sanitation, health risks, and health protection measures, including those related to CBRNE, and environmental and/or industrial threats are identified in the medical annex of OPLANs and OPORDs.

(17) **HSS for Medical CMO.** The JFS may be tasked to support or execute CMO, in coordination with CA elements. If assigned medical civil-military operations (MCMO) missions, the JFS and medical planner must consider the different types of medical resources required to conduct such operations and must coordinate closely with CA elements, information operations, the USG civilian agency or other agencies such as coalition partners, HN agencies, IGOs, NGOs, and other groups to include religious organizations, that may have the lead for all or part of a given operation, to ensure unity of effort. Coordination and support planning should be appropriately identified in the civil-military and interagency annexes of OPLANs and OPORDs. The JFS and medical planner should also ensure that during the various phases of planning for MCMO missions, consideration is given to ensuring the HSS staff includes an international health officer or SME with regional medical expertise. The international health officer or SME should foster partnerships with military, civilian, HN, multinational and USG personnel, NGOs, and IGOs, and provide technical expertise, and assistance in identifying and assessing foreign national public and private health systems, sanitation systems, health services, personnel, resources, and facilities.

(18) **Medical Waste and Other Environmental Considerations.** The JFS, medical planner, and preventive medicine personnel in conjunction with the J-4, should develop plans to address the disposal of regulated medical waste (blood and blood products, infectious, pathological, sharps, isolation, and microbiological cultures) and radiological waste. This plan should consider all aspects of operations to prevent pollution, protection of the environment, compliance with pertinent regulatory guidance/policy to mitigate exposure of US and MNFs or subject the US to unfavorable publicity and future claims for damages. The JFS and medical planner should ensure the plan for medical waste and other environmental considerations are published in the medical annex and environmental consideration annex of OPLANs and OPORDs, and appropriate FRAGORDs.

(19) **Interagency Coordination.** As the US military increasingly integrates its operations with other organizations and nations, joint HSS operations will require an increased contact and collaboration between the US military, USG agencies, foreign governments, NGOs and IGOs, all of which will influence the development and execution of HSS and FHP operations. Close coordination and cooperation with these groups may prevent duplication, lessen the friction of potential rivalry, and improve results. The JFS and medical planner must consider processes and procedures to fully integrate the interagency perspective and position into HSS planning, execution, and the assessment process; and should consider how joint HSS and FHP operations, and the actions of involved interagency organizations contribute toward the desired end state. This consideration requires extensive liaison and coordination with all involved parties.

b. **Other Considerations.** Other planning considerations that the HSS planners must take into account to support joint operations include:

(1) Ensure that an adequate joint medical communications architecture is established to provide compatible and responsive communications for the military HSS system.

(2) Ensure that adequate standardization and interoperability policies are in place to ensure that all deployable medical systems supporting joint operations are interoperable between Service components.

(3) **Medical engagement protocols.** While it is anticipated that medical care may be provided by the HN or other IGOs, the US may be requested to provide for certain categories of forces and other personnel within the JOA. Consequently, HSS planning consideration may include many different populations, such as: DOD civilians, contractors (including third country nationals [TCNs] and CDF), indigenous civilians, MNFs, other government agencies, NGOs, IGOs, and other personnel requesting assistance in circumstances of life, limb, or eyesight emergencies. JFSs and medical planners should review entitlements, applicable laws, and regulations for the provision of US military medical care to nonmilitary beneficiaries and military and nonmilitary personnel of other nations (to include eligibility for AE movement and procedures for obtaining SecDef designee status) and in consultation with the SJA, establish medical engagement protocols recommendations for the GCC/CJTF. Once established, JFCs, JFSs, and

medical planners should ensure that the approved medical engagement protocol policies are published and disseminated to all joint force personnel.

(4) Coordinate HSS requirement in support of natural disasters. (Such coordination can be facilitated by conferring with the United Nations (UN) Office for Coordination of Humanitarian Affairs (OCHA), www.reliefweb.int, to prevent duplication of efforts by other countries, solicit current needs, and increase the effectiveness of response efforts from multiple responding countries and NGOs.)

(5) Coordinate support with outside relief agencies (Red Cross, NGOs, and IGOs) in theater to ensure complete visibility for overall medical situation and requirements, including integrated transfer of responsibilities for policies and procedures.

(6) Amphibious Task Force. Amphibious task force HSS planning responsibilities are closely related to those of the landing force. Detailed, coordinated, and parallel planning is required between the commander of the amphibious task force and the commander of the landing force. Each surgeon of these commands has specific HSS planning responsibilities that are detailed in Joint Publication (JP) 3-02, *Joint Doctrine for Amphibious Operations*.

(7) Airborne Operations. Airborne operations establish a lodgment in an isolated uncertain or hostile environment. Detailed, coordinated, and joint planning is required between the commander of the airborne task force and the JFC. Each surgeon of these commands has specific HSS planning responsibilities that are detailed in JP 3-17, *Joint Doctrine and Joint Tactics, Techniques, and Procedures for Air Mobility Operations*, and JP 3-18, *Joint Doctrine for Forcible Entry Operations*.



Hospital ship USNS Mercy.

2. Planning for Joint Health Service Logistic Support

a. **HSS is reliant upon the specialized materiel and services** provided by HSLs; therefore, the joint HSLs plan is an integral and critical component of the medical services (Annex Q). HSS units as well as maneuver units usually begin requesting HSLs support immediately upon arrival as they provide area medical support to organic personnel, identify unit shortages, or begin early operations in support of forces in the JOA. The HSLs planner must consider a number of factors to ensure the overall concept of HSS is sustainable. These factors include:

- (1) CONOPS and commander's guidance.
- (2) Type and expected duration of the operation.
- (3) Types of HSS capabilities supported, especially for theater hospitalization and specialty care.
- (4) Theater plan for the time-phased arrival of HSS capabilities.
- (5) PAR for the force to be supported.
- (6) Medical occupational and environmental threats in the operational area.
- (7) Anticipated number and types of casualties.
- (8) Theater PM policy.
- (9) Availability of pre-positioned war reserve materiel (WRM).
- (10) Availability of HN or multinational support.
- (11) Requirements to provide HN or multinational support.
- (12) Requirements to provide support to contractors.
- (13) Theater plans for distribution channels and transportation management, and the impact of distribution capabilities and distances upon estimated customer wait time.
- (14) Theater plans and capabilities for secure and non-secure communications.
- (15) Designation of a TLAMM.
- (16) PBAs between the CCCR and DLA.

b. **The HSLs plan must understand the CCCR CONOPS** and the HSS concept of support. This includes understanding any requirements to provide or receive HSLs. This includes anticipated

medical risks and planned countermeasures for environmental and occupational threats, and contingency plans for CBRN consequence management (CM). The HSLS planner should also assess the possibility for mission expansion into HA or 'nation building', and identify the additional capabilities that may be required to support these missions.

c. **The HSLS planner must coordinate with the command J-4 and the DDOC** or other designated movement control organization. The HSS system does not own or manage transportation resources, and medical materiel typically flows through the same distribution channels and is subject to the same movement controls as all other classes of supply. HSLS capabilities should be located at or near theater distribution nodes to enable access to intratheater distribution capabilities. Medical materiel normally flows into the theater by strategic air (military or commercial); therefore, primary medical theater distribution activity should be located where there is access both to strategic and intratheater distribution channels.

d. **The HSLS planner must consider several key aspects of support** to ensure the appropriate supplies, equipment, and HSLS services will be available to meet HSS requirements. Considerations include but are not limited to:

- (1) The assignment of SIMLM responsibilities, if necessary.
- (2) The role of a designated TLAMM.
- (3) The establishment of theater HSLS capabilities for medical supply chain management, biomedical equipment maintenance, optical fabrication, and medical equipment management such as PMIs, maintenance floats, or new equipment fielding.
- (4) Theater stockage objectives, to include the need to preposition medical materiel in the theater to sustain early operations, provide individual medical biological/chemical defense materiel (MBCDM), and/or provide initial capability for CBRN CM.
- (5) Theater requirements for materiel beyond those computed for replenishment of unit medical equipment sets (MESs), to include the establishment of a theater pharmaceutical formulary by the JFS. Examples of requirements that were not sufficiently anticipated and have posed challenges in prior operations include:
 - (a) Expanded formulary for sick call/primary care.
 - (b) Prescription refills for chronic medications.
 - (c) Pediatric supplies.
 - (d) Materiel for care of detainees.
 - (e) Laboratory reagents.

(6) The number of days of supply units must bring into theater to achieve initial operating capability IAW CCCR's guidance.

e. **The HSLs planner and JFS must identify the HSLs capabilities** that are necessary to support the HSS plan for incorporation into the CCCR's force requirements and ensure they are programmed for movement into the theater. The time-phased force and deployment data (TPFDD) is the portion of the OPLAN containing movement data for both cargo and personnel. Strategic lift into the theater is typically limited, and the CCCR will establish guidance on movement priorities. The arrival of HSLs capabilities must be phased to permit the accomplishment of all theater preparatory tasks and enable support to forces as they arrive in theater.

3. Planning Factors for Joint Operations

In addition to coordinating joint force HSS requirements, HSS planning for joint operations involves other major considerations, including coordinating HSS requirements with other combatant commands and other friendly forces. The tool approved for calculating medical requirements is the medical analysis tool (MAT). MAT is an automated application program that takes Service-specific casualty rates, admission rates, and PAR from TPFDD, contingency planning, theater PM policy, and merges those figures to generate joint medical requirements. The planners then perform a risk assessment and COA analysis to assess the most effective use of medical forces. MAT produces credible medical requirements for beds, patients to be evacuated, CL VIII (both medical resupply and blood), losses to be replaced, and numbers of hospital admissions. In addition, it provides medical requirements for PAR reports, planning factors used, and bed capabilities (as compared to bed requirements) report. The MAT can input a PAR report from the TPFDD, and merge Service scenarios to create a joint scenario. Services are responsible for generating and maintaining casualty rates for contingency operations. JFSs should obtain Service-specific casualty rates through the combatant command.

a. Theater Patient Movement Policy

(1) The theater PM policy is established in the Logistics Supplement to the Joint Strategic Capabilities Plan, HSS Enclosure. The supported commander, in conjunction with supporting commanders and USTRANSCOM/Air Mobility Command (AMC) set the specific theater policies prior to OPLAN execution. Upon execution, the CCCR adjusts the theater PM policy as needed.

(2) The theater PM policy is executed by the CCCR. The theater PM policy delineates the maximum number of days that patients may be held within the command for treatment prior to further movement or RTD. Patients who cannot RTD within the specified number of days are evacuated to the next higher level of care for further treatment. Shorter movement policies within the theater reduce theater bed requirements and increase the number of beds required elsewhere. Shorter movement policies also increase movement requirements. The theater PM policy is flexible and can change as the tactical situation dictates.

(3) IAW SecDef policy and CJCS guidance, the PM policy is normally 7 days for the combat zone and a combined total of 15 days for the combat zone and communications zone. This does not imply that a patient must be held in theater for the entire period. Patients not expected to RTD within the number of days expressed in the theater PM policy will normally be evacuated:

(a) As soon as their medical condition permits or when local stabilization capabilities have been reached.

(b) When medical authorities have determined that travel will not aggravate their medical condition (at a minimum, patients will have their airway secured, bleeding stopped, shock treated, and fractures immobilized).

(c) When suitable receiving MTFs and transportation have been arranged.

b. Estimate for Theater HSS Requirements. The estimate for theater HSS requirements is based on empirical data accumulated for each Service for the major categories of patients wounded in action and DNBI. Planning factors, such as the theater PM policy, bed availability, casualty rates, admission rates, and the PM delay policy are analyzed to calculate HSS theater requirements. Empirical data includes:

(1) PAR.

(2) PM delay.

(3) Average length of stay.

(4) Percent evacuated.

(5) Dispersion factors. Dispersion factors are contained in the Joint Strategic Capabilities Plan, Health Service Planning Guidelines. These guidelines should be used as defaults for all CJCS-directed planning factors.

c. Planning Factor for CL VIII (b) Blood Products. The planning factor for blood products in a theater is 4.0 units of liquid red blood cells per initial admission. This factor accounts for all blood use through all levels of care. An appropriate breakout is 1.0 unit per wounded in action and/or NBI at FRC capability, 2.0 units at theater hospitalization capability, and 1.0 unit at definitive care capability. The receipt, storage, and distribution of blood products require special consideration and procedures to ensure a coordinated effort and maximum use of communications, storage facilities, and transportation. The Air Force component will staff and operate BTCs. The centers are located at major airfields, and blood products are managed by the JBPO or area JBPO. One or more BTCs are located in each area of responsibility (AOR) and/or JOA.

4. Checklist for Health Service Support Planning

- a. Are the medical tasks, functions, and responsibilities delineated and assigned?
- b. Is a comprehensive deployment health surveillance plan developed? Predeployment (e.g., predeployment health assessments, serum samples collected, preliminary hazard assessment conducted and preventive medicine countermeasures integrated into the plan); deployment (e.g., site assessments and baseline, routine and incident-specific occupational and environmental monitoring and DNBI/BI statistics); and post-deployment health assessments, serum sample collection actions fully planned, with responsibility delineated and task assigned?
- c. Are there any specific plans, policies, agreements, or treaties to consider?
- d. Are provisions made to provide emergency medical assistance to US nationals (Federal government employees, contractors, retirees, civilians, NGOs, IGOs) in the JOA and to EPW, detainees, civilian internees, dislocated civilians, and any others?
- e. Has the theater PM policy been established? If so, have requirements for hospitals and PM workload been identified?
- f. Are all units on the TPFDD and scheduled for timely arrival, including sufficient preventive medicine assets to protect the health of the personnel as they begin to arrive in theater (time of highest health risk).
- g. Are procedures in place to obtain PAR data from the personnel community at least once weekly for the calculation of DNBI rates?
- h. Have estimates of medical sustainability and anticipated resupply requirements been established?
- i. Has a JTF JPMRC been established to coordinate movement of patients within and out of the assigned JOA?
- j. Has a blood program system been established?
- k. Has a JBPO been activated to plan and coordinate the handling, storage, and distribution of whole blood within the assigned JOA and consolidate and forward resupply requirements to the ASBPO?
- l. Have medical personnel augmentation packages been identified and requirements submitted? Do hospitals have enough personnel and equipment to support movement of critical patients? Are there sufficient litters, straps, blankets, and other supplies as required, to support anticipated workload?
- m. Has a medical PM policy been established?

- n. Have the numbers, types, and locations of PM conveyances been identified? Are they sufficient to meet projected workload?
- o. Has an evacuation plan for ground and air ambulances been prepared?
- p. Are noncombatant evacuees a consideration for HSS?
- q. Are sufficient aeromedical staging assets planned or in place?
- r. Are AE liaison teams located at key locations within each component's medical system?
- s. Have preventive medicine procedures been established and sufficient personnel identified to ensure protection of the health and well-being of personnel assigned to the JTF?
- t. Have medical communications channels, frequencies to be used by medical personnel, and all medical communications requirements been identified?
- u. What medical and nonmedical threats could impact HSS operations and requirements? What finished medical intelligence products are available from the AFMIC on the AOR?
- v. Has the supported commander requested that the AFMIC be tasked to provide an area medical threat assessment? Have HSS planners identified and received all required threat information, medical and nonmedical, needed for effective planning?
- w. What military forces are involved? What are their organic medical capabilities?
- x. If other nations are involved, what are their unique medical requirements?
- y. Are HN medical support systems in place?
- z. What are the HSS reporting requirements and have responsibilities been assigned to meet requirements.
- aa. Should civilian contracts for medical support be considered?
- bb. Is pre-regulation of patients to specific hospitals required?
- cc. Are sufficient supplies and equipment in place; has a program for sustainability and resupply been established; is a theater single integrated medical logistic system required?
- dd. Has liaison or coordination with other agencies been established?
- ee. Have all other areas of joint HSS been addressed such as dental, mental health, and veterinary support?

ff. Have special teams been identified and contacted to provide reachback consultation as needed?

gg. Ensure religious support teams are in place to provide service to staff as well as sick and injured persons.

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CHAPTER IV

HEALTH SERVICE SUPPORT OPERATIONAL CONSIDERATIONS

“Pay every attention to the sick and wounded. Sacrifice your baggage, everything for them. Let the wagons be devoted to their use, and if necessary your own saddles.”

Napoleon I

1. Civil Support Operations

a. Introduction

(1) **The US military organizes, trains, and equips forces primarily to conduct combat operations.** Inherent within the combat capabilities of the Services, is the military’s ability to rapidly respond to assist civil authorities for domestic emergencies such as disasters, authorized law enforcement, and other activities that exceed the capability of civilian agencies. This capability described as civil support (CS) is one of two HSS mission areas for DOD.

(2) **National Response Plan (NRP).** The most prominent CS plan is the NRP, which is the primary federal mechanism through which DOD support is requested for domestic emergencies. The NRP describes the policies, planning assumptions, and a CONOPS that guide federal operations following a Presidential declaration of a major disaster or emergency. The NRP is coordinated and managed by DHS and FEMA and is the result of agreements between DHS/FEMA and the primary and supporting federal agencies responsible for providing disaster relief support, including the DOD. DOD resource support under the NRP includes personnel, equipment, and supplies in the absence of other national disaster system resource capabilities. Support is provided with the provision that it does not conflict with DOD’s mission or its ability to respond to operational contingencies.

b. Principles of Defense Support of Civil Authorities (DSCA)

(1) The President and the SecDef establish priorities and determine what DOD resources will be made available for CS. CDRs ensure that DOD resources are used judiciously by adhering to the following principles:

(a) Civil resources are applied first in meeting requirements of civil authorities.

(b) DOD resources are provided only when response or recovery requirements are beyond the capabilities of civil authorities (as determined by DHS/FEMA, Joint Director of Military Support [JDOMS], or another lead federal agency for emergency response).

(c) DOD specialized capabilities (e.g., airlift) are used efficiently.

(d) Military forces shall remain under military C2 under the authority of the DOD EA at all times.

(2) DOD components shall not perform any function of civil government unless absolutely necessary and then only on a temporary basis under conditions of immediate response.

c. **Roles and Responsibilities.** Requests for HSS during disasters in CONUS will normally be initiated by DHS, through submission of a request for assistance or mission assignment. Requests typically flow from FEMA to JDOMS and are processed forward to SecDef for approval.

For more information, see JP 3-26, Homeland Security and JP 3-28, Civil Support.

2. Stability Operations and Crisis Response Contingencies

a. **General.** Stability operations encompass various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, and provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief.

(1) Stability operations objectives could include the restoration of services such as water, sanitation, public health, and essential medical care. The desired military end state in the health sector should be an indigenous capacity to provide vital health services. In stability operations, another government agency will typically serve as the lead; DOD should be prepared to support this agency. However, the US military forces should be prepared to lead the activities necessary to accomplish these tasks when indigenous civil, USG, multinational, or international capacity does not exist or is incapable of assuming responsibility. Once legitimate civil authority is prepared to conduct such tasks, US military forces may support such activities as required or necessary.

(2) Crisis response contingencies are normally limited in scope and size, and are often conducted to achieve a specific objective in an operational area. Joint response contingencies may be conducted as stand-alone operations in response to a crisis or executed as an element of a larger, more complex campaign or operation. As an example, crisis response may include the following: employment of overwhelming force in peace enforcement, a single precision strike, or a noncombatant evacuation.

(3) The JFC and JFS should ensure medical personnel and capabilities are prepared to meet not only the military but also the civilian health requirements to address patient populations (e.g., children, elderly, pregnant females) similar to those encountered during FHA operations or humanitarian and civil assistance activities. Further, the JFC and JFS should ensure medical personnel and capabilities are prepared to perform with other government agencies, HN ministries, IGOs, and NGOs. Military-civilian teams that plan and conduct stability operations should include personnel with HSS expertise.

(4) The JFS should coordinate with public affairs to ensure the release of HSS information that will inform the indigenous, international, and US domestic audiences of HSS efforts and health threat information.

b. **Health Service Support Planning Considerations.** Commanders planning for HSS in stability operations should use Chairman of the Joint Chiefs of Staff Instruction (CJCSI) 3110.03C, *Joint Strategic Capabilities Plan Logistics Supplement*, as guidance. Additional considerations include; and are not all encompassing.

(1) Medical Intelligence

(a) When planning for and conducting HSS during stability operations, the JFC and JFS must consider the health threat to the indigenous population, multinational forces, USG employees, contractors and; as appropriate, IGOs and NGOs; as well as its impact as a contributing factor to social, political, and economic stability. Stability operations are often conducted in areas where social services have been disrupted resulting in poor sanitation, inadequate food and water distribution, civil disturbances, and general civil unrest. Significant health threats are likely with the high prevalence of diseases that are endemic and/or can become epidemic, uncontrolled distribution of hazardous wastes and hazardous materials, and environmental extremes.

(b) Personnel likely to serve in areas where stability operations are conducted may enter with very little, if any, natural immunity to endemic diseases. The degree of cultural and social interaction required to support the mission, as well as the sharing of food, quarters, and recreational facilities with local nationals, may increase the exposure of personnel to diseases endemic to the host country. For the most part, stability operations may last for extended periods of time (months or years, not days or weeks) increasing the risk of contracting endemic disease. The enforcement of proper FHP measures is critical to minimize the risk to personnel.

(2) **Medical Logistics.** HSLS plays a significant role in the delivery of health care during stability operations. Prior to a deployment, the JFS determines if there are any special medical supplies or equipment requirements required for the operation. The HSLS planner must obtain and coordinate transportation and receive, sort, store, and distribute CL VIII materiel. Further, health service logistic personnel can assist IGOs, NGOs, and the HN by conducting an assessment of the military or civilian medical supply infrastructure and industry. Secondary and tertiary effects of direct assistance must be considered. Procurement of supplies, including pharmaceuticals, for use on the affected civilian population may be best obtained locally or regionally. Coordination with the United Nations (UN) Joint Logistics Center, World Food Program, or World Health Organization may be desirable.

(3) **Preventive Medicine.** Often the HSS structure will require reliance on contracting from local sources for food, water, sanitation, public health, and health industry resources. Procurement of fresh foods and beverages and contracting of food storage facilities are supported by veterinary personnel through sanitary inspection of local and regional wholesale food establishments in the operational area. Preventive medicine units can provide health inspections of retail food establishments and water sources (potable and non-potable).

(4) **Force Protection.** Insurgent or terrorist forces may not recognize the protection afforded to medical personnel by the Geneva Conventions. HSS activities may be prime targets

by these groups, especially if these activities are perceived as contributing to the international effort and/or the supporting US and/or HN strategic goals. MTFs may be vulnerable to theft and raids on CL VIII supplies by insurgents or terrorists for their own support or to support black market activities. The JFC and JFS should ensure adequate force protection measures are appropriately planned and provided to protect medical personnel from enemy actions.

(5) **Legal Issues.** Medical obligations under international law will be particularly crucial to the management of nonmilitary personnel such as HN civilians or TCNs, detainees, civilian refugees, and internally displaced persons (IDPs). US military forces should be prepared to lead the activities necessary to accomplish this medical task when indigenous capacity does not exist or is incapable of assuming responsibility. The JFC and JFS must plan to address these obligations. Once legitimate civil authority is prepared to conduct and sustain the medical support task to these populations, US military forces may provide support as required or necessary.

c. When preparing for and conducting operations during stability operations and joint response contingencies, elements of the health threat to the indigenous population, allied and coalition forces, USG employees, DOD contractors and, as appropriate, IGOs and NGOs must also be assessed. The impact of the health threat as a contributing factor to social, political, and economic stability in both peace and other operational environments must be considered. The general environment in which these types of operations are conducted ranges from peaceful, developing countries with no apparent internal or external instabilities to countries with limited resources and a poorly led population assailed by active insurgent movements, diseases, and dependency on FHA.

d. Within stability operations and joint response contingencies, US efforts may focus on foreign internal defense operations such as security assistance, FHA, or HN logistic support. These operations are often conducted in areas where social services have been disrupted, resulting in poor sanitation, inadequate food and water distribution, civil disturbances, and general civil unrest. Significant health threats are likely, with the high prevalence of diseases that are endemic and/or can become epidemic, uncontrolled distribution of hazardous wastes and hazardous materials, and environmental extremes.

e. In general, areas where assistance teams and units may be employed will likely have a very low standard of living and high incidence of endemic and epidemic diseases. US forces serving in these areas will enter with very little, if any, natural immunity to endemic diseases. The degree of cultural and social interaction required to support the mission, as well as the sharing of food, quarters, and recreational facilities with local nationals, will increase exposure of US personnel to diseases endemic to the host country. For the most part, assistance operations will last a relatively extended period of time (past 30 days) and will increase the risk of contracting the endemic disease.

f. Insurgent or terrorist forces may not recognize protection afforded to MTF and HSS personnel by the Geneva Conventions. HSS activities may be perceived as prime targets by these groups, especially if these facilities are perceived as making a major contribution to international efforts and/or the HN government. MTFs will also be vulnerable to theft and raids

on CL VIII supplies by insurgents or terrorists for their own support or to support black market activities.

g. In some situations, the in-country components of the US logistic system in support of US assistance forces will be austere. Often the HSS structure will require reliance on contracting from local sources for food, water, sanitation, public health, and health industry resources if in compliance with regulatory and policy guidance. Procurement of fresh foods and beverages and contracting of food storage facilities are supported by veterinary personnel through sanitary inspection of local food establishments in the operational area.

h. HSLS plays a significant role in the delivery of health care during stability operations and joint response contingencies. Prior to a deployment on noncombatant evacuation operations, the senior medical person accompanying the force determines if there are any special medical supply or equipment requirements. In disaster relief operations, the management of CL VIII materiel is critical to the successful completion of the mission. In FHA operations, the health service logistic planner must obtain and coordinate transportation and receive, sort, store, and distribute CL VIII materiel. In nation assistance operations, health service logistic personnel can assist the international community and a HN by conducting an assessment of the military or civilian medical supply infrastructure and industry. In peace support operations, the HSLS mission is more the traditional support to a deployed force.

i. Coordination with the Commander, USTRANSCOM for intertheater PM can be greater in stability operations and joint response contingencies scenarios than in war. US Navy and US Marine Corps transportation assets may be used to support all aspects of HSS in stability operations and joint response contingencies, based on the availability and proximity to coastal waters.



Immunizations are a vital part of force health protection.

When tarmacs are available, coordination with US Air Force transportation should be considered when time is a factor. These circumstances will demand comprehensive HSS planning. HSS planning must be based on current, accurate medical intelligence and include the total involvement of the US country team and coordination with relevant international and HN civilian officials prior to the execution of operations. Some principles of HSS logistic support in stability operations and joint response contingencies can be seen in Figure IV-1.

j. Medical obligations under international law will be particularly crucial to the management of lawful or unlawful personnel such as EPWs, refugees, IDPs, detainees, and lawful or unlawful combatants. HSS plans must detail the degree of care offered to these groups and how continuity of care is to be provided, when needed.

(1) Urgent medical treatment, not otherwise available, will be offered, in coordination with mandated IGOs, to refugees, IDPs, and other civilians, and is dependent upon the operational situation.

(2) Detainees and lawful or unlawful combatants may receive urgent medical treatment in MTFs, but are unlikely to remain in theater hospitals or be evacuated to definitive and rehabilitative care MTFs in CONUS. An alternative source of definitive treatment must be organized as part of the overall HSS plan.

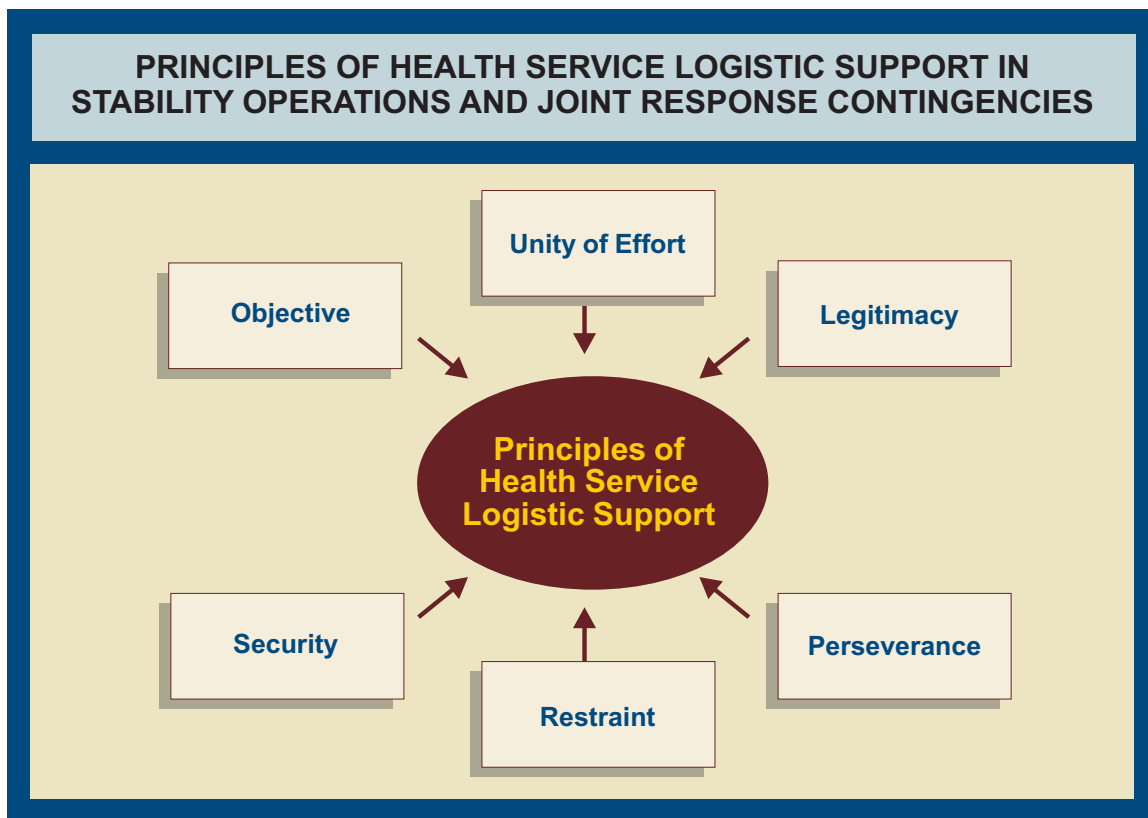


Figure IV-1. Principles of Health Service Logistic Support in Stability Operations and Joint Response Contingencies

k. National law will concern a range of issues, particularly regarding the provision of medical evidence for inquiries into deaths and severe injury.

l. Financial issues for consideration during stability operations and joint response contingencies include:

(1) The size and shape of HSS resources available to support the HSS CONOPS.

(2) Maintenance costs, particularly the provision of medical materiel, resupply, and PM.

(3) Medical supplies approved for donation, eligibility determination, credentialing, malpractice suits, and reimbursement procedures for HSS and supplies.

3. Medical Civil-Military Operations

a. Civil-military medicine is a discipline within operational medicine comprising public health and medical issues that involve a civil-military interface (foreign or domestic), including military medical support to civil authorities (domestic), medical elements of security cooperation activities, and MCMO.

b. MCMO are health-related activities in support of a JFC that establish, enhance, maintain, or influence relations between the joint or coalition force and HN, multinational governmental authorities and NGOs, and the civilian populace in order to facilitate military operations, achieve US operational objectives, and positively impact the health sector. MCMO will normally be performed by joint or coalition medical personnel and CA forces, in coordination with other USG or multinational agencies. The subsets of MCMO include peacetime medical elements of security cooperation activities, HA, disaster response and disease outbreak response in a permissive environment, pre-conflict health-related civil-military activities, and health related civil-military activities during major campaigns and operations, and post-conflict stability operations. HSS personnel may be tasked to conduct or support MCMO in activities that build HN capacity in the public health sector. Close coordination between the JFS and CA elements is essential to the success of MCMO. General guidance for CMO is provided in JP 3-57, *Joint Doctrine for Civil Military Operations*. MCMO actions may be in addition to activities covered under Title 10 USC, Section 401. These operations are often conducted in areas where social services have been disrupted, resulting in poor sanitation, inadequate and unsafe food and water (as well as distribution problems), civil disturbances, and general civil unrest, diseases, uncontrolled distribution of hazardous wastes and hazardous materials, and environmental extremes. In this environment, there are several HSS activities that may be appropriate for MCMO that include: public health activities, to include preventive medicine, personal sanitation and hygiene, safe food and water preparation and handling, infant and child care, preventive dental hygiene, immunizations of humans and animals, veterinary care and behavioral health surveillance and support; development of logistic programs, preventative health measures for local/intrinsic industry, continuing HSS education programs and HSS intelligence and threat analysis, and assistance in upgrading and devising methods for supplying and sustaining existing

HN medical infrastructure and facilities. The focus of HSS initiatives during MCMO is to improve HN capacity to provide public health and medical services to its population, thereby enhancing legitimacy of the HN, enhancing force protection, and accomplishing the JFC's political-military objectives. HSS initiatives during MCMO should emphasize long-term developmental programs that are sustainable by the HN.

c. Medical elements of security cooperation activities encompasses military health-related peacetime activities with other nations that are projected to shape the security environment by building the capability and interoperability of allies, and potential coalition partners. Programs include military-to-military exercises and operations that establish, shape, maintain, and refine relations with other nations; and capacity building projects in the health sector that transfer technical knowledge, skills, and other resources to individuals and institutions so they acquire the long-term ability to establish and deliver competent public services. These activities are designed to support a geographic combatant commander's (GCC's) theater strategy and security cooperation plan.

d. If assigned MCMO missions, JFSs and joint medical planners must consider, in consultation with counterparts in civilian USG agencies, the different types of medical resources required to conduct such operations. HSS must coordinate closely with CA elements and information operations to ensure unity of effort. Every effort must also be made to ensure proper coordination with the USG civilian agency or agencies that may have the lead for all or part of a given operation. Coordination with other agencies in the JOA may also be necessary. These agencies may include, but are not limited to: allies, coalition partners, HN agencies, NGOs, IGOs, and other groups to include religious organizations. The JFC and JFS should not assume the lead for projects in the HN health sector (except during an occupation). The HN should have ultimate ownership of all projects, so that activities are sustainable. The JFC and JFS should ensure that HSS planning for MCMO missions include cultural awareness, and should take measures to guarantee that these operations support and not detract from the legitimate authority of a HN government. Furthermore, the JFC and JFS should consider that the unique venue for MCMO missions is contingent upon several factors that include, but are not limited to: the level of hostilities, rules of engagement, political climate, economic status, cultural influences and biases, religious preferences and cultural standards, and other socioeconomic considerations. Accordingly, the JFC and JFS should ensure that during MCMO missions the HSS staff includes an international health officer or SME with regional medical expertise and linguistic proficiency that can foster partnerships with military, civilian, multinational and USG personnel, IGOs and NGOs, and provide technical expertise, and assistance in identifying and assessing foreign national public and private health systems, sanitation systems, health services, personnel, resources, and facilities. Careful attention must be paid to avoiding the appearance of preferential treatment of individual ethnic groups during MCMO. Efforts should be made to support an equitable HN health system.

e. The JFC and JFS should also organize HSS elements based on the anticipated needs of both the joint force and the civilian populace, within the limits of the military mission and applicable laws and regulations. HSS representatives should seek to participate in all relevant civilian and military coordination mechanisms. HSS personnel should also be aware of, and

consider joining, any existing coordination centers, such as the UN-OCHA's on-scene operational coordination center. In order to adequately anticipate noncombatant needs, JFSs and joint medical planners must conduct a health service assessment that examines the factors listed in Figure IV-2. Standards of care should be agreed upon with HN and the lead USG agency during mission planning; normally, HN standards or international consensus minimum standards (such as Minimum Standards in Disaster Relief, World Health Organization) should be used. The JFC, JFS, and CA should monitor MCMO throughout planning and execution and should utilize both measures of performance and measures of effectiveness. Planners should anticipate unintended consequences and should correct for these during and after execution. The JFC and JFS should be cognizant that in MCMO, the provision of HSS and health education play a direct role in countering both medical and general threats and provide a noncontroversial and cost-effective means of utilizing the military element to support US national interest in another country by:

- (1) Assisting with the development and refinement of the HN medical infrastructure.
- (2) Provide and assist with sustaining the basic necessities of life for the general population through development and/or enhancement of the HN civilian medical programs.
- (3) Providing assistance in establishing, repairing, or improving basic health and sanitation services, especially if these have been degraded by military operations.
- (4) Monitoring civil health indicators and health risk (i.e., life expectancy, infant mortality rate), in conjunction with medical intelligence and the J-2.

f. Significant health benefits can be derived from nonmedical interventions, such as improving the water supply, electrical grid, ensuring security of health facilities, etc. JFSs and



Figure IV-2. Health Service Assessment Factors

joint medical planners should coordinate with other sections of the JTF (such as the J-4 logistics and engineers, J-3 force protection, etc.) to accomplish this.

4. Special Operations Forces

a. **General.** SOF are specially organized, trained, and equipped forces of the Army, Navy, and Air Force that conduct unconventional warfare, direct action, special reconnaissance, foreign internal defense, counterterrorism, psychological operations, CA operations, counterproliferation of WMD, and information operations. SOF missions are often highly classified and conducted in remote and/or denied settings. The nature of SOF missions requires small, highly skilled, self-contained teams that can be easily inserted and extracted by air, sea, and land.

b. Organic HSS Capability

(1) **Medical planning.** The Commander, US Special Operations Command, provides SOF to the supported commanders. To provide the necessary unity of command, each GCC has established a subordinate unified command to serve as the functional special operations command (SOC). The SOC component commander coordinates conventional HSS packages to augment SOF organic medical capability.

(2) **SOF HSS.** SOF HSS includes limited quantities of medical, surgical, critical care management, CASEVAC, patient holding, and primary care capabilities. SOF enlisted medical personnel receive enhanced medical training that allows independent duty capabilities which exceed those of their conventional counterparts. HSS of special operations units is characterized by an austere structure and a limited number of medical personnel with enhanced medical skills, to include emergency treatment, advanced trauma management, preventive medicine and limited veterinary and dental care. The primary focus of SOF HSS is to provide essential care and manage casualties until force extraction from the operational area. Consequently, joint medical planners must develop a flexible medical structure linking the required conventional HSS as far forward as the joint special operations task force, forward operations bases, and intermediate staging bases. Critical support requirements include forward surgical support, blood and blood products, and linkage to strategic air movement.

(3) SOF Operational Medicine

(a) SOF medics are all SOF paramedic and special operations combat medics. They are capable of providing advanced tactical combat casualty care. Additionally, special forces, Air Force SOF medical element, and senior sea-air-land team (SEAL) corpsmen are advanced medics with Service independent duty designations. These enlisted medics are trained as independent, interoperable combat medics with the Service/mission unique medical capabilities (sea based, small unit operations, veterinary, or aviation medicine).

(b) Air Force pararescuemen, SOF medical element medics, and Special Operations Aviation Regiment medics provide SOF with a personnel recovery and CASEVAC

capability aboard Air Force and Army special operations aviation assets. Both Air Force and Army assets support all SOF operations – regardless of the lead Service.

(c) Squadron, group, platoon, battalion, or team physicians, physician assistants (PAs), dentists, veterinarians, and preventive medicine professionals providing augmentation, advice, and expertise to the SOF health care team support SOF medics at forward staging bases. Air Force and Army special operations support organizations provide advanced trauma management, sick call, logistic support, blood, laboratory, patient hold, and transportation capabilities to support special operations bed down locations.

(d) Forward surgical capabilities are provided by Air Force Special Operations Command's special operations surgical teams and special operations critical care evacuation teams (SOCCETs). These small, mobile, lightweight teams are comprised of specially trained and equipped general/trauma surgeons, orthopedic surgeons, emergency physicians, nurse anesthetists, cardiopulmonary and surgical medical technicians. These teams, when combined with the US Army Special Operations Command's special operations support organizations create a more robust SOF medical capability.

(e) CA units do not have an organic HSS capability. CA battalions have medical personnel assigned, but are organized to only provide advice and expertise to the supported missions and not HSS to the force. Medically trained personnel in CA battalions provide assistance in identifying and assessing foreign public and private health systems, to include health and sanitation systems, agencies, personnel, and facilities. CA specialties may work with NGOs and IGOs to rehabilitate or develop functional health care systems within the JOA.

(f) Naval special operations forces (NAVSOFF). HSS assets assigned to SEALs, SEAL delivery teams, and special boat teams have first responder capabilities for basic clinical care, emergency medicine, trauma care, and CBRN casualties. NAVSOFF units have no organic FRC, aeromedical, MEDEVAC, preventive medicine, laboratory, veterinary or dental capabilities. Deployed NAVSOFF forces rely on other conventional Army, Navy, Air Force and SOF HSS for nonorganic medical capabilities. HSS personnel assigned to NAVSOFF support units include undersea medical officers, PAs, independent duty hospital corpsmen, diving medical technicians, hospital corpsmen and special operations medics, providing first response capabilities. NAVSOFF units deploy with basic allowance of medical supplies and equipment and can be resupplied.

c. SOF Health Service Support Planning

(1) The goal of special operations HSS planning is twofold: first, provide integrated, augmented conventional support into the concept of the special operations mission without compromising the objectives; second, articulate the unique challenges of the operation that will complicate the delivery of HSS by conventional units (see Figure IV-3). The SOF HSS must ensure that the conventional HSS planner understands these aspects. The conventional HSS planner must translate SOF-unique requirements into the conventional HSS infrastructure best suited to support the mission.

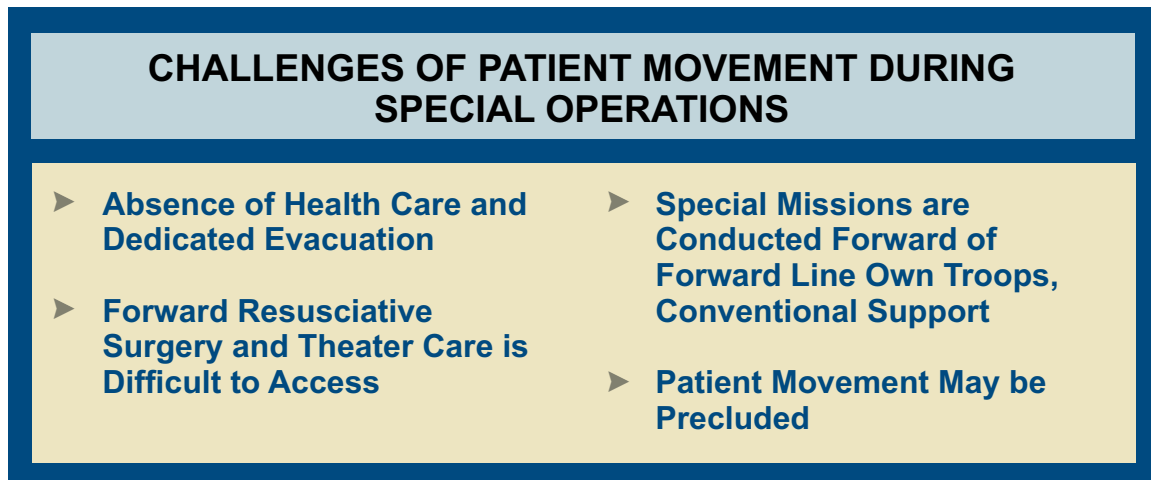


Figure IV-3. Challenges of Patient Movement During Special Operations

(2) Unique challenges of HSS to SOF must be incorporated into HSS planning at the theater JFS staff level, with full knowledge and concurrence of SOC planning staff. HSS must be planned and coordinated with subordinate joint force elements by the theater JFS staff.

(3) The JFS and theater SOC and/or SOF component HSS planners develop comprehensive operational area-specific plans to support the special operations mission planning and execution cycle. Essential aspects of these plans link SOF with conventional HSS. Additionally, strategic and operational circumstances may require arrangement for HN hospital support for special operations missions terminating in friendly territories within a theater.

(4) SOF missions that may require special management of SOF personnel will be coordinated by the SOF medical planner or special mission unit medical or counterintelligence professionals to ensure SOF operations are integrated into conventional medical capabilities with the least opportunity of mission compromise.

(5) SOF entry to the conventional HSS system may occur at the nearest forward resuscitative care capability but will normally occur at the first MTF of admission.

5. Multinational Operations

a. **Introduction.** Joint operations conducted in today's global environment will normally be multinational in nature, not unilateral. Multinational operations occur when two or more nations join their armed forces to accomplish a common objective. The two types of multinational force structures are alliances and coalitions.

(1) These forces must create a structure that meets the needs, diplomatic realities, constraints, and objectives of the participating nations. Multinational operations may also be conducted under the auspices of an IGO, such as the UN.

(a) **Alliances are the result of formal agreements** between two or more nations to accomplish broad, long-term objectives. The alliances normally adopt interoperability standards and procedures, which are codified in standardization agreements. The North Atlantic Treaty Organization (NATO) is an example of an alliance.

(b) **Coalitions are ad hoc arrangements** between two or more nations for the accomplishment of a specific objective. Once the objective is accomplished, the coalition is disbanded.

(2) Multinational support operations are complicated by a number of characteristics that impact fundamentally upon the provision of HSS.

(a) Unique nature of every individual operation.

(b) Geographic, topographic, and climatic variations of the operational area.

(3) Numbers of individual nations involved in each operation.

(4) Variations in national standards of HSS and equipment.

(5) Language and communications differences.

(6) Political complexity and dynamic nature of each operational scenario.

(7) Mission of medical support forces.

(8) Differences in individual national objectives and/or restrictions for participation in operations and integration of overall mission goals.

(9) Medical staffs may face numerous challenges affecting the health of multinational personnel deployed on operations. Therefore, multinational HSS operations require clearly defined guidance. Common HSS challenges in multinational operations are shown in Figure IV-4.

(10) HSS plans must be tailored to each operation and meet the demands of geography, individual national needs, language, and communication difficulties. Plans must be capable of rapid implementation, but at the same time be flexible enough to manage rapidly changing operational demands.

(11) Every deployed multinational force normally has a surgeon and/or chief medical officer who has direct access to the multinational force commander (MNFC).

(12) Each deployed national contingent that has HSS personnel must have a single designated individual who has the clinical responsibility for all national HSS matters.



Figure IV-4. Health Service Support Challenges in Multinational Operations

b. **Principles of Multinational Operations.** To qualify to participate in the MNF (and for subsequent multinational resourced medical treatment, PM, and personal disability compensation), national contingents and individuals allocated or contracted to multinational operations must meet the basic standards of individual health and physical fitness laid down by the chief medical officer staff.

(1) Contributing nations bear ultimate responsibility for ensuring the provision of HSS to their forces allocated to multinational operations. This may be discharged in a number of ways, including agreements with other nations or the appropriate multinational planning staffs and MNFCs.

(2) International Conventions for the Treatment of the Sick and Wounded. HSS for operations will comply with provisions of the Geneva Conventions. Persons entitled under the terms of the Conventions shall, without discrimination, receive medical treatment on the basis of their clinical needs and the availability of HSS resources.

(3) Standards of HSS. Operational HSS to MNFs must meet standards that are acceptable to all participating nations. Care provided to US forces participating in a multinational operation must meet US standards.

(4) Estimation of Medical Risk. Estimation of medical risk and the associated casualty rates is the responsibility of the individual nation with HSS advice of the multinational operational staffs.

(5) Multinational HSS Capabilities. In multinational operations, medical resources are typically distributed into four tiers on a progressive basis to conduct treatment, evacuation, resupply and other functions essential to the maintenance of the health of the force. All medical resources are categorized into four Roles, according to their capabilities and are closely related, but are not directly interchangeable. Capability describes what function the medical resource can perform with capability increasing from Role 1 to Role 4. The minimum capabilities of each Role are intrinsic to each higher Role. As an example, a Role 3 facility has the ability to carry out Role 1 and Role 2 functions. A medical facility cannot be reduced below the minimum

capabilities of its given numeric descriptor. Therefore, a medical asset cannot be described as a Role “minus.” Under battle conditions, the flow of casualties generally follows the pattern from Role 1 to Role 3 facilities with medical evacuation to Role 4 hospitals taking place as appropriate.

(a) The Role 1 MTF provides primary health care, specialized first aid, triage, resuscitation and stabilization. Normally included within the basic Role 1 capabilities are routine sick call and the management of minor sick and injured personnel for immediate return to duty, as well as casualty collection from the point of wounding and preparation of casualties for evacuation to the rear. Role 1 is the lowest level where at least one medically qualified doctor is available.

(b) A Role 2 MTF is a structure that is capable of the reception and triage of casualties, as well as the capacity to perform resuscitation and treatment of shock to a higher level than Role 1. It usually includes damage control surgery and a limited holding facility for the short-term holding of casualties until they can be returned to duty or evacuated. The deployment of Role 2 MTFs is mission-dependent and some Role 2 MTFs are structured with improved clinical capability. These Role 2 MTFs are classified into Role 2 light maneuver (2LM) and Role 2 enhanced (2E).

1. 2LM MTFs are light, highly mobile MTFs designed to support land maneuver formations (normally brigade level). A Role 2LM MTF is able to conduct advanced resuscitation procedures up to damage control surgery. It will always evacuate its post surgical cases to Role 3 (or 2E for stabilization and possible primary surgery before evacuation to Role 4.

2. 2E MTFs are effectively small field hospitals. They provide basic secondary health care, built around primary surgery, intensive care unit, and nursed beds. A 2E MTF is able to stabilize postsurgical cases for evacuation to Role 4 without the requirement to first route them through a higher MTF.

(c) Role 3 MTFs are designed to provide theater secondary health care within the restrictions of the theater holding policy. Role 3 medical support is deployed hospitalization and the elements required to support it. It includes a variety of mission-tailored clinical specialties including primary surgery and appropriate diagnostic support.

(d) A Role 4 MTF provides the full spectrum of definitive medical care that cannot be deployed to theater or is too time consuming to be conducted in theater. It typically includes definitive care specialists, surgical and medical procedures, reconstructive surgery, and rehabilitation.

(6) Multinational HSS capabilities are normally provided appropriately to a particular operation. Policy for national contributions will generally be as follows:

(a) Role 1 — National responsibility.

(b) Role 2 — National and/or lead nation. For the United States, Role 2 is a national responsibility.

(c) Role 3 — National and/or lead nation. For the United States, Role 3 is a national responsibility.

(d) Role 4 — National and/or force provided (contracted). For the United States, Role 4 is a national responsibility.

c. Multinational Planning Considerations

(1) Contributing nations retain ultimate accountability for the health of their forces, but, the MNFC will normally share the responsibility for or has an interest in the health of assigned forces. To meet this requirement, the MNFC needs appropriate HSS staff available at the early stages of planning HSS for an operation.

(2) National HSS systems should be retained as an organic force structure to the contributing nation's forces as much as possible. However, HSS planners must seek to take advantage of economies of scale which may be achieved from multinational concepts such as lead nation responsibilities, role specialization, and mutual assistance.

(3) The HNS resources available in the operational area are the key to determining the size and capability of the HSS organization that the MNF must establish. The more HNS available for use, the less that has to be found from contributing nations. Overall, a mixture of medical intelligence analysis and on-the-ground reconnaissance assesses HNS capabilities. A key issue will be the standards of HSS available, compared to the MNF and national contingent criteria.

(4) HSS requirements are to be determined by the appropriate MNFC in consultation with contributing nations and the HSS planning staff. HSS resources will be specified as those necessary to prevent and control DNBI and to collect, evacuate, and treat casualties.

(5) Maximum effort must be made to tailor HSS mission requirements. HSS planners must find a balance of capabilities. An example may be to organize a single nation to provide a particular function, such as AE, for all contingents.

(6) From the outset of an operation, policy must be established regarding the entitlement of non-US military and/or nonmilitary staffs and other authorized personnel in-theater and for all medical treatment other than emergency measures.

(7) Establishing the PM policy is a command decision of each nation. HSS and logistic staffs will advise. The force theater surgeon will promulgate recommendations and will monitor the established PM policy.

(8) A comprehensive and effective communications system and intelligence plan is fundamental to multinational HSS planning considerations. It begins prior to deployment, with

the establishment of a competent HSS planning team at the MNF HQ. It is also crucially dependent upon the following.

(a) Clearly established lines of accountability and control agreed to by all participating contingents.

(b) Liaison at every level including HNS and any NGOs in theater.

(9) Preventive Medicine Capability. The expertise to manage preventive medicine responsibilities must be made available at all levels. The requirement will be for preventive medicine units as well as individual experts. The provision of this capability lends itself well to a lead nation approach. The shape and size of in theater preventive medicine capability will be dictated primarily by the following.

(a) The size of the MNF to be supported, its dispersal, and the theater topography.

(b) The capability of national contingents to implement preventive measures independently.

(c) The responsibility to ensure that personnel are prepared and appropriately trained in field preventive medicine measures prior to deployment to an operation. This must include the necessary pretreatments, chemoprophylaxis, barrier creams, and immunizations.

1. Recommendations for pretreatment, immunization, and chemoprophylaxis for the MNF will be made by the chief medical officer during the initial planning stage, but it remains the responsibility of each nation ultimately to ensure that its personnel are adequately protected.

2. A MNF policy must be issued as early as possible regarding the prophylaxis measures that must be taken by all individuals deploying into the operational area. Instructions must cover measures to be taken prior to deployment, while in-theater, and during post-deployment.

(d) It is a national responsibility to maintain high standards with regard to the provision of food and water, as well as field sanitation standards.

1. JFS and/or chief medical officer will inspect and audit national measures to ensure that acceptable standards are maintained in these areas.

2. Minimum standards acceptable to all participating nations must be maintained if the MTFs are to be used to support personnel outside the respective national force.

(10) The chief medical officer's force hygiene officer is responsible for coordinating preventive medicine services such as regional spraying or vector control and advising on placing local population centers and/or facilities off limits.

- (11) Education on prevention of diseases is a national responsibility.

d. **Patient Movement in Multinational Operations.** The theater PM policy, known in some nations as a holding policy, is the key to balancing the treatment capability available at each level of care against the required medical PM assets. The provision of resources will be coordinated by the MNF HSS planning staff, but will comprise assets from a number of sources, including HNS. Theater medical PM requires careful planning and an acquisition and cross-servicing agreement.

- (1) PM from point of injury to Role 1 — National responsibility.
- (2) PM from Role 1 to Role 2/3 — National, force, and lead nation.
- (3) PM movement to Role 4 — National, force, and lead nation.

e. **Personnel in Multinational Operations**

(1) National contingents will be expeditiously notified through designated national liaison POCs of individuals that become critically injured and/or ill or die.

(2) Medical obligations under international law will be particularly crucial to the management of lawful or unlawful personnel such as EPWs, refugees, IDPs, and other civilians, detainees, and lawful or unlawful combatants. HSS plans must detail the degree of care to be offered to these groups and how continuity of care is to be provided, when needed.

(3) Only urgent medical treatment, within the capability of the deployed multinational medical force and not otherwise available, will be offered to refugees and IDPs.

(a) Detainees and lawful or unlawful combatants may receive urgent medical treatment in force MTFs, but are unlikely to remain in theater hospitals or be evacuated to force-provided definitive and rehabilitative care MTFs for continuing treatment. An alternative source of definitive treatment must be organized as part of the overall HSS plan.

(b) Customary international, US, and HN law will concern a range of issues, particularly regarding the provision of medical evidence for inquiries into deaths and severe injury.

f. **Health Service Logistics in Multinational Operations.** The holding, issuing, and accounting for all medical, dental, and veterinary supplies (equipment, pharmaceutical, and consumables) to a MNF is a major undertaking. It is a joint responsibility of the chief medical officer and the chief health service logistic officer, whose offices must cooperate to create a system with the necessary reliability, flexibility, and speed. The supply of blood and blood products to multinational operations is a complex and sensitive issue, stemming from the wide disparity of standards between nations and the legal constraints incumbent upon some of them. Consequently it is considered as a separate function within health service logistics. The availability

of blood and blood products is essential for management of the seriously injured and sick. For the majority of multinational operations, this will require its provision at theater hospitals and at FRC capabilities if providing resuscitative surgical care.

(1) For multinational operations, the general principle is that national contingents should be responsible for the supply of blood to their own injured and sick. In reality, this is not always a practical proposition. The requirement must, therefore, be that all blood and blood products used in theater comply with internationally agreed upon standards. Where a particular nation cannot accept this as policy, they must organize their own system of supply at national expense.

(2) The most cost-effective and rational approach is for the force HSS planning staffs to coordinate supplies through the lead nation, using supplies from a nation whose blood and blood products are acceptable to all contingents.

(3) Consider laws and regulations of each country applicable to their personnel (FDA regulations).

g. Legal Issues in Multinational Operations

(1) Both international and national law, particularly concerning the medical management of refugees, detainees, and non-entitled civilians, must be considered in multinational operations. The JFS should be particularly sensitized to the limits imposed by title 10, USC, which outlines under what conditions non-DOD beneficiaries can receive medical treatment from US medical forces.

(2) Any pathological materials and/or tissues taken in the course of conducting an autopsy or preparing a death certificate must be turned over to the decedent's national representative. Human remains are returned through designated mortuary affairs personnel. In addition to the legal issues, social and cultural customs with regard to the disposition of deceased personnel should be respected to the extent possible.

6. Detainee Considerations

a. During the conduct of joint and coalition operations, the JFS and component medical forces must be prepared to provide HSS to a wide array of individuals that may be detained by US forces. JP 3-63, *Detainee Operations* provides detail guidance for planning and executing detainee operations.

b. The Army is the DOD EA for the administration of the DOD EPW/Detainee Program, whereas GCCs are responsible for the overall execution of the program within their respective AORs.

c. It is DOD policy that all persons detained by the Armed Forces of the US during the course of military operations shall be treated humanely from the moment they fall into the hands

of US forces until their release. The inhumane treatment of detainees is prohibited by the Uniform Code of Military Justice, domestic and customary international law, and DOD policy.

d. It is DOD policy that all DOD personnel (military and civilian personnel) and contractor employees who obtain information about a reportable incident (such as abuse) as set forth in DODD 5100.77 and ASD(HA) Policy Memorandum 05-006, will immediately report the incident through their chain of command or supervision. Reports also may be made through other channels, such as the military police, a judge advocate, a chaplain, or an inspector general, who will then forward a report through the appropriate chain of command or supervision.

e. It is also DOD policy that the Armed Forces of the US comply with the principles, spirit, and intent of the international law of war, both customary and codified, to include the Geneva Conventions.

f. **Medical Care and Treatment.** The medical program support for detainee operations shall comply with the principles, spirit, and intent of the international law of war and the Geneva Conventions. To the extent practicable, treatment of detainees should be guided by professional judgments and standards similar to those that would be applied to personnel of the Armed Forces of the US. Medical program support for detainee operations should:

(1) Provide medical care that focuses upon emergency surgery and essential postoperative management to prevent probable death or loss of limb or body functions; essential care; sanitary and preventive medicine measures to include isolation areas, as necessary to prevent epidemics, routine sick call, and specialized medical care and treatment as appropriate.

(2) Ensure the provision of an initial detainee medical screening that includes an examination and documentation of the detainee's physical and medical condition upon initiation of detention; a monthly medical screening to monitor the general state of health, nutrition and cleanliness of detainees; and ensures that the detainee repatriation and release procedures include a medical screening, instructions for the use of prescribed medications, a supply of medications, and that all appropriate medical and dental records accompany the detainee.

(3) Ensure that the appropriate health care providers are available to address the health care needs of female and juvenile detainees. Copies of the medical record should accompany the detainee whenever they are transferred to another facility or repatriated.

(4) Establish accurate and complete medical records on all detainees. Medical records must be established and maintained for all detainee medical encounters, whether in fixed facilities or through medical personnel in the field.

(5) Ensure that detainees are not utilized as human subjects for medical/scientific experimentation.

(6) Ensure that health care professionals charged with any form of assistance with the interrogation process, to include interpretation of medical records are not involved in any aspect

of detainee health care. Health care providers charged with the care of detainees should not be actively involved in the interrogation process, advise interrogators how to conduct interrogations, or interpret individual medical records/medical data for the purposes of interrogation or intelligence gathering.

(7) Ensure that the psychologist assigned as the behavioral science consultant that assists interrogators and the detention staff with interrogations and the management of detainees is not assigned a mission of patient care. Personnel that comprise the behavioral science consultation team (BSCT) are not assigned to MTFs and employ their professional training not in a provider-patient relationship. Therefore, BSCT members should not consult with the detainee medical treatment team on issues of detainee medical care.

g. **Detainee HSS Planning Considerations.** The JFS in conjunction with the SJA should develop detainee medical care policy recommendations for the JFC IAW applicable laws and regulations. Additionally, the JFS should consider the following when developing HSS plans for supporting detainee operations:

(1) Ensuring that the medical annex of OPLANs and OPORDs, and appropriate CONPLANs and FRAGORDs includes procedures for the treatment of detainees that is guided by professional judgments and standards similar to those that would be applied to personnel of the Armed Forces of the United States. Medical support should specifically include: emergency and essential care, and all sanitary aspects of food service including provisions for potable water, pest management, and entomological support, preventive medicine (to include immunizations as directed and established by applicable policies), professional medical services and medical supply; reviewing, recommending, and coordinating the use and assignment of medically trained detainees and medical material; and establishing policies for the medical repatriation of detainees.

(2) Tasking subordinate MTFs/units to support detainee operations and provide medical care that focuses upon emergency surgery and essential postoperative management to prevent probable death or loss of limb or body functions; essential care; higher medical care as required (including dental and optometry); isolation areas (for contagious disease) if necessary, and routine sick call.

(3) Recommending to the JFC an immunization policy for detainees as dictated by the disease health threat.

(4) Ensuring the provision for an initial medical screening of detainees that includes an examination and documentation of the detainee's physical condition upon initiation of detention, and the examining of detainees for contagious diseases.

(5) Ensuring that interpreters are available to translate patient complaints to attending medical personnel.

(6) Ensuring that plans and appropriate intervention procedures are established for prisoners on hunger strikes or who refuse treatment.

(7) Ensuring that plans and appropriate procedures are developed to manage an outbreak of contagious disease within the detainee population.

(8) A process to document detainee authorization for all surgical or invasive procedures performed on detainees.

7. Chemical, Biological, Radiological, and Nuclear Operations

a. The JFC, at all levels, is faced with the possibility that any operation may have to be conducted in a CBRN environment. The term “CBRN environment” includes the deliberate or accidental employment or threat of CBRN weapons and attacks with toxic industrial chemical, biological, or radiological material. The threat of having to conduct operations in a CBRN environment pose unique challenges to HSS forces worldwide.

b. The component command surgeons, working with the appointed JFS/JTFS are responsible for guiding and integrating all HSS capabilities available to the command to support mission accomplishment in an CBRN environment. In planning for HSS in potential CBRN environments, preparations should include pre-exposure immunizations, pretreatments, prophylaxis, and medical barrier materials applicable to the entire force including multinational, interagency, and civilian participants.

c. Concerning Support to Civil Authorities. Terrorist groups may employ CBRN weapons, or natural and manmade disasters may contaminate areas with toxic materials whose mitigation will require the efforts of specialized military forces. HSS forces may require coordination and cooperation with agencies, organizations, and individuals outside the military chain of command or direct control. In many situations, the JFC may be in a supporting role to civil authorities, or to HN authorities. Regardless of the role, the JFC and joint force elements must be prepared for CBRN use and contamination with toxic materials at any point, including the transition from noncombat to combat environment. In the US, there may be a requirement to augment civilian medical capabilities in the handling of casualties resulting from CBRN attacks or other toxic material contamination. The ability of domestic and HN medical facilities to handle MASCALs from CBRN effects should be assessed and factored into US joint and multinational planning. Close coordination with HSS and other public health providers in the theater is a vital means of detecting chemical or biological attacks, since casualties from such an attack may appear initially in the civilian medical system.

d. **Planning for CBRN Operations.** In planning to conduct CBRN defensive operations, the JFS should make good use of the numerous publications each Service produces and consider potential defensive measures. These defensive measures should include targeting key areas for surveillance, employing personal protective measures to help prevent exposure, and instituting detection strategies.



C-17 taking off with aeromedical evacuation patients.

e. **Casualty management.** CBRN operations can create large numbers of casualties who have been exposed to agents, toxins, radiation, or infections. The fact that the exposure was deliberate does not alter the basic principles of treatment. Medical facilities should, however, be prepared to respond rapidly as casualty workload will likely peak quickly with little advance warning. As some biological agents are transmissible between humans, they may cause problems for some time after any initial attack.

f. **Preventive medicine.** Preventive medicine specialists play an important role in assessing the medical threat posed by a CBRN attack. They can identify potential health threats and determine when to use immunizations, prophylaxis, and other prevention measures. Following any CBRN attack, special emphasis should be placed upon food and water sanitation, hygiene, and common prevention measures that reduce the spread of disease. All food, except canned goods, must be thoroughly inspected before consumption. Insect and rodent control becomes more important following a CBRN attack because vectors can serve as continuing sources of infection and spread of contamination. Rigid enforcement of water sanitation and personal hygiene measures may reduce the attack's effects.

g. **Patient evacuation.** One of the first considerations following a CBRN attack is to determine to what extent evacuation assets will be committed to contaminated areas. In general, the transport of contaminated patients should be limited to movement that is essential to provide patient care. Treatment in-place should be weighed against the risk of degrading military operations by overwhelming in-theater medical assets. If AE assets are requested, prior approval must be given by the GCC and the Commander, USTRANSCOM. If uncontaminated personnel are to be sent into contaminated areas to evacuate casualties, some type of exposure guide must



Decontamination team moves a patient during a field training exercise at Sagami Depot, Japan.

be established and followed. Every effort should be made to limit the number of assets and people that become contaminated. The decontamination of patients before evacuation will help limit the spread of contaminants. Further information is contained in the ASD(HA) policy letter available from the GPMRC web site at: <https://business.transcom.mil/gpmrc> under the heading of USTRANSCOM Policies.

h. Patient decontamination and triage. Decontamination of patients serves two purposes. It reduces the amount of contaminant that is absorbed by the patient, and it protects the medical staff. Decontamination and triage of CBRN casualties will obviously vary with the situation and the contaminant. Therefore, medical units should have a basic CBRN MASCAL plan that can be modified to meet varying situations. Decontamination should be decentralized to avoid a backup of casualties awaiting cleanup at a central location. Each medical facility must be able to establish its own decontamination area. As in any MASCAL situation, arriving casualties should be examined at a triage point and directed to the proper area. An additional triage decision in CBRN MASCAL situations is whether patients have medical conditions that take priority over decontamination. Ninety percent of all decontamination can be performed without interfering with medical treatment simply by removing a casualty's outer clothing and shoes.

i. Impact on HSS. Even if a CBRN attack produces few fatalities, it may likely result in numerous casualties who require extensive treatment, and a large number of patients who are well but will report for medical treatment anyway. Medical staffs will be taxed. Additionally, medical personnel may need to work in mission-oriented protective posture gear, which will reduce their effectiveness. Decontamination efforts may reduce staff available to perform medical functions. As a result, the unit will be considerably less effective.

8. Mass Casualty Operations

a. The term mass casualties means that a large number of casualties have been produced simultaneously or within a relatively short period of time. It also means that the number of patients requiring medical care exceeds the medical capability to provide treatment in a timely manner. MASCALs may occur at any time – in peace, during stability operations and joint response contingencies, or during major operations. They may occur as a result of a natural disaster, the deliberate or accidental release of CBRN agents, or the effects of a CBRNE attack. If a CBRNE device has been used, the JTF surgeon and his staff will need to consider the following: consolidating contaminated personnel to certain hospitals or areas, casualty estimates, additional medical resource requirements, reallocation of medical resources, and management of the casualties.

b. In nuclear attacks, many more burns, low-velocity missile wounds, and ionizing radiation injuries can be expected as compared to a predominance of high-velocity missile wounds associated with conventional warfare. Casualties will be produced faster, and locally available means for early resuscitative care may quickly prove inadequate. At the time of triage, it will not be possible to predict which patients with thermal or blast injuries will develop radiation sickness. It will not always be possible to determine the dosage of irradiation which a patient has received. In these cases, reliance must be placed on clinical symptoms, which may suggest that the patient has received a significant dose of irradiation.

c. Under biological conditions, the control of epidemics will be of paramount importance. Because of the large numbers of patients expected following a biological attack, it is probable that:

(1) Evacuation facilities will be unable to support the additional requirements.

(2) Units will have to stay on location and look after themselves. If required, however, medical personnel and equipment could be moved into the area to assist. Keeping affected units on location will prevent the spread of infection to unaffected areas.

d. In a chemical environment, there will be a need to consider the individual protection of medical personnel and of patients. There will also be a need for decontamination of patients. Decontamination will be time-consuming and will place heavy demands on manpower, especially medically trained personnel. The disposal of contaminated clothing and supply of clean clothing and decontaminants will present a unique logistic challenge.

e. Directed-energy weapons are likely to cause large numbers of casualties and equipment disruptions if effective countermeasures processes are not in place. HSS units should have adequate organization, procedures, and resources to address directed-energy threats.

f. Civilian casualties may be a significant problem in populated areas. HSS may be required to assist in treating civilian patients when the civilian medical resources become overwhelmed and inundated with patients.

g. In a MASCAL situation, conventional treatment priorities may have to be abandoned. This means a radical departure from the traditional practice of providing early complete definitive treatment to each patient on the basis of his/her individual needs.

h. JFS's responsibilities in MASCAL operations:

(1) The JFS's role in preparing for a MASCAL situation includes the development of a MASCAL plan. In addition to providing support to the normal mission, the JFS recommends protective measures against other forms of warfare, which could result in the generation of MASCAL. When a MASCAL situation occurs, the JFS is responsible for the management of patients.

(2) The JFS must develop a MASCAL plan that is clearly defined and which is sufficiently detailed for understanding at all levels. It must be practiced at regular intervals and executable at the appropriate level.

(3) The JFS must address in the plan such items as:

(a) The medical situation.

(b) The movement policy (including alternate plans) and responsibilities for PM and medical regulation.

(c) Alternate treatment locations and evacuation routes.

(d) CBRN and WMD considerations. (For example, should patients with CBRN injuries or contamination be relegated to designated hospitals or will all hospitals receive CBRN casualties? Other issues include casualty estimates, additional medical resource requirements, reallocation of medical resources after attack, categorization of combined injury casualties/patients, and treatment and management of CBRN casualties, including restriction of movement of persons exposed to CBRN agents.)

(e) Directed-energy considerations. (For example, what are the requirements for ballistic/laser protective spectacles, protective filters, magnifying optics, and vision blocks?)

(f) Protection of patients and HSS resources to include medical personnel from contamination. (Protection includes both individual and collective protection. Patients need individual protection in either patient protective wraps [clean patient across a contaminated environment] and/or transport isolation units [moving contagious patients], to include collective protection for all treatment facilities, if available.)

(g) Emergency resupply for CL VIII including blood.

(h) Nonmedical resources (especially personnel and transportation).

- (i) Assistance including evacuation support from other Service components.
 - (j) The types of additional nonorganic medical assets needed.
 - (k) Priority of support and communications between evacuation assets and treatment assets.
 - (l) A clear delineation of medical responsibilities throughout the operational, technical, and administrative channels.
 - (m) Procedures for the distribution and documentation of any pharmaceuticals.
 - (n) Procedures for keeping necessary records and reports of the flow of patients.
 - (o) Procedures to cover situations where an unusual number of blinded patients seek medical attention.
 - (p) Required liaison with civilian authorities, where and when applicable.
- i. MASCAL operations should be coordinated through and approved by the commander and incorporated into an MASCAL plan. The MASCAL plan must be coordinated with echelons above and below. It must also be adaptable to day and night operations.

9. Contingency Contractor Personnel

a. In the 21st century operational environment, contractor support is a growing force-multiplier option for supporting US military operations. Contracted support spans the spectrum of combat support and combat service support functions; and may include interpreter, communications, infrastructure, and other non-logistic-related support. It also has applicability to the full range of military operations, to include offense, defense, support, and stability within all types of joint and coalition operations, from small-scale contingencies to major operations. Contractors can expect to be employed anywhere in a GCC's AOR necessary to support operations and weapon systems, subject to the GCC's risk assessment and terms and conditions of the contract. Department of Defense Instruction (DODI) 3020.41 provides detailed guidance for contractor personnel authorized to accompany the Armed Forces of the United States.

b. This section provides the basic doctrine for DOD contractors and their subcontractors at all tiers under DOD contracts, including TCN and HN personnel, who provide support to US military forces in contingency operations or other military options designated by the GCC, under such contracts. It also addresses a subcategory of contingency contractor personnel, called CDF that are authorized to accompany a joint force and are provided with an appropriate ID card under the Geneva Conventions. The doctrine does not apply to those contractor personnel in the US and its territories; nor does it apply to contractor personnel who support long-term forward-deployed US organizations and facilities located outside any declared contingency area.

c. Theater medical preparation. Prior to deploying, certain medical readiness requirements must be satisfied for contingency contractor personnel to deploy to an operational area. These predeployment requirements identified during the planning process and included in the appropriate contract, communicate to the contractor the specific theater medical readiness requirements. GCCs should ensure that contingency contractor personnel are not permitted entry into their theaters without first being medically evaluated and prepared for entry into the operational area by processing through a deployment center. Medical and dental screening of contingency contractor personnel should be accomplished prior to deploying to avoid returning medically unfit individuals from the theater. Similar to military personnel, contingency contractor personnel should pass a complete medical evaluation based on the functional requirements of the job required by contract in the operational area. Emphasis should be placed on diagnosing cardiovascular, pulmonary, orthopedic, neurologic, endocrinologic, dermatologic, psychological, visual, and auditory conditions, which may preclude performing the functional requirements of the contract, especially in austere work environments encountered in some contingency operations. Additionally, contingency contractor personnel should have a thorough dental exam and complete all necessary dental work prior to deployment. Individuals that are deemed not medically qualified at the deployment center or during the deployment process, or require extensive preventive dental care, should not be authorized to deploy.

(1) DOD contractors are responsible for providing medically, physically, and psychologically fit personnel to perform contracted duties in contingency or crisis operations as outlined in the contract. Fitness specifically includes the ability to accomplish the tasks and duties unique to a particular operation, and the ability to tolerate the environmental and operational conditions of the deployed location. SecDef may direct immunizations as mandatory for CDF personnel performing essential DOD contractor services per DODI 3020.37, *Continuation of Essential DOD Contractor Services During Crisis*, and DODI 6205.4, *Immunization of Other Than US Forces (OTUSF) for Biological Warfare Defense*.

(2) Any CDF personnel deemed unsuitable for deployment due to medical or dental reasons should not be authorized to deploy with the military force. Additionally, CDF should not be authorized to deploy without collection of required medical, dental, and deoxyribonucleic acid reference specimens for accession into the Armed Forces Repository of Specimen Samples for the Identification of Remains, per DODI 5154.30, *Armed Forces Institute of Pathology Operations*.

(3) GCCs should ensure that all contracts requiring CDF contain, or incorporate by reference, minimum medical and dental standards and require the contractor to make available CDF medical and dental records per DODD 6485.1, *Human Immunodeficiency Virus-1 (HIV-1)*.

(4) The geographic combatant command surgeon and JTFS should ensure that HSS, either as a responsibility of the contractor or the GCC/CJTF, is fully delineated in OPLANs, OPORDs, and contracts to assure appropriate medical staffing in the AOR/JOA; and should also include CDF who are providing essential contractor services, in their medical surveillance plans per DODD 6490.2, *Joint Medical Surveillance*.

(5) The geographic combatant command surgeon and JTFS should also assist the GCC/CJTF with establishing specific theater medical readiness requirements to include predeployment and FHP requirements and any requisite individual medical training to include safety, first aid, sanitation, health risks, and health protection measures, including those related to CBRN, and environmental and/or industrial threats; necessary for contingency contractors supporting and/or deploying with the joint force in the AOR/JOA.

d. Medical support. The austere environment that contingency contractor personnel may deploy to and operate in, coupled with the potential for limited availability of indigenous medical capabilities in theater, dictates that GCCs through the contract, establish and enforce the requirements for health, dental, and physical standards. Contingency contractor personnel who become unfit to perform their contractor duties in theater through their own actions (e.g., pregnancy, alcohol or drug abuse), should be removed from the theater at the contractor's expense.

(1) During contingency operations in austere and nonpermissive environments, contingency contractor personnel may not have access to emergency medical support established by their employer. MTFs within the theater of operations should provide resuscitative care, limited hospitalization for stabilization and short-term medical treatment, with an emphasis on return to duty or placement in the PM system; and assist with PM to a selected civilian facility, in emergencies where loss of life, limb, or eyesight could occur. All costs associated with the treatment and transportation of contingency contractor personnel to the selected civilian facility are reimbursable to the Government and is the responsibility of the contingency contractor personnel, their employer, or their health insurance provider.

(2) Contingency contractor personnel are afforded resuscitative and medical care, when life, limb, or eyesight is jeopardized, and emergency medical and dental care while supporting contingency operations. Emergency medical and dental care include, but are not limited to: refills of prescription or life-dependent drugs (Note: contractor personnel are required to deploy with 180 days of required medication and cannot be assured that their specific medication will be included on the theater pharmaceutical formulary), broken bones, lacerations, broken teeth, or lost fillings.

(3) Contingency contractor personnel are not authorized primary and routine medical or dental care unless specifically authorized under the terms of the DOD contract. Primary medical and dental care includes inpatient and outpatient services; nonemergency evacuation; pharmaceutical support; dental services and other medical support as determined by the GCC/CJTF based on recommendations from the JFS and existing capabilities of the forward-deployed MTFs. Contractors must make non-DOD arrangements to obtain all of their chronic prescription therapy.

(4) In instances where contingency contractor personnel require PM for medical reasons from the AOR/JOA to an MTF funded by the Defense Health Program, normal reimbursement policies would apply for services rendered by the facility. Should contingency contractor personnel require MEDEVAC to CONUS, the sending MTF should assist the contingency contractor personnel in coordinating arrangements for transfer to a civilian facility of their choice. When

US forces provide emergency medical care to TCN and HN personnel hired under theater, systems or external support contracts, these patients should be evacuated/transported via national means (when possible) to their medical systems.

(5) HN and locally hired TCN contractor personnel and subcontractor personnel hired under theater support contracts are not authorized to receive medical and dental support from US military facilities, but may receive resuscitative care from US medical sources when injured on the job while working within the confines of a US military facility or in direct support of US military operations on a reimbursable basis. When resuscitative care is provided to contractor personnel not authorized full medical care, they should be transferred to a local medical facility as soon as medically feasible.

APPENDIX A

PATIENT MOVEMENT

Annex	A	Aeromedical Evacuation
	B	Patient Movement Items

PATIENT MOVEMENT

1. Introduction

a. The primary mission of the DOD PM system is to transport US military casualties from within the combat zone to field or fixed medical treatment facilities either in or out of the combat zone, as required. Timely PM plays an important role in HSS and supports the JTF CONOPS and evacuation requirements. PM is a system that provides a continuum of care and coordinates the movement of patients from site of injury or onset of disease, through successive levels of medical care, to an MTF that can meet the needs of the patient. Each Service component has an organic PM capability and is responsible for evacuation from point of injury to initial treatment at a health care facility.

b. CASEVAC, a term used by all Services, refers to the unregulated movement of casualties aboard ships, vehicles, or aircraft. MEDEVAC traditionally refers to US Army (USA), US Navy (USN), US Marine Corps (USMC), and US Coast Guard PM using predesignated tactical or logistic aircraft, boats, ships, and other watercraft temporarily equipped and staffed with MAs for en route care. However, USA has traditionally had dedicated air and ground evacuation assets. AE specifically refers to USAF provided fixed-wing movement of regulated casualties using organic and/or contracted mobility airframes with AE aircrew trained explicitly for this mission. In addition the civil reserve air fleet (CRAF) may be used for the AE mission.

c. The operational environment during major operations and campaigns may present lethal threats requiring the evacuation of casualties to highly developed medical capabilities in the JOA and locations outside the theater of operations for advanced medical services and rehabilitative care. The decreased medical footprint and the increased PM requirements demand a more interdependent medical community, improved interagency and multinational partnerships, and developing joint solutions.

2. Roles and Responsibilities

a. The GCC, in conjunction with the supporting commanders and the USTRANSCOM, sets the theater PM policy for contingency planning. Upon execution, the CDR adjusts the theater PM policy as needed.

b. GCCs are responsible for PM within their theater. The joint command validates theater requirements for peacetime and contingency PM and identifies potential channel movement to USTRANSCOM J-3's DDOC as part of the transportation validation process. Combatant command OPLANs will include appropriate information to support Service planning for patient evacuation.

c. USTRANSCOM is the DOD single point manager for intertheater and CONUS PM services. As such, it is responsible for validating all PM requests and coordinating with the appropriate lift agencies to meet these requirements.

d. US Northern Command (USNORTHCOM) is responsible for PM within CONUS. This includes support for natural disasters, terrorist activities, and the redistribution of military casualties returning to CONUS. USTRANSCOM will most likely not transfer operational control of Service assets to USNORTHCOM, as is typical with other CCDRs. USTRANSCOM will normally support USNORTHCOM through a direct support (DS) relationship rather than transferring forces.

e. Each Service is responsible for organizing, training, and equipping their forces to ensure the capability to meet their PM requirements. Evacuation, through the taxonomy of care, may require any combination of air, ground, or sea resources. To ensure that patients receive continuous, timely, and quality care, all personnel involved in the evacuation system must be fully trained and essential evacuation assets (i.e., personnel, platforms, equipment, and supplies) must be programmed, procured, and sustained. Establishing a seamless evacuation system requires close coordination with the Services on employment of evacuation doctrine, concepts of operation, modernization and sustainment of equipment and platform capabilities, and interoperability of PMIs.

f. PMRCs are a joint activity responsible for PM management, validation, and coordination in their respective theaters. PMRCs shall exist at the joint level, as an element of the DDOC, to ensure visibility of joint assets for PM. The PMRC validates patient movement requests (PMRs), maintains visibility of bed availability and medical capability within the theater, regulates patients to the appropriate medical facilities for continued medical care, and determines the mode of transportation (air, sea, ground). The PMRC matches available beds to available transport modes and passes this transport to bed plan to the appropriate Service component to execute the PM mission. A theater validating flight surgeon (VFS) is assigned, or delegated by the theater command surgeon, to provide physician medical direction and oversight of PM validation and transfer/en route care, as needed, during evacuation. Patients who do not require en route care, but require transportation for further medical care, recuperation, or to their home to convalesce or unit of record to be reintegrated with their unit may also be moved using commercial tickets, when appropriate. This option allows the member to reach their destination faster and more direct. Using commercial tickets also decreases the organic PM requirement and reduces the stress on Service lift.

(1) **Global Patient Movement Requirements Center.** The GPMRC is a joint activity reporting directly to the USTRANSCOM. The GPMRC provides medical regulating services, including clinical validation, limited patient in transit visibility and evacuation requirements planning for intertheater PM and intratheater for CONUS. The GPMRC coordinates with supporting resource providers to identify available assets and communicates transport to bed plans to Service components, or other agencies, to execute the mission.

(2) **Theater Patient Movement Requirements Center.** Both the US Pacific Command (USPACOM) and US European Command (USEUCOM) have a permanent TPMRC that manages the validation and regulation of intratheater PM within their respective theaters. The TPMRC is responsible for theater-wide PM (e.g., medical regulating and AE scheduling) and coordinates with theater MTFs to allocate the proper treatment assets required to support its role. The TPMRC communicates this transport to bed plan to the theater Service transportation component or other agencies responsible for executing the mission. The TPMRC coordinates with the GPMRC for intertheater PM.

(3) **Joint Patient Movement Requirements Center.** The JPMRC is a deployable PMRC, under the operational control (OPCON) to the CJTF. The JPMRC maintains coordinating relationships and is normally collocated with the JTF joint movement control center and communicates movement requirements to the transportation component responsible for executing the mission. The JPMRC coordinates closely with the TPMRC and GPMRC for movement into theater controlled beds outside the JOA.

3. Patient Movement Process

a. Various forms and formats (i.e., voice, radio, message) are used by each Service to request initial evacuation. To request further evacuation, a PMR is normally submitted by the Service medical facility patient administration or medical regulating office to the appropriate PMRC. The PMRC evaluates the request for necessity, acuity, eligibility, priority, and mode (see Figure A-1). PMRs are normally submitted through TRAC2ES for patient in-transit visibility (ITV). PMRs may also be submitted by facsimile, voice telephone, radio and/or satellite communications, using a standard PMR worksheet, when TRAC2ES is inaccessible. Patient information items required to request PM will be determined by the PMRC and will depend on the operational environment.

b. The PMRC is responsible for maintaining visibility of medical capability within its AOR, clinically validating patients, and coordinating with Service components for patient evacuation. This process matches the patient to a facility with the necessary capabilities and bed availability. Once the PMR is validated, it is passed to the appropriate Service component for execution.

c. The JPMRC, as executor of PM validates PM requirements and maintains ITV. Lift operations centers may request other destinations due to availability of lift and routes to support evacuation. Delivery to alternate or other destinations can be executed, with the approval of the PMRC, upon evaluation ensure patient care is not compromised.

d. Patient administration director (PAD) (clerk/officer) or the medical regulating officer (MRO) is responsible for contacting the PMRC with PM requirements and submitting PM data. This individual manages patient numbers and bed classifications, determines availability of facility-based resources to assist with the movement of patients, and coordinates the use of those assets. The PAD/MRO serves as the liaison between the referring physician and medical staff, the patient, and the PMRC and is responsible for inputting patient data for PM requests.

e. Unregulated Casualties. When security or operational conditions exist that would require casualties to be moved immediately, patients may be moved without prior PMRC validation. However, a VFS or medical authority will be identified to clear the patients for evacuation.

4. Patient Movement Operations

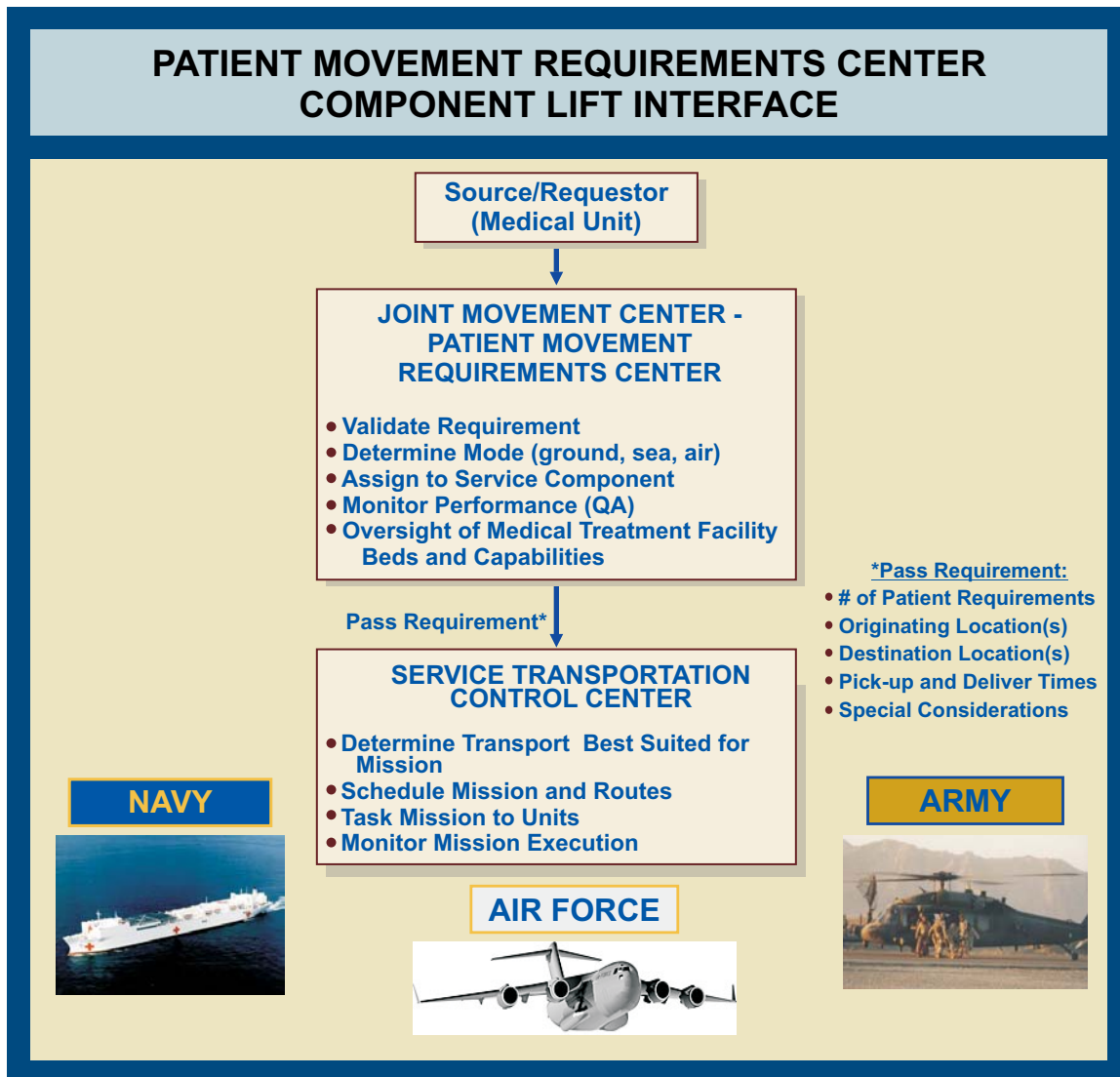


Figure A-1. Patient Movement Requirements Center – Component Lift Interface

a. Movement of patients between points within a CCDR's AOR is referred to as intratheater, while movement of patients between CCDR's AORs to points outside a CCDR's AOR, is referred to as intertheater (see Figure A-2).

(1) Intratheater operations are regional in nature and serve a single GCC's requirements. These operations are normally conducted using forces assigned, attached, or made available for tasking to the CCDR. Patients enter the system at the point of injury or onset of disease and are moved to appropriate capabilities of care within the theater. Patients are most likely to enter the joint system for evacuation and medical regulation at the theater hospitalization capability. However, casualties can enter at the FRC capability, depending on the type of operation and forces supported. Intratheater PM requires a coordinated effort between Service and HN MTFs, the responsible PMRC, and Service component organic and theater evacuation assets. The JFS is responsible for developing intratheater PM policies in coordination with Service component evacuation representatives.

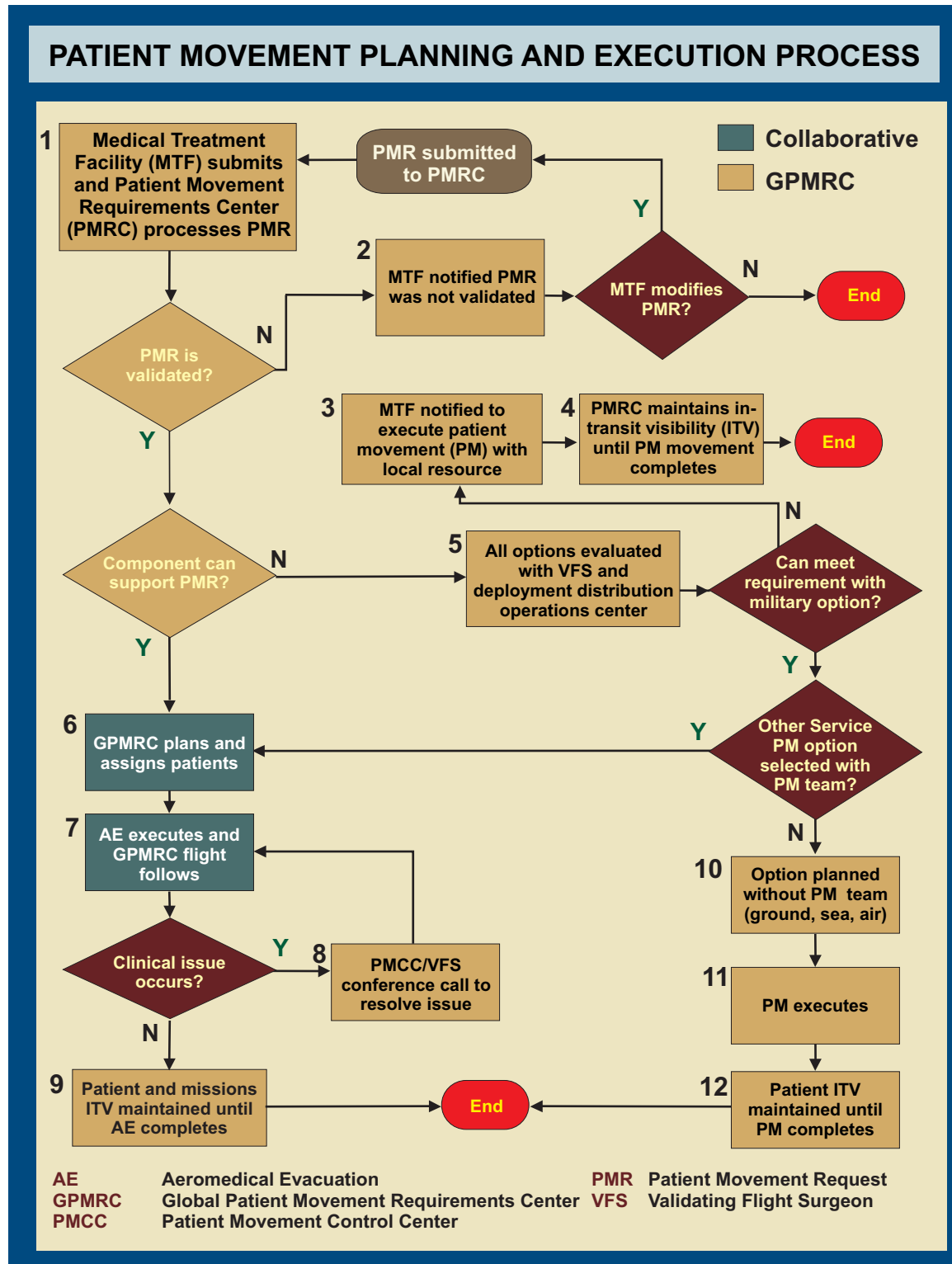


Figure A-2. Patient Movement Planning and Execution Process

(2) Intertheater operations are generally global in nature and serve the transportation needs of the combatant command outside the AOR that support the conduct of operations within the AOR. USTRANSCOM directs policies and procedures for intertheater PM and identifies transport resources. Currently intertheater PM is primarily conducted utilizing airlift assets as long evacuation distances may preclude other modes of PM in supporting rapid evacuation out of combatant command AORs. However, circumstances permitting other modes and lift assets may be used for intertheater PM. Patients are most likely to enter the intertheater system from a theater hospitalization capability for movement to a definitive care capability, outside the theater, and eventually to CONUS. Intertheater PM requires a coordinated effort between Service or HN MTFs, responsible PMRCs, GPMRC, and transportation agencies.

b. Patient Movement and Joint Capabilities of Care

(1) **Point of Injury or Illness to FRC Capability Operations.** Generally, the component commands are responsible for CASEVAC from point of injury or illness to casualty treatment stations, and casualty movement from the first responder capability to FRC capabilities via dedicated, designated, or opportune ground or air transportation. This is accomplished through a combination of litter carries, manual carries, ground transportation, and limited air (fixed- or rotary-wing) transport. The USA generally employs dedicated patient evacuation assets such as ground and air ambulances. The USN normally relies on lifts of opportunity. The USMC has some dedicated ground evacuation and relies on designated air and other lifts of opportunity. If USAF assets are required, at this level, lifts of opportunity may be used.

(2) **FRC Capability to Theater Hospitalization Capability Operations.** Movement within and from FRC capabilities is normally a Service component responsibility; however, some operations may require evacuation by the joint common-user PM system. For example, the USMC has no organic theater hospitalization capabilities, and this capability of care is provided by the USN. The USN does not have dedicated or designated evacuation vehicles with the capacity to go-forward and retrieve patients from the first responder and FRC capabilities and evacuate to them to the theater hospitalization capability. Requests to the joint common-user PM system are submitted to the JPMRC for coordination.

(3) **Theater Hospitalization Capability to Definitive Care Capability Operations.** If a patient cannot be returned to duty within the limits of the theater PM policy, the originating MTF will normally request PM to another MTF for more definitive care and disposition. The originating MTF will submit a PMR, IAW prescribed procedures, using TRAC2ES or other prescribed communications systems. PMRs are submitted to the appropriate JPMRC, if a JPMRC established. The JPMRC validates and regulates movement requirements and coordinates the requirements with the TPMRC for intratheater PM or with the GPMRC for intertheater PM. The JPMRC will identify intratheater PM requirements through the joint movement center (JMC) to the air mobility division's (AMD's) aeromedical evacuation control team (AECT), and the TPMRC will coordinate with the theater air mobility operations control center (AMOCC) to identify theater airlift assets available and with the GPMRC to identify intertheater PM requirements through the USTRANSCOM's Joint Mobility Control Group.

(4) **First Responder/FRC Capability to Definitive Care Capability or CONUS Operations.** Some joint operations may present unique situations and considerations where a theater hospitalization capability may not exist. Stabilized casualties may enter the joint common-user PM system near the first level of formalized medical care and be evacuated directly to a definitive care capability in another theater. In such cases, the component command medical regulating officer will submit a PMR to the JPMRC. CONUS movement includes redistribution of patients to their home or unit of record. Members discharged from medical care and requiring movement to their home station instead of the theater will typically be managed through the personnel system in a duty passenger status.

5. Planning Considerations

a. Wartime PM requirements are documented in combatant command OPLANs using CASEVAC output from the MAT (see Figure A-3). The combatant command validates Service projected casualties and merges them into one integrated, casualty stream. A key component in determining the casualty stream is the theater PM policy.

(1) The theater PM policy is a planning factor that delineates the maximum number of days that patients may be held within the theater for treatment prior to further movement or RTD. Patients who cannot be RTD within the specified number of days are moved to the next higher level of care for further treatment. The length of the PM policy impacts the number of casualties requiring movement, as well as the infrastructure required to treat patients in both the theater and the evacuation system. A short evacuation policy reduces the forward medical footprint, in terms of MTFs and associated infrastructure, and normally places a higher demand for more frequent evacuation missions. Conversely, a longer PM policy increases the forward medical footprint and requires fewer evacuation missions.

(2) The theater PM policy is set by the GCC and approved during the contingency planning cycle prior to OPLAN execution. Upon execution, the GCC adjusts the theater PM policy as needed. IAW SecDef policy and CJCS guidance, the evacuation policy is normally seven (7) days for the combat zone and a combined total of fifteen (15) days for the combat and communication zones. This does not imply that the patients must be held in theater for the entire period. Patients not expected to RTD within the number of days expressed in the policy will normally be evacuated:

(a) As soon as their medical condition permits or when local stabilization capabilities have been reached.

(b) When medical authorities have determined that travel will not aggravate patient condition (at a minimum, patients will have their airway secured, bleeding stopped, shock treated, and fractures immobilized).

(c) When suitable receiving MTFs and appropriate PM means have been coordinated.

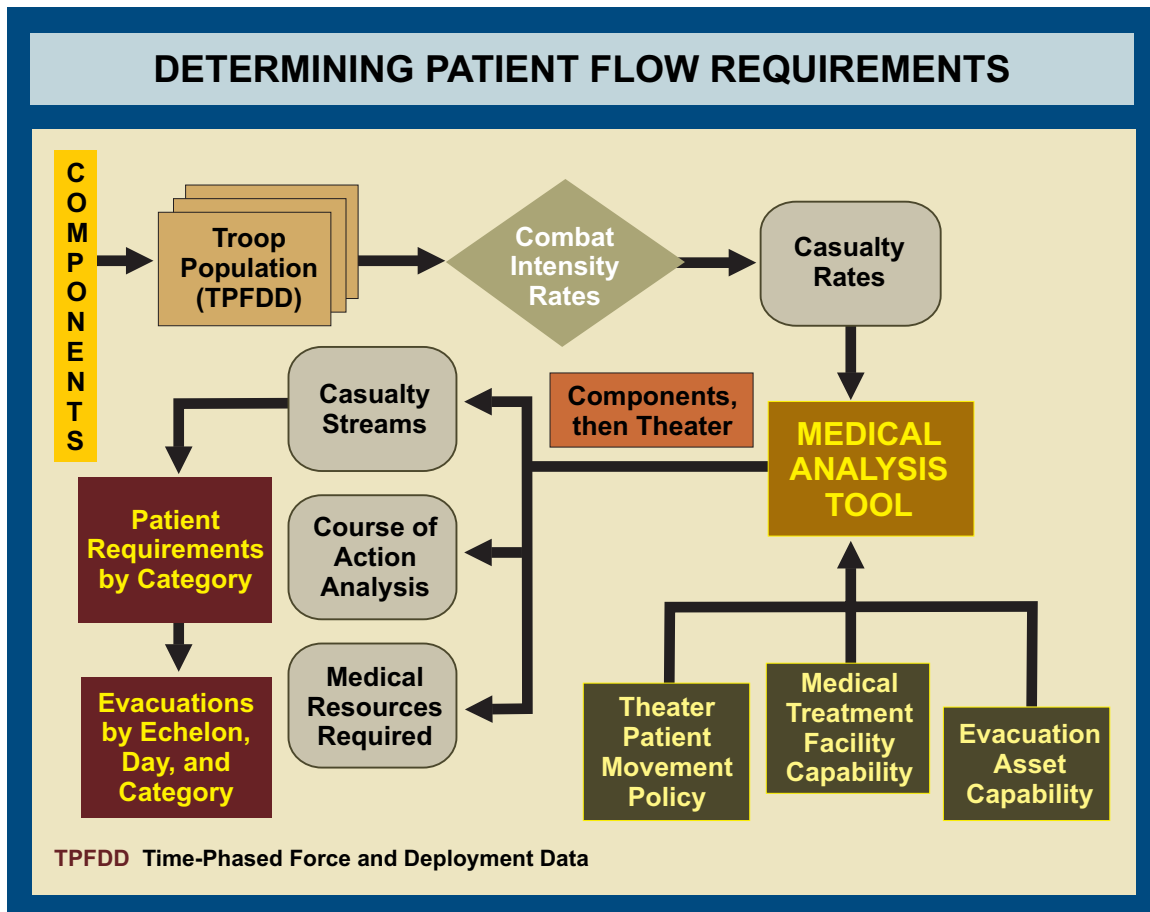


Figure A-3. Determining Patient Flow Requirements

b. Each OPLAN also identifies the infrastructure necessary to support medical care and CASEVAC. Planners use infrastructure lay down data, PAR, and casualty rates defined by Service personnel components and combat intensity identified within the theater OPLAN to generate joint casualty streams. The user must define the casualty rates, and adjust them by day and/or casualty source as necessary. Casualty rates fall under the following categories: wounded in action (WIA), DNBI, NBI, combat and operational stress reactions, and CBRN rates. The planners use the MAT to combine the user-defined PAR and casualty rates to create a joint stream of patients requiring medical attention. The tool estimates daily number of evacuees, beds, blood products, medical staffing, and other logistic requirements by level. The MAT estimates supportability and sustainability requirements in terms of evacuations, beds needed, staff, operating rooms and gross medical materiel requirements for a theater.

c. The joint PM system can support CONUS/domestic PM requirements identified under activation of the National Disaster Medical System (NDMS) and the NRP under the auspices of DSCA. USTRANSCOM is the validating authority for PM requirements as the supporting command to USNORTHCOM in its CS mission under the NRP. The Services will provide PM assets from existing regular and reserve component forces in execution of the NRP in the CONUS. These include activities and measures taken by DOD components to foster mutual assistance and support between DOD and any civil government agency in planning or preparing for, or in the application of resources for response to, the consequences of civil emergencies or attacks, including national security

emergencies. National Guard PM assets, as part of their state's emergency management plan, may be mobilized and deployed/employed in a state activated status prior to federalization. If federalized, under DCSA in response to the NRP, the National Guard will coordinate the laydown of PM assets with USTRANSCOM in order to facilitate coordinated PM.

d. Medical Concept of Operations. Each Service component is responsible for all functions of the Service specific PM system, including operational guidance, intelligence, medical direction, logistics, and communications support. From initial injury to definitive care, the treatment and evacuation of casualties from the battlefield transcends many levels of communication and coordination, routinely crossing Service boundaries. Thorough knowledge of the PM systems will expedite casualty care and save lives. Patient evacuation must be planned to support any combat operation. JFCs should integrate and coordinate the use of evacuation resources towards the common purpose of reducing mortality while maintaining medical treatment. It is therefore critical that each Service component properly plan to operate its portion of the overall PM system. Planning ensures a coordinated effort in providing timely and effective PM that involves determining theater movement estimates, identifying frequency channel lift requirements, and regulating to appropriate MTFs. All available forms of transportation must be considered within the constraints of the tactical situation and the details of patient handling.

(1) Evacuation plans should integrate and include ground ambulances rotary-and fixed-wing evacuation platforms, crew, and attendants. Plans should also include en route (ground and air) critical care teams for transporting patients with critical care needs, Service staging or holding facilities, Service liaisons, appropriate Service operational requirements, C2 elements, equipment, and handling of PMIs.

(2) The USA is responsible for providing medical rotary-wing support to ship-to-shore and shore-to-ship patient transport operations in support of PM requirements on-off of USN afloat medical platforms. This includes hospital ships (T-AHs) and casualty receiving and treatment ships. USA MEDEVAC support to a theater is conducted as an area support mission that includes support to all Services operating within the assigned grid coordinates. Requests for USA evacuation support under the auspices of its area support role from the USN and/or USMC will be prioritized by urgency and not by Service of origin. Plans should reflect this arrangement when it supports the commander's CONOPS. If USA MEDEVAC assets are not available or are not deployed as part of the operation, the USN and USMC have responsibility for ship-to-shore and shore-to-ship movement of patients.

(3) The USAF is responsible for providing fixed-wing AE. The AE system provides fixed-wing movement of patients under the care of aeromedical evacuation crew members (AECMs) to locations offering appropriate care capabilities. Critical care air transport teams (CCATTs) may be added to the basic AE crew to provide a higher level of care to critically ill patients during AE staging and flight. The AE system can operate as far forward as USAF fixed-wing conventional aircraft are able to conduct air/land operations. The system is designed to be flexible to enable it to operate across the spectrum of potential scenarios and interface with joint, coalition, and special operations.

(4) Activation and utilization of the USAF AE segment of the CRAF should be considered when CRAF stage II is implemented. AE CRAF should be planned for if appropriate. Planners should note, however, that per USTRANSCOM policy for movement of contaminated/contagious casualties/personnel, CRAF will not be used to support movement of contagious biological casualties.

e. **Integration of Coalition Evacuation Support.** Other Services and coalition forces use various ground transport, and rotary and fixed-wing aircraft for PM. They also use their own medically trained crew members or MAs. US MEDEVAC personnel may perform appropriate duties on non-US evacuation platforms if it is in the interest of the US Government and approved by the GCC. Conversely, coalition forces may also integrate with US MEDEVAC forces. The AE planner will identify the potential need and the operations center will work inter-fly agreements.

f. **Service Component Transportation Assets.** A detailed listing of Service component evacuation resources and their capabilities can be found in Appendix B, “Service Component Transportation Assets.”

g. **Protection Under the Geneva Conventions.** Depending upon the designation of patient evacuation assets, protection under the Geneva Conventions differs.

(1) **Dedicated** PM assets are configured for patient evacuation, externally marked with a red cross and specifically dedicated to support the MEDEVAC mission (an USA ambulance for example). Dedicated assets need not be organic to the unit. Dedicated evacuation assets are authorized protection under the Geneva Conventions.

(2) **Designated** are USN/USMC and USAF evacuation assets whose primary mission is nonmedical, are not externally marked, and are allocated on the air tasking order and configured for PM. Designated evacuation assets are not afforded protection under the Geneva Conventions.

(3) **Opportune Lift.** That portion of lift capability available for use after planned requirements have been met. These nonmedical assets convey cargo/passengers throughout the AOR and could be used to move patients. While patients are protected under the Geneva Conventions, these conveyances are not. Movement of patients with opportune lift should have medical personnel and medical equipment aboard commensurate with patient condition to provide appropriate care for the patient.

(4) **Commercial.** Patients who do not require care, but require transportation for further medical care, recuperation, or to their home to convalesce or unit of record to be reintegrated with their unit may be moved using commercial airlift when appropriate. This option allows the member to potentially reach their destination faster and more directly. Using commercial airlift also decreases the organic PM requirement and reduces the stress on Service lift.

For more information on how the Geneva Conventions affect HSS, see Appendix H, “Geneva Convention Information.”

h. Patient Movement Items

(1) The medical equipment and supplies required to support the patient during evacuation are referred to as PMIs. The handling and return of equipment to the originating theater through the evacuation system requires a reliable supporting logistic infrastructure to ensure that PMIs are available and serviceable. The plan for a PMI exchange system and the return of evacuation equipment and PMIs to the originating theater should be addressed in the respective theater OPLAN. Large medical logistics (MEDLOG) units will support smaller units (MEDEVAC and special operations) without an organic MEDLOG capability.

(2) For more information on PMIs, see Annex B to Appendix A, “Patient Movement Items.”

i. **Categories of Evacuation Precedence.** The process of patient categorization determines how quickly a patient will be evacuated within the PM system and has a significant impact on lift assets. PM priorities will be derived from situational factors and/or individual patient clinical conditions. Refer to JOPES Annex Q directives for specific joint operation priorities. The physician at the originating facility recommends the precedence for PM to the PMRC based on each patient’s condition/status. Patient condition/status may be upgraded or downgraded at each succeeding level of patient care. Timeframes to provide evacuation assets on-site ready to conduct PM begin once a PMR is passed to the responsible PMRC. The tables in Appendix B, “Service Component Transportation Assets,” identify these timeframe objectives within which the PM system should respond.

(1) **Routine** — a patient who requires movement but can wait for a regularly scheduled channel/AE mission, a scheduled military airlift channel mission, or commercially procured airlift service.

(2) **Priority** — a patient who requires prompt medical care not available locally. This precedence is used when the medical condition could deteriorate and the patient cannot wait for routine evacuation. Normally movement begins within 24 hours; however, the timeline for movement will be defined by the attending provider and determined by the validating surgeon.

(3) **Urgent** — a patient who requires movement as soon as possible to save life, limb, or eyesight, or prevent serious complications of injury or existing medical condition. Immediate action shall be taken to obtain PM or other suitable transportation to meet patient requirements. Terminally ill or psychiatric patients are not considered urgent patients. The timeline for movement shall be defined by the attending provider and determined by the validating surgeon.

6. Multinational Considerations

a. **Patient Movement in Multinational Operations.** CCDRs are responsible for intratheater PM. This may include the movement of allies, coalition forces, neutrals, and even EPW. The CCDR’s policy should be recorded in his PM policy.

(1) The theater PM policy, known in some nations as a holding policy, is the key to balancing the treatment capability available at each care capability against the required PM assets. The provision of resources will be coordinated by the MNF planning staff and will be comprised of assets from a number of sources, including HNS. Theater PM requires careful planning and is dependent on whether the US partners and other coalition nations require the establishment of an acquisition and cross-servicing agreement. Other standing agreements may already cover support arrangements between the US and the participating nations such as members of the UN or NATO. Establishing the PM policy is a command decision of each nation. HSS and logistic staffs will advise. The combatant command surgeon and/or JTFS will provide recommendations and monitor the established PM policy.

(2) Contributing nations bear ultimate responsibility for ensuring the provision of HSS to their forces allocated to multinational operations. This may be discharged in a number of ways, including agreements with other nations or the appropriate multinational planning staffs.

(3) Medical planners should always consider the quality, suitability, and availability of coalition and HNS to meet PM requirements. Allied/HNs may possess unique evacuation assets that could augment national capabilities. The use of these evacuation assets, regardless of mode, should be coordinated through appropriate multinational and HN agreements.

b. **Host-Nation Support.** HNS can be a significant force multiplier. HNS should be equivalent to US standards or acceptable to the GCC. The JFS must assess HN medical capabilities and make recommendations to the JFC on their use for deployed US forces. HNS may reduce the lift requirements necessary to deploy HSS to the JOA.

7. Patient Stability

Patients validated for AE must be stabilized (secure airway, controlled hemorrhage, treated shock, and immobilized fractures) as much as the local situation and resources allow. Interventions (i.e., intravenous (IV) or foley catheter) should be initiated prior to flight, if possible. Patients not clinically stable due to severity of wounds or medical condition, limited medical resources, or time constraints may require advanced clinical capability while awaiting transport at an airhead or during flight. At times, the patient's clinical instability may be the very reason that they are being moved by air from a lesser capable facility to another of greater capability. Each Service evacuation system must consider en route requirements to provide this capability. The USAF AE en route system provides qualified flight nurses and AE technicians. CCATT or other MAs can be added based on patient stability and conditions.

a. **Stable.** One who, in the best clinical judgment of the responsible physician, can withstand a bed to bed evacuation of up to 12 hours for intratheater movement and 48 hours intertheater, who is unlikely to require intervention beyond the scope of standard en route care capability during the evacuation.

b. **Stabilized.** Patient condition may require emergency, but not surgical intervention, within the evacuation phase. Patient's condition is characterized by secure airway, control or absence of hemorrhage, shock adequately treated, and major fractures immobilized.

c. **Unstable.** A patient whose physiological status is in fluctuation. Emergent, treatment and/or surgical intervention are anticipated during the evacuation. Unstable patients rapidly changing status and requirements are beyond the standard en route care capability and require medical/surgical augmentation. Patient transport validation is essential to ensure the evacuation environment is conducive to an optimal outcome.

8. Contaminated Patients

Decontamination and processing procedures must be in place to prevent spreading the CBRN agents and ensuring the appropriate protection for patients, medical and support staff, and evacuation platforms. Contaminated patients must be decontaminated before entering the intertheater AE system unless the CDR and Commander, USTRANSCOM approve and direct otherwise.

a. Patients with disease conditions resulting from biological warfare should be decontaminated and have appropriate treatment initiated. Care givers at the referring facility must ensure that patients with communicable diseases are prevented from spreading the disease through the use of protective equipment by the patient and/or the crew as deemed necessary by competent medical authority.

b. Patients exposed to chemical warfare agents must be decontaminated prior to evacuation. Once patients are externally contaminated, further evacuation decisions are based on actual or suspected clinical diagnosis and patient condition(s). Commanders, evacuation elements, and medical personnel should apply specific contamination control measures.

c. Biological warfare casualties may be evacuated using transmission based infection control guidelines. Evacuating biologically contaminated/contagious or infected patients and/or potential biologically contagious or infected patients requires the approval of the destination country, overflight privileges, and approval of any country where the aircraft will land for servicing or where patients will remain overnight. Close coordination between the supporting and supported GCCs and the Department of State (DOS) is required for such movements. The preferred solution is to treat contagious or potentially contagious patients in place to reduce transmission risk.

9. Communications System Support

a. A responsive communications system is essential to the conduct of PM. The JFC should establish a system that integrates the available capabilities of the PM system, synchronizes its application, and prepares to employ air, land, and sea forces to achieve PM objectives. This system should also support the operational requirements of HSS information management as it relates to patient accounting and reporting, medical regulating, and patient ITV.

b. Service component commanders are responsible for C2 of their respective transportation agencies involved in joint PM. However, the JFS is responsible for establishing a joint PM CONOPS and identifying communications requirements necessary to integrate the functional aspects of the joint PM, medical regulating, and evacuation protocols out of the theater. This may include defining the requirements needed for intratheater and intertheater support. Effective PM during joint operations will require a closely coordinated and mutually supportive effort of all participating forces carefully balancing mission requirements while contributing to the total theater PM effort.

c. The JFC may provide detailed theater communications plans or assign theater communication management responsibilities to a single-Service component for specific functions during joint PM operations. Early ID of a theater's communications system requirements for evacuation connectivity is essential. At a minimum, HSS communications in support of PM must provide reliable, real time and, when possible, redundant communications within a theater and from theater to CONUS. They must also provide a link between the most forward point where the patient enters the PM system, long haul communication to PMRC, and each level in the HSS system to the destination MTF or medical element.

d. The degree of success of PM operations is a function of the availability of reliable communications over dedicated and interoperable systems. Planners must identify frequencies that are common between Service component support forces assigned a PM mission. If no commonality exists, the JFC will develop a theater plan that ensures adequate communications support to all Service components. All frequency requirements for organic equipment must be coordinated with the GCC's plans staff.

e. Short-range radio communications should be provided by each Service component to ensure communication between MTFs, evacuation vehicles, boats, aircraft, and evacuation operational C2.

f. When available, theater-based, long-range communications will be provided by high-frequency radios, satellite communications, defense voice services such as the Defense Switched Network, Defense Information Systems Network, and the Defense Messaging System.

g. Satellite communications offering access to commercial telephones or point-to-point systems should be used when available.

h. Secure communications are provided through voice and data security communications equipment.

i. CJCSM 6120.05, *Manual for Tactical Command and Control Planning Guidance for Joint Operations; Joint Interface Operational Procedures for Message Text Formats*, outlines responsibilities and message text format requirements for operational PMRs and evacuation procedures. User Services should have the communication equipment and personnel to identify their PM requirements to the PMRC. These messages include the following:

- (1) Medical regulating (MEDREG) report.

(2) PMR.

j. TRAC2ES provides a responsive communications system essential to the conduct of PM. TRAC2ES is a web-based system, which maximizes the internet while maintaining and protecting patient privacy and troop strength information. It replaced the defense medical regulating information system (DMRIS), Automated Patient Evacuation System (APES) and theater Army medical management information system (TAMMIS) MEDREG module. TRAC2ES provides global support throughout the full operational medical continuum: fixed and deployable medical treatment facilities and global and TPMRCs. TRAC2ES links GPMRC and TPMRCs through global communications.

ANNEX A TO APPENDIX A AEROMEDICAL EVACUATION

1. Introduction

a. The USAFAE system provides a critical PM capability that cuts across traditional Service lines. Since World War II, the preponderance of AE patients generated during wars and contingency operations have come from USA and USMC ground combat units. Therefore, it is important that the AE system integrates well with the medical components of all Services. Moreover, during the past decade, it has become increasingly important that the USAF AE system continue to develop its capability to integrate with components of our Nation's allies.

b. The USAF lead command for AE is AMC with HQ at Scott Air Force Base, IL. AMC is charged with the responsibility to operate the common-user USAF fixed-wing AE system, to procure and execute commercial augmentation, and administer and execute the AE CRAF. USAF AE provides fixed-wing movement of patients requiring in-flight care and supervision by AECM to locations offering appropriate levels of medical care. AE can significantly improve casualty recovery rates by providing rapid transportation of the sick and wounded to medical facilities for treatment. The AE system can operate as far forward as conventional fixed-wing aircraft are able to conduct air/land operations.

c. The AE system provides:

- (1) Integrated control of casualty movement by air transport.
- (2) Clinical and operational support personnel.
- (3) Equipment for inflight supportive medical care and ground support operations.
- (4) CCATT to monitor and manage specific patients requiring intensive care.

(5) En route staging capability/patient preparation at or near secure airstrips for the processing and care of casualties entering, en route, or leaving the AE system.

2. Aeromedical Evacuation Command and Control

a. C2 of AE is consistent with overall USAF air mobility C2. In contingency operations, AE specific items will be outlined in Annex C of the OPORD and general PM guidance should be outlined in Annex Q. AE assets should be integrated within the inherent mobility structure established to support airlift operations from the AMD to the wing and down to each element.

b. Steady-State/Peacetime AE Structure. The AE system has been standardized to ensure peacetime processes mirror wartime processes. This allows for the system to exercise its wartime infrastructure in peacetime and enhances wartime training. C2 of AE assets, to include tasking authority for AE and mobility forces, resides with the normal airlift and mobility C2 structure.

Field and AE squadron (AES) operations will be conducted through operational wing C2 channels. The tanker airlift control center (TACC) or the theater AMOCC provides C2 for tasking and execution for air mobility assets used to accomplish AE missions within their respective areas.

(1) The TACC serves as the air operations center (AOC) for the AMC air mobility mission and is responsible for tasking and controlling operational missions for all activities supporting AMC's global air mission.

(2) The theater AMOCC integrates intratheater air mobility operations and provides centralized planning, tasking, scheduling, coordinating, and C2 for assigned and attached intratheater air mobility missions.

c. Contingency AE Structure (see Figure A-A-1). Deployed expeditionary air and space forces are organized to ensure unity of command. Deployed AE forces will be organized within the constructs of the air and space expeditionary task force and will be tailored based on the size and scope of the operation. C2 of theater AE forces in contingency operations will be defined in the warning/execution/OPORD.

(1) The commander Air Force forces (COMAFFOR)/joint force air component commander (JFACC) derives authority from the JFC to exercise OPLAN, assign missions, direct coordination among subordinate commanders, and redirect/organize forces to ensure unity of the air effort to accomplish the overall mission. During contingency operations, the COMAFFOR's special staff may include a senior AE expert to provide extensive experience of the AE system and interface with airlift operations and plans. This individual will assist with the development of initial AE force laydown, C2, policy, and interface with airlift operations. Additionally, an AE planner should be incorporated into the COMAFFOR A-5 staff to outline, develop, and coordinate AE theater plans along airlift routes and coordinate with AMC/Director of Operations for the number and location of AE assets needed to support operational requirements. The AE planner should also coordinate with the Air Force forces surgeon to ensure visibility of theater medical facilities/capabilities that may affect AE plans. These functions may be provided from AMC/director of operations personnel, utilized in a reachback status to support the operation until a senior AE expert or AE planner is identified.

(2) The director of mobility forces (DIRMOBFOR) is a senior mobility officer who is familiar with AOR or the JOA, and who possesses an extensive background in airlift operations. The DIRMOBFOR, working with the JFACC/COMAFFOR, has a responsibility to ensure that AE assets are in-place, aligned in the airlift C2 structure, and that AE missions are planned and executed. An AE officer with extensive AE experience and knowledge of plans and operations may serve as a deputy to the DIRMOBFOR.

(3) The AECT is located within the AMD of the AOC and is responsible for current AE operational planning, tasking, and mission execution to the theater. Once a transport to bed plan is received, the AECT coordinates airlift and AE assets to meet AE requirements. The AECT tasks the appropriate airlift wings through the airlift control team (ALCT) and air tasking order (ATO) and passes mission information to the PMRC. This team also coordinates airlift with air mobility element, AMC TACC, or theater AMOCC to meet AE requirements for their operational area.

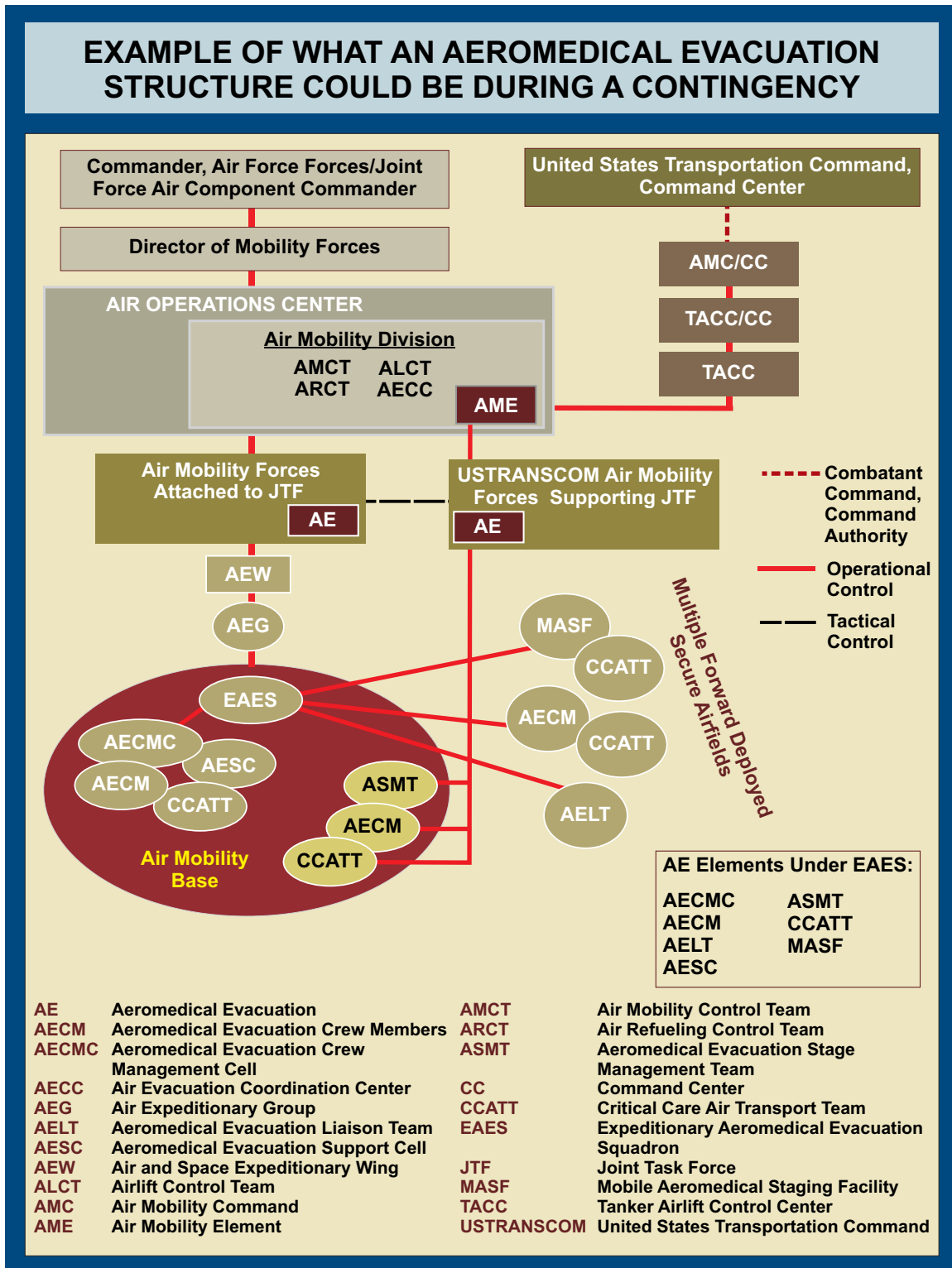


Figure A-A-1. Example of What an Aeromedical Evacuation Structure Could be During a Contingency

3. Aeromedical Evacuation Operations

a. HQAMC manages and operates the intertheater and AE subsystems, CRAF, and provides AE elements and planning assistance to the theater, in intermediate supporting theaters, or in CONUS. United States Air Forces in Europe and United States Pacific Air Force are responsible for their theater-assigned AE units and associated airlift units. When contingencies exceed theater AE capabilities, AMC will provide mission-specific augmentation forces to support increased theater requirements and will expand or establish the intertheater capability to support movement between theaters, or to and within CONUS, as required.

b. AE forces are modular by design and can be tailored and deployed to meet situational requirements. The AE process is dependent upon reliable, pertinent, and timely communication and coordination between the originating requestor, the PMRC, the appropriate airlift agency, AE elements, and the destination medical facility (see Figure A-A-2).

c. The airlift agency (TACC/AMOCC/AMD) will execute the AE mission by optimizing the use of available multi-mission aircraft; mixing cargo and AE on mobility missions, and integrating AE requirements into cargo channel routes. Airlift for urgent and priority patients will be tasked from alert AE crews, diversion of in-system select (ISS) aircraft, or contracting with a civilian air ambulance. Each patient's clinical requirements may also dictate specific airframe use. To enhance responsiveness, AE crews and CCATTs should be strategically positioned based on airlift and key patient originating locations. During contingencies AE CRAF may also be called into service. On execution, AE plans may integrate allied and/or other Services' airlift capabilities, when appropriate.

(1) See Appendix B, "Service Component Transportation Assets," for more information on air transportation assets.

Air Tasking Order

Planners in the AMD use the ATO to task and disseminate requirements through the airlift command and control and subordinate units for sorties, capabilities, and forces to execute missions. Normally the ATO provides specific instructions to include call signs, times, airfields, controlling agencies, etc., as well as general instructions.

(2) AE and airlift elements are tasked through the air and space expeditionary wing (AEW) using an ATO. The AEW will provide airlift, aircrews, and augmentation assets (equipment and/or specialized medical personnel) to comply with the tasking. AE assets are placed at strategic locations throughout the AOR for rapid response.

d. AE Interface with Special Mission Operations and Rescue. Some special mission operations and expeditionary forward deployed operations, such as SOF, Marine expeditionary forces, and combat

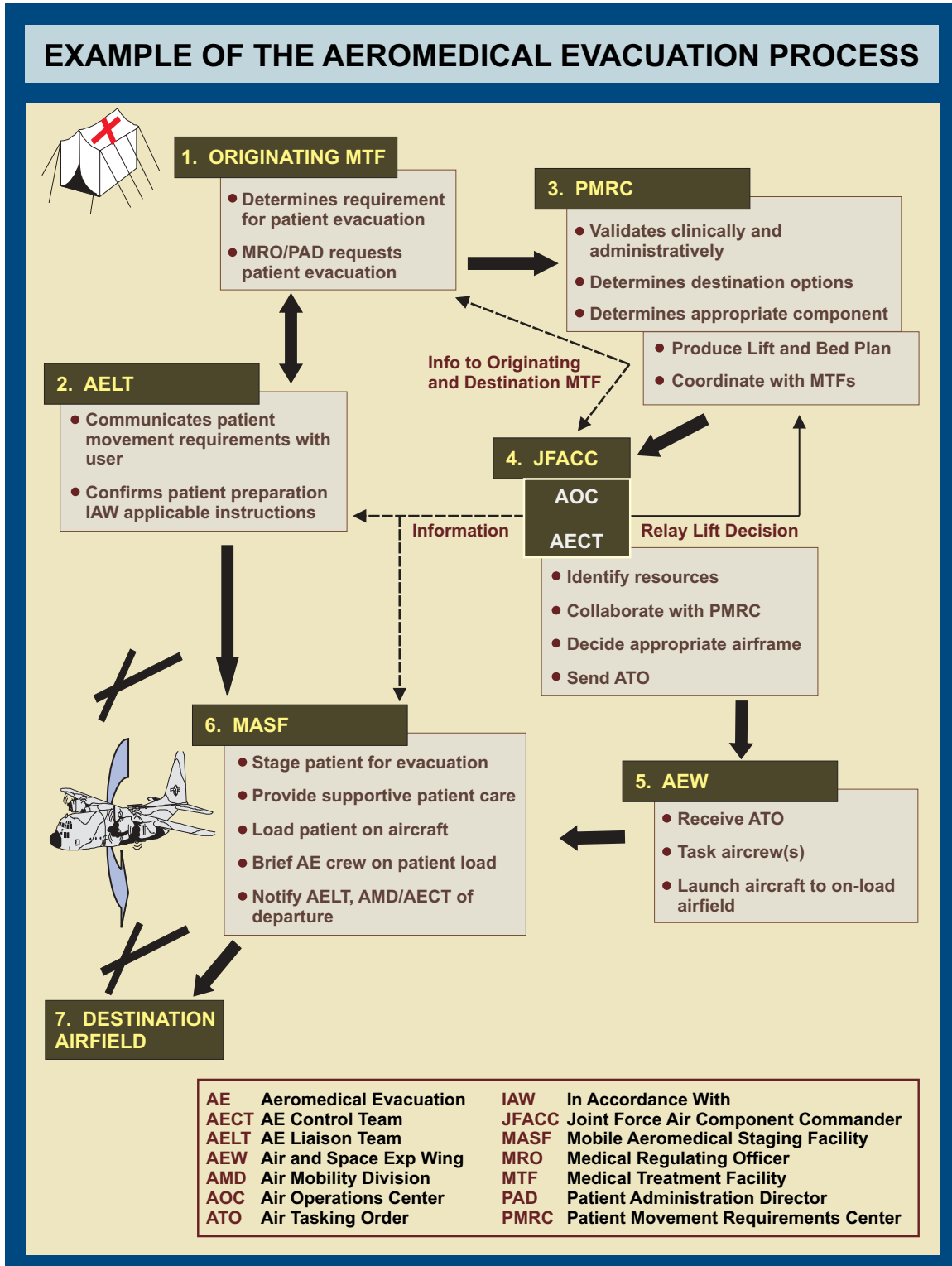


Figure A-A-2. Example of the Aeromedical Evacuation Process

search and rescue at times may not possess organic conventional AE capability augmentation support and must identify requirements to obtain conventional AE support at forward airbases.

(1) Evacuation of casualties within the joint special mission arena can be a particularly complex issue since these forces often operate in small, widely dispersed teams, and in locations not easily accessible. Flexibility and sensitivity to the particular needs of the special mission community, both clinically and administratively, is important to consider in determining how to best support their AE requirements. The special mission forces are responsible for care and evacuation of casualties from the forward location to the secure airfield where AE forces will assume responsibility for the casualties, freeing special mission medical assets to return to forward locations. The AE planner must understand the need for limited resources and yet versatile, flexible capability to support special missions.

(2) USAF Special Operations Critical Care Evacuation Team (SOCCET). A specially trained and equipped form of CCATT, SOCCETs are organic to Air Force SOF to meet their unique mission requirements. These teams provide care to casualties transiting the SOF casualty evacuation system and provide continued trauma and postoperative casualty management aboard organic SOF aircraft and other opportune evacuation platforms.

e. Detainee Missions. Detainee missions fall under the responsibility of security forces and are politically sensitive. Normally a CONOPS is written to outline roles and responsibilities. AE policies and process exist for moving patients/EPWs on AE missions. Transport missions that move detainees between holding locations are not AE missions and are not supported by AE personnel.

f. Inter-fly Agreements with Major Commands (MAJCOMs), Service, and Coalition AE Support. USAF AE aircrew members may perform appropriate duties in non-USAF aircraft if it is in the interest of the USG and approved by both the GCC and the controlling aircraft authority. Conversely, coalition forces may also integrate with AE forces. The AE planner will identify these requirements. The operations center, in peacetime or wartime, will work inter-fly agreements through the line of the USAF. In peacetime, MAJCOMs may require inter-fly agreements to be processed before AE crews from one command can fly with others.

4. Operations Phasing and Force Sequencing

AE forces provide a rapid, flexible, incremental, mobile response. Unit type code (UTC) are employed to provide command, control, communications, patient care, and system support. The AE system needs to have the capability to move casualties after minimal stabilization from forward areas. The concept is to employ an immediate, versatile, and flexible AE presence to respond to the needs of the deployed forces. After the initial buildup, the planners can augment the deployed teams with more manpower and equipment (augmentation packages), as required, to support more intense or ongoing operations.

a. **Aeromedical Evacuation Crews (AECs).** AECs perform in-flight medical care, are experts on aircraft configuration, and provide the operational interface between the patient, medical equipment, and aircraft systems.

b. **Critical Care Air Transport Team.** CCATTs provide specialized care, in conjunction with AE crews, to evacuate critical patients requiring advanced care during transportation. CCATT represents a specialty or critical care team that can be added to the basic AE crew in order to offer a higher level of care to stabilized patients during AE staging and flight. (IAW Air Force Instruction [AFI] 41-307, 1.7.2, *Aeromedical Evacuation Patient Considerations and Standards of Care*.) AE missions that require the addition of a CCATT will be validated by the PMRC and tasked by the AECT.

c. **Mobile Aeromedical Staging Facility (MASF).** The MASF provides rapid response patient staging, limited holding and emergent AE crew support capability. The MASF is designed to provide forward support with the smallest footprint and is usually the AE element used in support of SOF. The MASF will be located at or near airheads capable of supporting conventional mobility airlift. A CCATT should be assigned to forward based MASFs to enhance rapid evacuation of all categories of casualties. The MASF may be augmented with additional personnel and equipment to increase patient staging capability as needed.

d. **Contingency Aeromedical Staging Facility (CASF).** The CASF may be used at major intertheater hubs to support the full spectrum of contingency operations. The CASF interfaces with the AE mission and falls under the C2 of the medical group commander.

e. **AE Liaison Team (AELT).** The USAF AELT provides support between the forward user and the AE system in the form of operational and clinical interface. This interface may occur at locations that do not otherwise have USAF personnel on them such as far forward/bare bases and shipboard. The flight nurse liaison assists the local medical unit in preparing AE patients for flight. The administrative officer is responsible for working with the airlift center and aerial port elements to ensure the aircraft is properly configured and equipment pallets, patients, and AE support personnel are properly manifested on the AE mission. The communications personnel may be integrated into the airlift operations element supporting flight line operations or the wing operations center (WOC). Establishing a communication network with airlift operations is essential for rapid evacuation.

f. **Expeditionary AE Squadron (EAES).** The EAES is assigned to an AES and air expeditionary group (AEG). The deployed UTC aeromedical evacuation command squadron (AECS) integrates into AEW operations. The EAES provides command functions for all AE personnel assigned to the AEW. The EAES ensures all elements are prepared to conduct AE operations as tasked by the AOC and will provide AE assets to support the WOC. The EAES can arrange support requirements for follow-on AE forces, as required. In larger contingencies, there may be more than one EAES assigned to an AEW or AEG.

g. **Crew Management Cell (CMC).** The CMC provides direct supervision and crew management for assigned, attached, and transiting AE crews and CCATTs in conjunction with

the TACC/AMOCC, AEOT and base operations, as applicable. The CMC coordinates requirements to include launch and recovery, life support, billeting, food service, transportation, and administration for AECMs/CCATTs.

h. **AE Operations Team (AEOT).** The AEOT may be integrated into the air mobility control center (a permanent en route C2 function). AEOTs are located at strategic airlift hubs or en route locations to support aircrews, equipment, and launch and recover operations. The AEOT supports AE missions through assigned aircraft configuration, and equipment to include CRAF support, patient loading interface, and resupply of in-flight kits, medications, and patient liquid oxygen. They may assist staging facility with enplaning and deplaning.

i. **AE Support Cell (AESC).** The AESC provides communications and air and space ground equipment maintenance support to all UTCs assigned to the theater aeromedical evacuation system (TAES). The AESC should be staged with equipment at key locations, normally with the EAES, within the AOR to support AE requirements. Communications networks will be integrated with airlift operations.

j. **PMI Teams.** PMI teams are composed of medical logistic teams and biomedical equipment repair teams. The logistic teams provide manpower for operational management of the PMI center. The equipment repair teams support regional maintenance and repair capability for equipment in PMI centers and/or cells. These teams will provide scheduled preventative maintenance and calibration, repair and maintenance services, and updating the PMI information system.

5. Planning for Aeromedical Evacuation

AE planners are an integral part of the airlift planning team and should build appropriate AE support into the en route structure. The AE planner should interface with medical planners to ensure appropriate medical capability along airlift routes. Comprehensive planning will ensure a coordinated effort in providing timely and effective AE.

a. **AE Planning Factors.** AE planners must take many factors into account to select the best or most appropriate means of executing each AE mission. Airlift routes must be identified in order to establish potential AE plans. Based on planning directives the combatant command OPLANs/CONPLANs will include: beddown of AE capable airlift, strategic APODs and/or aerial ports of embarkation (APOEs), planned mission routing, availability of intra/intertheater retrograde airlift for AE missions, and planned PM requirements (evacuees) by C-Day.

b. **Airframe Considerations.** It is critical to identify airframe availability and capability based on patient load and the clinical requirements of the patients expected to be moved.

(1) **Organic mobility lift and in-system select.** Organic aircraft are airframe assets that have been obtained primarily through mission tasking or through en route diversion and mission reprioritization for AE use. Organic airlift is the major airframe component of expeditionary AE. Requirements can vary from obtaining seat space to move ambulatory patients,

or procuring a pallet position to move litter patients, to tasking an entire aircraft to perform a single mission or routine channel mission. The airlift operations centers have visibility of airlift operating in the AOR and may divert a mission, ISS, to support the patient request.

(2) **AE Civil Reserve Air Fleet.** The AE CRAF program provides airlift platforms, upon contract activation, from commercial airlines specifically to perform/support AE missions. AE CRAF is the intertheater AE solution in contingency planning.

c. **Airfield Capability.** The mobility en route structure and proximity of medical facilities to the airfield determines AE laydown. Proposed onload, en route, and offload airfields must be able to support the operation. Mission planners must consider flight line security, secured launch, and PHOENIX Raven requirements for designated airfield locations.

d. **Potential Hostile or Terrorist Locations.** The requirements for security forces to support aircraft during AE missions must be considered in the planning process. The PHOENIX Raven program provides these specially trained security forces personnel to protect AMC aircraft and will be included on all AE missions to locations designated “Ravens required.” AECs will carry weapons, when appropriate and authorized, to protect themselves and their patients.

e. **Base Operating Support.** AE operations depend on integration with the line of the Air Force and the joint host Service to provide base operating support. This support is needed for AE units attached to specific locations as well as en route transient support during patient evacuation through the system and must be coordinated with appropriate agencies prior to deployment. These requirements include, but are not limited to, transportation (including patient transportation), messing and other consumable materials, water, fuels, cryogenics, liquid oxygen (LOX) and other gases (obtained from fuels or on a contract basis), billeting, latrines, showers, laundry, and security. Additional requirements include: alternate generator support, fire protection, vehicle maintenance support, vehicle decontamination, maintenance and logistics, life support, contracting, supportive information/communications systems maintenance, waste management, and personnel decontamination.

f. **Resupply.** Sustained AE operations are dependent upon a well-designed resupply system for the continued availability of consumable medical supplies and PMIs at all en route support locations. Planning for onboard or transportable therapeutic oxygen and any associated resupply is essential to prevent mission delays. The AE planner should work with the medical planner to outline logistics hubs and personnel to support LOX refill and PMI, biomedical equipment technician (BMET) support in the theater and en route.

g. **Biomedical Equipment Technician Support.** Equipment repair is essential in the theater for routine maintenance and minor repair. Deployed MTFs (and potentially civilian and coalition facilities) can support AE equipment repair and maintenance in steady state but not surge periods. Therefore the AE planner should insert AE BMET capability into airlift hubs and align with local medical treatment facilities to ensure AE equipment is processed to meet mission requirements.

h. **Communications.** Planners must ensure AE communication capability is integrated with the mobility airlift and communication squadron network. Communication must be maintained with subordinate deployed AE elements that may not be on or near an Air Force wing.

i. **Ground Transportation.** Most AE units deploy with integral transportation capability for limited patient and crew transport at forward locations. AE planners should ensure proper aircraft support equipment is available at the airfield, i.e., support pallets and loading systems. The MTF is responsible for transport to the aircraft. Medical planners should determine the availability of other Service ambulances, other vehicles and, if necessary, establish contracts or obtain HNS.

ANNEX B TO APPENDIX A

PATIENT MOVEMENT ITEMS

1. Introduction

a. The medical equipment and supplies required to support the patient during evacuation are referred to as PMIs. Examples of PMIs include ventilators, litters, patient monitors, and pulse oximeters. The function of the PMI system is to support in-transit patients, to exchange in-kind PMI without degrading medical capabilities, and to provide prompt recycling of PMIs. The handling and return of equipment to the PMI system requires a reliable supporting logistic infrastructure to ensure that PMIs are available and serviceable. The plan for a PMI exchange system including the return of AE equipment and PMIs to the theater of origin should be addressed in the respective theater OPLAN.

b. When a patient requires evacuation, it is the originating MTF's responsibility to provide the PMI required to support the patient during evacuation. This PMI accompanies a patient throughout the chain of evacuation from the originating MTF to the destination MTF, whether it is an intra- or intertheater transfer. The Services will include and maintain initial quantities of DMSB PMIs in the appropriate medical assemblages. They should not assume or plan for shortfalls of PMIs being satisfied by USAF PMI centers. Through the DMSB, the Services will identify and approve PMI equipment items. Medical equipment for use in PMIs must be certified for use in aircraft by the joint airworthiness certification-testing agency. A joint certification label is required to designate airworthiness certification for all PMI equipment. The joint certification label must be affixed to each piece of AE certified equipment. To reduce medical equipment shortfalls experienced within the theater, the JFC must ensure that detailed procedures are established to resupply and refurbish PMIs.

2. Patient Movement Item System

The objective of the PMI system is to sustain the PM/evacuation system without diminishing the capability of forward medical units. This is done by providing in-kind exchange of equipment for treatment continuity or by using equipment that is Service specific, DMSB approved. Equipment listings are maintained by the Service medical logistic agencies. Prompt recycling of PMI is essential for minimal inventory investment. The USAF PMI system comprises the management of PMI equipment and materiel. The PMI system will provide a seamless in-transit patient and/or equipment management process from initial entry to the patient's final destination. The PMI system will deploy with the AE system, be managed and supplied through the AE system, and collocate with AE intratheater and/or intertheater interfaces in order to provide initial AE operational capability, sustainment of AE operations, and minimize equipment turnaround time.

3. Patient Movement Item Centers

Establishment of theater PMI centers is a Service and combatant command responsibility. Air Force medical units will be tasked, trained, organized, and equipped to perform AE missions, including PMI operations. The USAF has established five PMI centers to support worldwide AE operations based on theater requirements. Service PMI centers should be located at ports of embarkation and/or debarkation within CONUS and outside the continental US that best support PM/evacuation/treatment plans as identified in combatant command OPLANs and Service/agency support plans (e.g., NDMS activation). PMI centers are responsible for the overall management, in-transit visibility, and tracking of PMIs. PMI centers will receive, refurbish (i.e., technical inspection, calibration, repair, and provision of 1 day of expendable supplies), redistribute, and return PMIs collected from MTFs. The US Army Medical Materiel Agency may be required to provide the same level of maintenance support in CONUS if required. PMI centers can be augmented with personnel and equipment from the other Services in the event of surge and sustained requirements. Service liaison personnel can also be assigned. MTFs will clean PMI equipment before returning it to another facility, PMI center and/or cell, or transportation point. Intratheater movement of PMI equipment is the responsibility of the CCDR.

APPENDIX B

SERVICE COMPONENT TRANSPORTATION ASSETS

SECTION A. SUPPORTING AIR FORCE AEROMEDICAL EVACUATION ELEMENTS AND TRANSPORTATION ASSETS

1. Aeromedical Evacuation Unit Type Code Employment Concept

a. This appendix provides a listing of the evacuation capabilities of Service component transportation assets and also includes rail transport resources. Although railway transportation assets are not Service owned or within the DOD inventory, it is important to know their capacities in the event they become available as evacuation platforms through wartime HNS agreements. The majority of the Service transportation assets listed in Figure B-1 are not dedicated MEDEVAC platforms, and when they are employed for MEDEVAC, their crew must be augmented with medical personnel to provide in-transit care. A listing of the recommended augmented medical personnel is provided for each transportation asset.

b. The role of the TAES and associated assets is to support joint force operations with an AE system that can be deployed worldwide to provide support across the range of military operations. The AE UTCs were developed based on the building block principle, which allows planners to select specific UTCs required to support a pending joint force operation or those used for developing OPLANs. Each UTC was developed to support C2, patient staging, support, operational or patient care requirements and has specific mission tasks and responsibilities. At a minimum, in order for a TAES to exist, UTCs must be deployed to establish a C2 structure and a communication link between the user and the AE system; provide patient staging at an airfield; and provide in-flight care. Force packages are groupings of UTCs that are deployed to meet a unique or enhanced capability requirement. AE UTCs are specifically designed to provide the maximum amount of flexibility to commanders and planners to meet the full spectrum of AE operations to include wartime, humanitarian, and disaster response operations. The UTCs are divided into three categories, C2, patient care, and AE support. The following sections provide a brief description of these UTCs.

2. Command and Control Unit Type Codes

a. **AE Command Squadron.** Provides C2 of assigned AE forces. The AECS can deploy in advance of other AE UTCs to establish the support required for AE forces and establishment of a theater AE system. The AECS will advise wing and operations group commanders, as well as other appropriate personnel/agencies on AE CONOPS, doctrine, capabilities, and requirements. This UTC provides procedural guidance, technical guidance and management oversight for assigned, attached, and transiting AE elements. The AE crew management cell and/or the AE support cell may augment the AECS as required.

b. **AE Control Team.** Located within the AMD of the AOC, this team is responsible for operational planning, scheduling, and execution of scheduled and unscheduled AE missions through the appropriate AE elements. Once the AECT receives the transport to bed plan from

SERVICE COMPONENT TRANSPORTATION ASSETS					
NOMENCLATURE	SERVICE	CONFIGURATIONS	LITTER	AMBULATORY (SEATS)	ATTENDANTS
TRANSPORT AIRCRAFT					
C-5 GALAXY	USAF	MAXIMUM	NOT EQUIPPED	70	2 FLIGHT NURSES 3 AEROMED EVAC TECHS
KC-135 STRATOTANKER	USAF	MAXIMUM	14 ON PSP	16	2 FLIGHT NURSES 3 AEROMED EVAC TECHS
KC-10 EXTENDER	USAF	MAXIMUM	8 ON PSP	42	2 FLIGHT NURSES 3 AEROMED EVAC TECHS
C-21	USAF	MAXIMUM	1	2	1 FLIGHT NURSE 2 AEROMED EVAC TECHS
C-130 HERCULES	USAF	MAXIMUM	72	92	2 FLIGHT NURSES
	USMC	COMBINED	50	24	
C-141B STARLIFTER	USAF	MAXIMUM	103	147	3 AEROMED EVAC TECHS
		COMBINED	48	38	
		MAX CAPACITY NOT GENERALLY USED DUE TO DIFFICULT IN-FLIGHT PATIENT CARE.			
C-17 GLOBEMASTER	USAF	MAXIMUM	36	102	2 FLIGHT NURSES 3 AEROMED EVAC TECHS
		COMBINED	36	102	
		12 PSPS CAN ALSO BE USED RESULTING IN 54 LITTER CAPACITY			

Figure B-1 Service Component Transportation Assets

SERVICE COMPONENT TRANSPORTATION ASSETS (cont'd)					
NOMENCLATURE	SERVICE	CONFIGURATIONS	LITTER	AMBULATORY (SEATS)	ATTENDANTS
TRANSPORT AIRCRAFT (cont'd)					
Civil Reserve Air Fleet (CRAF) (Stage II Activation)	CRAF	MAXIMUM	87	Carrier Specific	4 FLIGHT NURSES 6 AEROMED EVAC TECHS
OTHER AIRCRAFT					
U-21 UTE	USA	MAXIMUM	3	10	1 MEDIC
		COMBINED	Ñ	10	
C-12 HURON	USA USAF	MAXIMUM	2	8	
		COMBINED	Ñ	8	
ROTARY-WING AIRCRAFT					
UH-1N IROQUOIS	USMC	MAXIMUM	6	12	1 CORPSMAN
		COMBINED	3	5	
CH-46 SEA KNIGHT	USMC/USN	MAXIMUM	15	22	2 CORPSMEN
		COMBINED	6	15	1 CORPSMAN
CH-53D SEA STALLION CH-53E SUPER SEA STALLION	USMC/USN	MAXIMUM	24	37 (55 WITH CENTER LINE SEATING)	2 CORPSMEN
		COMBINED	8	19	

Figure B-1 Service Component Transportation Assets (cont'd)

SERVICE COMPONENT TRANSPORTATION ASSETS (cont'd)					
NOMENCLATURE	SERVICE	CONFIGURATIONS	LITTER	AMBULATORY (SEATS)	ATTENDANTS
ROTARY-WING AIRCRAFT (cont'd)					
UH-60Q BLACKHAWK	USA	MAXIMUM	6	7	1 MEDIC
		COMBINED	6	1	
UH-1H/V IROQUOIS	USA	MAXIMUM	6	9	
		COMBINED	3	4	
CH-47 CHINOOK	USA	MAXIMUM	24	33	
		COMBINED	8	19	
FIXED-WING AIRCRAFT					
C-2 (COD)	USN	MAXIMUM	NOT EQUIPPED	28	2 CORPSMEN
P-3 (SUB HUNTER)	USN	MAXIMUM	10	19	2 CORPSMEN
MEDICAL GROUND VEHICLES					
M996/M103 4X4 FRONTLINE AMBULANCE	NOT SERVICE UNIQUE	MAXIMUM	3	4	DRIVER ONLY
		COMBINED	2	1	1 CORPSMAN
M997 4X4 AMBULANCE	NOT SERVICE UNIQUE	MAXIMUM	4	8	
		COMBINED	2	4	

Figure B-1 Service Component Transportation Assets (cont'd)

SERVICE COMPONENT TRANSPORTATION ASSETS (cont'd)					
NOMENCLATURE	SERVICE	CONFIGURATIONS	LITTER	AMBULATORY (SEATS)	ATTENDANTS
MEDICAL GROUND VEHICLES (cont'd)					
M792 TRUCK, 6X6 AMBULANCE	USA	MAXIMUM	3	6	DRIVER ONLY
		COMBINED	2	3	1 CORPSMAN
M996 TRUCK, 4X4 AMBULANCE ARMORED HMMWV-MINI	NOT SERVICE UNIQUE	MAXIMUM	2	6	1 CORPSMAN
		COMBINED	1	3	
M997 TRUCK, 4X4 AMBULANCE ARMORED HMMWV-MAXI	NOT SERVICE UNIQUE	MAXIMUM	4	8	1 CORPSMAN
		COMBINED	2	4	
M1035 TRUCK, 4X4 AMBULANCE SOFT-TOP HMMWV-MINI	NOT SERVICE UNIQUE	MAXIMUM	2	6	DRIVER ONLY
		COMBINED	1	3	1 CORPSMAN
BUS, AMBULANCE	NOT SERVICE UNIQUE	MAXIMUM	20	44	2 CORPSMEN
		CAPACITY VARIES BY SIZE OF BUS			
M113 CARRIER, PERSONNEL, FULL-TRACKED ARMORED, WITH LITTER CONVERSION KIT	USA	MAXIMUM	4	10	1 CORPSMAN
		COMBINED	2	4	

Figure B-1 Service Component Transportation Assets (cont'd)

SERVICE COMPONENT TRANSPORTATION ASSETS (cont'd)					
NOMENCLATURE	SERVICE	CONFIGURATIONS	LITTER	AMBULATORY (SEATS)	ATTENDANTS
NONMEDICAL GROUND VEHICLES					
LAV 25, LIGHT ARMORED VEHICLE	USMC	MAXIMUM	0	4	CREW ONLY
LAVL, LIGHT ARMORED VEHICLE, LOGISTICS VARIANT	USMC	MAXIMUM	4	7	1 CORPSMAN
AAV, LVPT-7 AMPHIBIOUS ASSAULT VEHICLE, LANDING VEHICLE PERSONNEL	USMC	MAXIMUM	6	21	1 CORPSMAN
M1008 4X4/4X2 TRUCK, CARGO	USA, USMC	MAXIMUM	5	8	1 CORPSMAN
M998 4X4 TRUCK CARGO/TROOP CARRIER	USA, USMC	MAXIMUM	5	6	
M813, M923 TRUCK, CARGO 5 TON	USA, USMC	MAXIMUM	12	20	
RAIL TRANSPORT					
SLEEPING CAR	NATO/HOST-NATION SUPPORT (HNS) (CAPACITY VARIES BY NATION)	MAXIMUM	32	32	1 NURSE

Figure B-1 Service Component Transportation Assets (cont'd)

SERVICE COMPONENT TRANSPORTATION ASSETS (cont'd)					
NOMENCLATURE	SERVICE	CONFIGURATIONS	LITTER	AMBULATORY (SEATS)	ATTENDANTS
RAIL TRANSPORT					
AMBULANCE RAILWAY CAR	NATO/HNS (CAPACITY VARIES BY NATION)	MAXIMUM	24	30	1 NURSE
AMBULANCE RAILWAY CAR, PERSONNEL	NATO/HNS (CAPACITY VARIES BY NATION)	MAXIMUM	21	21	2 WARD ATTENDANTS
RAIL BUS	GERMANY	COMBINED	40	16	
WATERCRAFT					
LCVP, LANDING CRAFT, VEHICLE & PERSONNEL	USN	MAXIMUM	17	36	2 CORPSMEN
LCM-6, LANDING CRAFT MECHANIZED	USN	MAXIMUM	30	80	
LCM-8, LANDING CRAFT MECHANIZED	USN	COMBINED LIT/AMB	50	200	3 CORPSMEN
LCU, LANDING CRAFT UTILITY	USN	MAXIMUM	100	400	
LCAC, LANDING CRAFT AIR CUSHION	USN	IN CREW SPACES	3	12	2 CORPSMEN (1 IN EACH CREW COMPARTMENT)
					CORPSMEN AS NEEDED FOR CONFIGURATION

Figure B-1 Service Component Transportation Assets (cont'd)

the PMRC, the AECT coordinates airlift to meet AE requirements, tasks the appropriate AE elements, and notifies the PMRC when mission taskings are scheduled in order to maintain full patient in-transit visibility. The AECT also monitors execution of AE missions and coordinates/communicates with theater planning cells and AE command elements as necessary. The AECT advises the DIRMBOFOR and liaisons with JTF/component surgeons on AE issues. The AECT must be able to establish communication links with other AE components and PMRC.

c. **AE Plans and Strategy Team (AEPST).** Collocated with the combat plans and/or strategy division within the joint air operations center (JAOC), and reporting to the director, JAOC. Develops plans and strategies and determines number and location of AE assets needed to support operational requirements. Provides this information to the AECT in the JAOC AMD for approval by the JFACC and execution by the JAOC director. The AEPST communicates and coordinates with other AE components as necessary, but it does not exert any direct C2 functions.

3. Patient Care Unit Type Codes

a. **AE Crew.** The AEC is an AE building block UTC that manages in-flight care and safety for patients aboard fixed wing AE missions. An AE crew is used to move stabilized patients, who have been regulated by the PMRC, between levels of care using inter- or intratheater fixed wing airlift.

b. **Critical Care Air Transport Team.** CCATTs provide specialized care, in conjunction with AE crews, to evacuate critical patients requiring advanced care during transportation. Recognized as clinical experts, these teams are medically responsible for their patients and function under the in-flight direction of the mission clinical director and aircraft director. The CCATT physician is clinically responsible for care given to CCATT-assigned patients and may be asked to assist or advise on the care of the other patients. AE missions that require CCATT augmentation will be identified/validated by PMRC/AECT. The theater validating surgeon, in conjunction with the CCATT director, designated by the AES command center, normally coordinates individual CCATT mission requirements.

c. **AE Control Team.** The AECT is located within the AMD of the AOC and is responsible to the AMD chief, AOC director, and the DIRMBOFOR for current AE operational planning, tasking, and mission execution to the theater. Once a validated PMR is received, the AECT coordinates airlift and AE assets to meet AE requirements, tasks the appropriate airlift wings through the ALCT and ATO, and passes mission information to the PMRC. This team also coordinates airlift with TACC/AMOCC to meet AE requirements.

d. **Expeditionary AE Staging Team (EAST).** EASTs provide the initial capability to receive patients and administrative and supportive patient care on ground and in flight. They generally deploy as a follow-on staging capability to the expeditionary AE coordination team (EACT)/expeditionary AE crew member support (EACS). When combined with these two UTCs, they can provide short-term 24-hour staging capability for up to 10 patients at any one time.

e. **Mobile Aeromedical Staging Facility.** The MASF provides rapid response patient staging, limited holding, and AE crew support capability. Normally located at or near airheads capable of supporting mobility airlift, the MASF is designed to provide forward support with the smallest footprint. It is made up of a three person alert AEC, communications, liaison, and patient care teams. For contingency planning patient throughput is 40 patients per 24 hours. When crew is tasked from the MASF, staging capability is degraded. The MASF includes a capability to receive patients, provide supportive patient care, and meet administrative requirements on the ground while awaiting AE airlift. CCATTs can be assigned to forward based MASFs to enhance rapid evacuation of stabilized patients.

f. **MASF Augmentation.** The MASF may be augmented with additional personnel and equipment to increase patient staging capability as needed. Enhances ability to receive and provide administrative and supportive patient care for patients awaiting evacuation. Increases staging capability to 80 patients per 24 hours. Must deploy with or as follow-on to MASF (not a stand alone capability).

g. **Contingency Aeromedical Staging Facility.** The CASF may be used at major intertheater hubs to support the full spectrum of contingency operations. The CASF provides patient staging support the medical treatment facility, and differs from the MASF in that the CASF is fixed, not mobile. The CASF interfaces with the AE mission and falls under the command and control of the medical group commander.

4. Aeromedical Evacuation Support Unit Type Codes

a. **Aeromedical Evacuation Operations Team.** The AEOT is a building block team with force augmentation packages that conducts the activities associated with management and direction of assigned, attached, and transiting AECs, CCATTs and associated equipment. AEOT equipment includes office, communications, and logistical support items to accomplish the mission. The AEOT UTC supports AE operations at inter- or intratheater hubs including those at forward operating airfields. The team works directly with airlift C2 agencies such as the air mobility control center, the AMOCC, AECT, TACC or other airlift agencies to coordinate AE missions and ensure on-time launch and recovery. The AEOT works closely with other TAES elements including MASF, CASF, and service component medical treatment elements to accomplish its mission.

b. **AE PMI Medical Logistics Team.** This team provides manpower for operational management of PMI centers and/or cells. Their duties consist of storage, reception, inventory control, issue, palletizing, shipping, and ID of requirements and updating the supporting management information system. They liaison with AE and user Service personnel regarding PMI demands. They are collocated with the AEOT or key locations to facilitate PMI movement.

c. **AE PMI Biomedical Equipment Repair Team.** This team provides regional maintenance and repair capability for equipment in PMI centers and/or cells. Their duties involve scheduling and completing scheduled preventative maintenance and calibration, repair and maintenance services, and updating the PMI information system.

5. Force Packages

a. When certain AE UTCs are combined, an enhanced or specific capability can be achieved. The following are combinations of UTCs designed to create force packages that can be employed to meet mission requirements.

b. **AEOT Force Package.** (Includes AE command augmentation team [ACAT], AECMs, and AE administrative support team [AAST].) This package provides operational and mission management; crew management for assigned, attached, and transiting AE crews; and in-flight medical equipment management to include supplies, medications, and sufficient LOX. They direct launch and recovery activities and supervise ground handling and on/offload of patients. They ensure appropriate aircraft configuration and equipment availability. Their duties also involve scheduling and alerting crews; coordinating life support, food service, transportation, and lodging; and administrative duties, such as mission paperwork preparation. They support all aircraft transporting patients, including CRAF. The AEOT can be deployed incrementally, but a complete AEOT force package consists of an AE command augmentation team, AE crew, two crew management cells, and an AAST. The ACAT is the initial UTC to deploy from this force package and subsequent elements are added as mission requirements dictate.

c. **AELT Force Package.** (Includes expeditionary liaison team and AELT.) When fully employed, this package provides high intensity, long duration support with fully capable multiple communication capability to meet any possible requirement. They provide continuous 24-hour operations, communications, and flight clinical coordination interface with the user Service/customer. UTCs can be employed incrementally or in conjunction to meet mission requirements.

d. **Expeditionary Aeromedical Staging Facility (EASF) Force Package.** (Includes EACT, EACS, and EAST.) When fully deployed, this package provides 24-hour, short-term aeromedical staging capability for 10 patients at any one time. Extended or anticipated operations at surge capability beyond 72 hours may require augmentation by additional MASF UTCs.

e. **Mobile Aeromedical Staging Facility (ASF) Force Package.** (Includes EASF, MASF-25 package and MASF-50 package.) This package is designed to support major war requirements. It provides the personnel for supportive patient care, patient staging, and emergent AEC capability. It can be deployed incrementally or as a force package to meet mission requirements. It interfaces with fixed- and rotary-wing aircraft.

f. **ASF Force Package.** (Includes 50-bed ASF initial element and 25-bed ASF augmentation package.) This package supports the deployed aeromedical staging mission at strategic-tactical interface points within a theater or area of operations, strategic hub, or CONUS interface point. It provides the personnel to support AE command, control, communications, patient care, patient staging, and system support. It can be employed incrementally or as a force package to meet mission requirements.

6. Theater Airlift Resources

a. The primary Air Force aircraft available to support theater AE are the C-130 and C-17. The C-130 operates either as preplanned, retrograde, or opportune AE and is the primary aircraft for moving patients from and within the combat zone. Preplanned AE can be scheduled in either a preconfigured or retrograde operation at the discretion of the GCC and the theater's JMC. When using retrograde, the aircraft flies into an airfield, off-loads the cargo and/or passenger load, and is reconfigured for AE on the return, or retrograde leg. Retrograde aircraft utilize litter configuration equipment organic to the aircraft. To use preplanned airlift, the GCC must apportion theater airlift for the AE mission. These aircraft can then be configured for AE prior to mission origination. Dedicated and preconfigured preplanned aircraft enable AE mission planners to use the same aircraft to make multiple stops, facilitate scheduling of the mission(s) to meet AE requirements (e.g., increased flexibility with APOE and/or APOD selection), and permit an increased litter AE configuration. However, using preconfigured preplanned AE does reduce the number of airframes available to the GCC for other missions. Aircraft characteristics for theater support aircraft are outlined below. Patient stability may dictate changes in the mix of patients to crew members, crew augmentees, and medical attendants affecting standard planning assumptions.

b. **C-130 Hercules.** The C-130 is a high wing, four-engine turboprop aircraft. For AE purposes, it is predominantly used for intratheater rather than intertheater evacuation. AE planning factor is for 50 patients. The fuselage is divided into the cargo compartment and the flight deck. It can be fully pressurized, heated, and air conditioned. The C-130 can maintain a sea-level cabin altitude at an ambient altitude of 19,000 feet and an 8,000 foot cabin altitude at an ambient altitude of 35,000 feet. It can land and take-off on short runways, which allows rapid transportation of personnel and equipment. The C-130 can be readily configured for AE by using seat and litter provisions stowed in the cargo compartment. It can hold a maximum of 74 litters, depending on the availability and serviceability of inherent equipment and the model of the aircraft, 92 ambulatory patients and/or medical crew members, or a variety of combinations of litter and ambulatory. The C-130 poses several constraints for AE operations. These include cabin noise, which can make patient evaluation difficult and inadequate lighting for many patient care activities. The aircraft oxygen system needs to be supplemented by a self-contained AE system for therapeutic oxygen delivery. The single lavatory is on the cargo ramp and is impossible for some otherwise ambulatory patients to use. During engines-running on-load and off-load operations at unimproved airfields, blown objects and dust can present eye hazards and stress to crew and patients.

7. Intertheater Airlift Resources

a. The primary Air Force aircraft available to support intertheater AE are the KC-135 and C-17 aircraft. The commander AMC TACC normally has OPCON of these resources and allocates airframes to meet operational requirements. As with theater airlift resources, airlift can be scheduled in either a preplanned, retrograde, or dedicated, role as outlined above in theater airlift resources. AE CRAF aircraft would be the only aircraft dedicated to AE.

b. **KC-135 Tanker.** Tanker aircraft have begun augmenting the Air Force's AE mission to extend medical care to critically injured patients. A basic crew of five (two flight nurses and three medical technicians) is added for aeromedical evacuation missions. Medical crew may be altered as required by the needs of patients.

c. **C-17 Globemaster III.** The C-17 is the nation's newest operational strategic airlifter capable of transporting patients. It is powered by four turbofan engines and cruises at about 550 miles per hour with an unrefueled range in excess of 5,250 miles. The C-17 has three aeromedical stations stowed on the sidewall to accommodate 9 litters. If additional litter stanchions are added to the aircraft, the C-17 can transport a total of 36 litter patients. The C-17 can also be configured with patient support pallets. Five therapeutic oxygen outlets are provided, and there are twelve designated aeromedical utility receptacles for electrical power.

8. Civil Reserve Air Fleet

In order to overcome shortfalls in fulfilling wartime AE requirements with retrograde airlift, Commander, USTRANSCOM, in conjunction with a number of airlines and the Department of Transportation, can activate the AE CRAF segment to provide aircraft dedicated to the strategic AE mission. The CRAF is composed of civil air carriers who contractually commit themselves to provide operating and support personnel, facilities, and aircraft to USTRANSCOM under stated conditions. The primary aircraft to be provided to support aeromedical airlift is the Boeing 767. Once activated, each Boeing 767 would be reconfigured from its passenger configuration to an aeromedical configuration. With airline delivery time factored in, planning estimate is 72 hours from notification to the airlines to deliver an aircraft until the aircraft can be reconfigured. Since the AE CRAF is a dedicated AE aircraft, planning factors to be used when moving stable patients is 47 ambulatory-only patients per mission and 87 patients per mission when moving litter-only stabilized patients. Each Boeing 767 so configured would remain in the AE system until such time that the operation no longer requires it.

9. Non-Traditional Aeromedical Evacuation Aircraft

Instances may occur that require the use of aircraft other than those normally used to support AE operations (C-5, KC-10, C-12, C-21). AE missions can be flown on these aircraft with careful planning consideration for the loading and unloading of patients and placement of patients during flight. On those occasions when AECMs may be required to accompany patients on nontraditional aircraft, AECMs should work closely with the flight crew and receive, at a minimum, a briefing on emergency egress, oxygen, and electrical system capability as it relates to patient and/or emergency use. Guidelines followed on other AE missions should be observed as much as possible. AECMs should refer to AE regulations for further guidance on utilizing specific aircraft.

10. Ambulance Bus

The ambulance bus (AMBUS) is organic to the table of allowance for contingency hospitals and aeromedical staging squadrons. The AMBUS has an inherent capability to transport 12 litter

or a combination of litter and ambulatory patients from 4 litter and 24 ambulatory up to 12 litter and 0 ambulatory.

SECTION B. SUPPORTING NAVY/MARINE CORPS/COAST GUARD EVACUATION ELEMENTS

11. Navy

a. Currently, the Navy has no dedicated AE resources at theater level MTFs to go forward and retrieve casualties. Evacuation continues to be provided by lifts of opportunity from Navy as well as other JTF resources as identified during the planning process.

b. **Casualty Receiving and Treatment Ships (CRTSs).** Designated ships of the amphibious task force that can provide FRC capability and medical and dental support to the landing force. General-purpose amphibious assault ships are suitable for use as CRTS. AE to CRTS is by Navy or Marine Corps lift of opportunity or in some cases by Army helicopter.

c. The mission of the Fleet Hospital Program is to provide definitive health care to the Fleet and Fleet Marine Forces engaged in combat operations. Fleet hospitals can be configured from 10-bed expeditionary medical facilities (EMFs) to 500-bed fleet hospitals. Fleet hospitals are pre-positioned afloat and outside the continental United States (OCONUS) ashore. The “4/2” fleet hospital construct is composed of four modules and has the capability of deploying to two separate sites. The EMF has 1 operating room, and 10 beds, and is tent-based and air-mobile.

d. **Hospital Ships.** Two hospital ships operated by Military Sealift Command are designed to provide emergency, on-site care for US combatant forces deployed in war or other operations. No Navy or Marine Corps dedicated evacuation support currently exists for T-AHs. Current Joint Staff initiatives lead to the provision of an Army air ambulance company to support the evacuation requirements for T-AHs.

(1) **Features:** *United States Naval Ship (USNS) Mercy* (T-AH 19) and *USNS Comfort* (T-AH 20) each contain 12 fully-equipped operating rooms, a 1,000 bed hospital facility, digital radiological services, a diagnostic and clinical laboratory, a pharmacy, an optometry lab, a cat scan and two oxygen producing plants. Both vessels have a helicopter deck capable of landing large military helicopters, as well as side ports to take on patients at sea.

(2) **Background:** Both hospital ships are converted *San Clemente*-class super tankers. *Mercy* was delivered in 1986 and *Comfort* in 1987. Normally, the ships are kept in a reduced operating status in Baltimore, MD, and San Diego, CA, by a small crew of civilian mariners and active duty Navy medical and support personnel. Each ship can be fully activated and crewed within five days. *Mercy* went to the Philippines in 1987 for a humanitarian mission. Both ships were used during Operation DESERT SHIELD/STORM. The *USNS Comfort* twice operated during 1994 — once for Operation SEA SIGNAL’S Cuban/Haitian migrant interdiction operations, and a second time supporting US forces and agencies involved in Haiti and Operation

UPHOLD DEMOCRACY. On 12 September 2001, *Comfort* set sail for New York City and provided housing, laundry, food, medical and other services to volunteers and rescue personnel for nearly three weeks in the wake of the terrorist attack on the World Trade Center. *Comfort* was activated again in December 2002 and sailed to the Persian Gulf to support Operation IRAQI FREEDOM.

e. The Navy currently has no dedicated AE resources at definitive care capability MTFs. Therefore, Navy doctrine relies on the collocation of a staging facility with FHP elements to facilitate patient evacuation. Although movement assets are primarily provided by the Air Force, Figure B-1 depicts fixed-wing Navy assets which could be employed on a case-by-case basis.

12. Marine Corps

The Marine Corps depends on Navy and other JTF evacuation assets for support. The Marine Corps has no theater hospitalization capability assets.

13. Coast Guard

The Coast Guard depends on Navy and other JTF evacuation assets for support. The Coast Guard has limited first responder capability and no FRC capability or theater hospitalization capability.

SECTION C. SUPPORTING ARMY EVACUATION ELEMENTS AND REQUEST PROCEDURES

14. General

a. The USA typically is the primary provider of air and ground MEDEVAC assets to the CCDR. The Army has dedicated assets specifically organized to provide this function. As a member of the JTF, Army MEDEVAC provides forward PM to members of the JTF as well as: HN, interagency, NGOs, detainees, DOD and non-DOD civilians and contractors.

b. Army MEDEVAC in a theater may be provided in a general support (GS) or DS role based on the requirements of the JTF. If available and allocated, team or company sized elements of Army air or ground ambulances can be tasked to directly support those elements of the JTF that do not have sufficient organic evacuation assets.

c. The support roles and allocation of MEDEVAC units are directed through the GCC's joint PM system (appendix 1 to annex Q). The plan is based on many factors including: casualty estimates based on supporting the HN, DOD, and interagency populations, MTF locations, air and ground ambulance maintenance support locations, supported CJTF units, missions, and theater geography.

d. Army air and ground ambulance units are dedicated medical units and are afforded the protection of the Geneva Conventions. In compliance with the Geneva Conventions, these units may only perform the MEDEVAC mission (and other associated medical missions). Personal

weapons are carried for self-defense and the defense of patients. All platforms are marked with a red cross or equivalent symbology.

15. Evacuation Through the Joint Capabilities of Care

a. Within the area of operations (AO), patients are collected, triaged, treated, and returned to duty as far forward as possible. The patients are evacuated to the MTF most capable of providing the required treatment in the shortest possible time. The amount of evacuation activity is dependent upon combat intensity, environmental conditions, terrain, and other special circumstances.

b. Army patient evacuation of casualties in the AO occurs from point of injury or illness to the appropriate capability of care. The Army uses this system to move its patients from point of injury through theater hospitalization capabilities of care and coordinates with the JPMRC or the TPMRC to ensure a seamless and cogent integration with the joint intertheater PM system. CASEVAC is a part of the Army doctrine however; when utilized it requires deliberate and distinct planning, used when dedicated PM assets are overwhelmed.

16. Army Medical Evacuation Units

a. Air Ambulance Company

(1) Configuration: An air ambulance company consists of 12 HH-60's and approximately 85 assigned personnel. An air ambulance company is assigned to a GS aviation battalion.

(2) HH-60 Air Ambulance: Each HH-60 is capable of carrying either six litter patients and one ambulatory patient, seven ambulatory patients, or some combination thereof. A litter-only configuration for 12 HH-60 aircraft results in a total lift capacity of 72 patients.

(3) Mission. The air ambulance company's mission is to conduct MEDEVAC within an operational area.

(4) Capabilities. A typical air ambulance company provides the following:

(a) Evacuation of patients from point of injury or illness to the required capability of care.

(b) The ability to task organize into four forward support MEDEVAC teams of three air ambulances each.

(c) Air crash rescue support, less fire suppression, in combat search and rescue operations.

(d) Rapid delivery of whole blood, biologicals, and medical supplies to meet critical requirements.

(e) Rapid movement of medical personnel and their accompanying equipment and supplies in response to MASCAL, reinforcement and/or reconstitution, or emergency situations.

(f) Movement of patients between MTFs, airheads, and or ships.

b. Ground Ambulance Company

(1) Configuration. A ground ambulance company is 100% mobile and normally consists of 40 ground ambulances and 124 assigned personnel.

(2) Mission. The ground ambulance company's mission is to provide ground evacuation of patients within the operational area.

(3) Capabilities. There are a variety of Army ground ambulances. For light or varied operations, high mobility multipurpose wheeled vehicles (HMMWV) and HMMWV derivatives are used. Each has a 4 litter or 8 ambulatory patient capacity. For airborne or high mobility operations the M996 derivative is used, with a 2 litter capacity. For heavy (armor) operations, an armored personnel carrier (M113) derivative is used in some units. The Stryker MEDEVAC vehicle is a highly mobile armored evacuation vehicle and is the newest Army ground evacuation platform. The ground ambulance company provides the following.

(a) Evacuation of patients (consistent with evacuation priorities and operational considerations) from point of injury or illness.

(b) Movement of patients between MTFs, airheads, and or seaports.

(c) Emergency movement of medical supplies.

17. Evacuation Request Procedures

a. **General Instructions.** Procedures for requesting MEDEVAC are derived from an established joint PM system (appendix 1 to annex Q) of the OPORD. The same format is used for requesting both aeromedical and ground evacuation. Before initiating an evacuation operation, a unit must have an established medical evacuation plan. The plan may be an SOP or it may be designed for a particular operation.

b. **Medical Evacuation Patient Precedence Assignments.** Assignment of patient evacuation precedence is necessary and is made by the senior military person present based on the tactical situation. Precedence assignment provides the supporting medical unit and the controlling HQ with information to be used in decision-making with regards to the use of their evacuation assets. Patients are evacuated as soon as possible consistent with available resources and pending missions. Patient precedence and the criteria used in their assignment are as follows:

(1) **Priority I - URGENT.** Patients requiring emergency, short notice evacuation within a maximum of 1 hour to save life, limb, or eyesight and to prevent serious complications of the injury, serious illness, or permanent disability. NOTE: It may be necessary, in some cases, to skip a medical capability and evacuate a patient directly to a greater medical capability in order to increase the survivability of the patient. To do so, the patient must be stable enough to endure the additional flight time to the greater medical capability. This may result in an overall MEDEVAC time which exceeds the 60 minute standard for Urgent/Urgent Surgical patients but is justifiable to ensure patients are evacuated to the right level of care based on their injuries.

(2) **Priority IA - URGENT-SURGICAL.** Patients requiring FRC for life and limb saving measures, and to attain stabilization for further evacuation within a maximum of 1 hour.

(3) **Priority II - PRIORITY.** Patients requiring prompt medical care, within a maximum of 4 hours, to prevent the medical condition from deteriorating to an URGENT precedence, to prevent unnecessary pain or disability, or who require treatment not available locally.

(4) **Priority III - ROUTINE.** Patients who do not require immediate medical attention and whose condition is not expected to deteriorate significantly. They should be evacuated within 24 hours.

(5) **Priority IV - CONVENIENCE.** Patients for whom evacuation by medical vehicle is a matter of medical convenience rather than necessity.

c. **Unit Responsibilities in Evacuation.** A request for MEDEVAC places certain responsibilities on the requesting unit. To prepare for and assist evacuation operations, the unit must ensure the following.

(1) The tactical situation permits evacuation and patient information is ready when the request is submitted.

(2) An English-speaking representative at the pickup site when the evacuation is requested for non-US personnel.

(3) Patients are moved to the safest aircraft approach and departure point or ground ambulance exchange point.

(4) Unit personnel are familiar with the principles of helicopter operations. The unit typically:

(a) Prepares the landing site.

(b) Loads and unloads the helicopter according to the crew's instructions.

- (c) Briefs the pilot on the location of enemy troops.
- (d) Guides the helicopter using hand signals.

d. **Medical Evacuation Request Formats and Procedures.** The MEDEVAC request is used for requesting evacuation support for both air and ground ambulances. There are two established MEDEVAC formats and procedures: one for wartime use and one for peacetime use. The differences that exist between these two formats are noted in lines 6 and 9 in Figure B-2. Additionally, under all non-war conditions clear text transmissions of MEDEVAC requests are authorized. During wartime, evacuation requests are transmitted by secure means if possible.

e. **Transmission of the Request.** MEDEVAC requests should be made to the unit that controls evacuation assets, by the most direct communications means available. The communications means and the channels used will depend on factors such as the organization, location on the battlefield, distance between units, and the communications means available at the time. Primary and alternate channels to be used are specified in the unit evacuation plan.

(1) **Transmission Security.** Wartime conditions dictate all requests be transmitted by secure means if possible. Regardless of the type of communications equipment used in transmission, it is necessary to:

- (a) Make the proper contact with the intended receiver.
- (b) Use accurate call signs and frequencies from the unit at the pick up sight.
- (c) Provide the opening statement: "I HAVE A MEDEVAC REQUEST."

(d) The unit requesting the MEDEVAC must monitor the frequency they provided in the 9 line request (Figure B-2, line 2 of request) in order to receive contact from the evacuation vehicle.

(2) **Receiver Acknowledgment.** After the opening statement is made, the transmitter breaks for acknowledgment.

f. **Relaying Requests.** If the unit receiving the request does not control the evacuation means, it must relay the request either to the HQ or unit that has control or to another relaying unit.

18. Medical Evacuation Request and After-Action Record

Once the evacuation mission is completed, an after-action record of the mission will be completed to provide historical data and lessons learned. A sample of this record is shown in Figure B-3.

DESCRIPTION OF MEDICAL EVACUATION REQUEST PREPARATION				
LINE ITEM	FORMAT	SOURCE	NORMAL SOURCE	REASON
1 Location of pickup site	Encrypt the grid coordinates of the pickup site. When using the DRYAD Numeral Cipher, the same "SET" line will be used to encrypt the grid zone letters and the coordinates. To preclude misunderstanding, a statement is made that grid zone letters are included in the message (unless unit standard operating procedure specifies its use at all times).	From Map	Unit leader(s)	Required so evacuation vehicle knows where to pick up patient. Also, so that the unit coordinating the evacuation mission can plan the route for the evacuation vehicle (if the evacuation vehicle must pick up from more than one location).
2 Radio Frequency, Call Sign, and Suffix	Encrypt the frequency of the radio at the pickup site, not a relay frequency. The call sign (and suffix if used) of the person to be contacted at the pickup site may be transmitted in the clear.	From SOI	RTO	Required so that evacuation vehicle can contact requesting unit while en route (obtain additional information or change in situation or directions).
3 Number of patients by precedence	Report only applicable information and encrypt the brevity codes. A - URGENT B - URGENT-SURG C - PRIORITY D - ROUTINE E - CONVENIENCE If two or more categories must be reported in the same request, insert the word "BREAK" between each category.	From evaluation of patient(s)	Medic or senior person present	Required by unit controlling the evacuation vehicles to assist in prioritizing missions.

Figure B-2. Description of Medical Evacuation Request Preparation

DESCRIPTION OF MEDICAL EVACUATION REQUEST PREPARATION (cont'd)				
LINE ITEM	FORMAT	SOURCE	NORMAL SOURCE	REASON
4 Special Equipment Required	Encrypt the applicable brevity codes. A - None. B - Hoist. C - Extraction equipment. D - Ventilator.	From evaluation of patient or situation	Medic or senior person present	Required so that the equipment can be placed on board the evacuation vehicle prior to the start of the mission.
5 Number of patients by type	Report only applicable information and encrypt the brevity code. If requesting medical evacuation for both types, insert the word "BREAK" between the litter entry and the ambulatory entry. L+# of Pnt - Litter A+# of Pnt - Ambulatory (sitting)	From evaluation of patient(s)	Medic or senior person present	Required so that the appropriate number of evacuation vehicles may be dispatched to the pickup site. They should be configured to carry the patients requiring evacuation.
6 (Wartime) Security of Pickup Site	N - No enemy troops in area. P - Possible enemy troops in area (approach with caution). E - Enemy troops in area (approach with caution). X - Enemy troops in area (armed escort required).	From evaluation of the situation	Unit leader	Required to assist the evacuation crew in assessing the situation and determining if assistance is required. More definitive guidance can be furnished the evacuation vehicle while it is en route (specific location of enemy to assist an aircraft in planning its approach).
6 (Peacetime) Number and Type of Wound, Injury, or Illness	Specific information regarding patient wounds by type (gunshot or shrapnel). Report serious bleeding, along with patient blood type, if known.	From evaluation of patient	Medic or senior person present	Required to assist evacuation personnel in determining treatment and special equipment needed.

Figure B-2. Description of Medical Evacuation Request Preparation (cont'd)

DESCRIPTION OF MEDICAL EVACUATION REQUEST PREPARATION (cont'd)				
LINE ITEM	FORMAT	SOURCE	NORMAL SOURCE	REASON
7 Method of Marking Pickup Site	Encrypt the brevity codes. A - Panels. B - Pyrotechnic signal. C - Smoke signal. D - None. E - Other.	Based on situation and availability of materials.	Medic or senior person present	Required to assist the evacuation crew in identifying the specific location of the pickup. Note that the color of the panels or smoke should not be transmitted until the evacuation vehicle contacts the unit (just prior to its arrival). For security, the crew should identify the color and the unit verify it.
8 Patient Nationality and Status	The number of patients in each category need not be transmitted. Encrypt only the applicable brevity codes. A - US military. B - US civilian. C - Non-US military. D - Non-US civilian. E - Enemy Prisoner of War	From evaluation of patient	Medic or senior person present	Required to assist in planning for destination facilities and need for guards. Unit requesting support should ensure that there is an English-speaking representative at the pickup site.
9 (Wartime) Nuclear, Biological, or Nuclear Contamination	Include this line only when applicable. Encrypt the applicable brevity codes. N - Nuclear. B - Biological. C - Chemical.	From situation	Medic or senior person present	Required to assist in planning for the mission. (Determine which evacuation vehicle will accomplish the mission and when it will be accomplished).
9 (Peacetime) Terrain Description	Include details of terrain features in and around proposed landing site. If possible, describe relationship of site to prominent terrain feature (lake, mountain, tower).	From area survey	Personnel at site	Required to allow evacuation personnel to assess route/avenue of approach into area. Of particular importance if hoist operation is required.

Figure B-2. Description of Medical Evacuation Request Preparation (cont'd)

MEDICAL EVACUATION/AFTER-ACTION RECORD				
DTG RECEIVED	CALL SIGN	AIR/ GROUND	UNIT MISSION / MISSION NUMBER	
ITEM	CLEAR/ DECRYPTED	ENCRYPTED	BREVITY CODE	ACTUAL INFORMATION
1 LOCATION OF PICKUP SITE				
2 FREQUENCY/ CALL SIGN SUFFIX AT PICKUP SITE				
3 NUMBER OF PATIENTS BY PRECEDENCE			A - URGENT B - URGENT-SURG C - PRIORITY D - ROUTINE E - CONVENIENCE	
4 SPECIAL EQUIPMENT			A - NONE B - HOIST C - EXTRACTION EQUIP D - VENTILATOR	
5 NUMBER OF PATIENTS BY TYPE			L + # OF PNT - LITTER A + # OF PNT AMB (SITTING)	
6 SECURITY OF PICKUP SITE*			N - NO ENEMY TROOPS P - POSSIBLE ENEMY TROOPS (CAUTION) E - ENEMY TROOPS IN AREA (CAUTION) X - ENEMY TROOPS IN AREA (ARMED ESCORT REQUIRED)	

Figure B-3. Medical Evacuation/After-Action Record

MEDICAL EVACUATION/AFTER-ACTION RECORD (cont'd)				
ITEM	CLEAR/ DECRYPTED	ENCRYPTED	BREVITY CODE	ACTUAL INFORMATION
7 METHOD OF MARKING PICKUP SITE			A - PANELS B - PYROTECHNIC SIGNAL C - SMOKE SIGNAL D - NONE E - OTHER	
8 PATIENT NATIONALITY AND STATUS			A - US MILITARY B - US CIVILIAN C - NON US MILITARY D - NON US CIVILIAN E - EPW	
9 NBC CONTAMINATION*			N - NUCLEAR B - BIOLOGICAL C - CHEMICAL	
NEAREST AXP	DESTINATION MTF		DEST FREQ/CALL SIGN	ETE
NOTES: (EXPLAIN DELAYS) (LIST NSB'S OR AIR CORRIDORS) (LIST EXCHANGE REQUIREMENTS) *WARTIME				

Figure B-3. Medical Evacuation/After-Action Record (cont'd)

MEDICAL EVACUATION/AFTER-ACTION RECORD (cont'd)				
DTG REQUEST RECEIVED BY EVACUATION UNIT		DTG REQUEST RECEIVED BY EVACUATION CREW		EVAC VEHICLE/AIRCRAFT DESIGNATION (BUMPER NUMBER/AIRCRAFT NUMBER)
DTG ARRIVED AT PICKUP SITE		DTG DEPARTED PICKUP SITE		EVACUATION ORGANIZATION
DTG ARRIVE AT MTF 1		DESIGNATION OF MTF 1		LOCATION OF MTF 1
DTG ARRIVE AT MTF 2		DESIGNATION OF MTF 2		LOCATION OF MTF 2
DTG ARRIVE AT MTF 3		DESIGNATION OF MTF 3		LOCATION OF MTF 3
DTG ARRIVE AT MTF 4		DESIGNATION OF MTF 4		LOCATION OF MTF 4
PATIENT DATA				
NAME	RANK	SER/ID NUMBER	UNIT	MTF EVACUATED TO
MISSION NARRATIVE: CHRONOLOGICALLY COVER AS MUCH INFORMATION AS IS AVAILABLE.				
EVAC CREW, INDIVIDUAL IN CHARGE:			SIGNATURE OF INDIVIDUAL IN CHARGE	
PILOT/DRIVER:				
MEDIC:				
CREW CHIEF:				
CONTINUATION OF INFORMATION:				

Figure B-3. Medical Evacuation/After-Action Record (cont'd)

APPENDIX C

HEALTH SERVICE LOGISTIC SUPPORT

1. Introduction

a. HSLS provides the specialized products and services required to support HSS and FHP. These products and services are used almost exclusively by the HSS system, are critical to its success in delivering health care, and are usually subject to strict standards and practices that govern the health care industry in the United States. HSLS functions are managed within the HSS system using DOD standard business processes and medical information systems, and are supported by organizations and business processes that are adaptable, scaleable, and tailored to the HSS mission. Primary HSLS functions provided in support of the CCDR include:

- (1) Medical supply chain management (Class VIIIa).
- (2) Provision and management of medical equipment.
- (3) Biomedical equipment maintenance.
- (4) Optical fabrication.
- (5) Storage and distribution of blood and blood products (Class VIIIb).
- (6) Medical facility management.
- (7) Provision of medical gases.

b. HSLS requires intensive management and close, personal collaboration among medical logisticians and clinicians throughout all levels of HSS to ensure that HSLS is responsive to clinical demands. The vast majority of medical supplies and equipment used in HSS are commercial, nonstandard, nondevelopmental items that are subject to rapid changes in technology and clinical practice. HSLS is characterized by a lean, intensively managed supply chain that extends from the national industry base to customers deployed far-forward in the theater. Effective management of this supply chain has led to close collaboration and formal partnerships that integrate strategic programs managed by DLA with the Services' operational HSLS capabilities.

2. Organization for Health Service Logistic Support

a. **The ASD(HA)** establishes DOD policies, programs, and standards that govern the provision of military health care. This includes the establishment, in coordination with the DLA and the Military Service Surgeons General, of performance standards for the provision of medical materiel support to the Military Health System. See Figure C-1 for organization diagram.

b. **The Military Departments** provide fully equipped and provisioned operational HSS units, to include the necessary force structure to operate HSLS for their respective Services. The

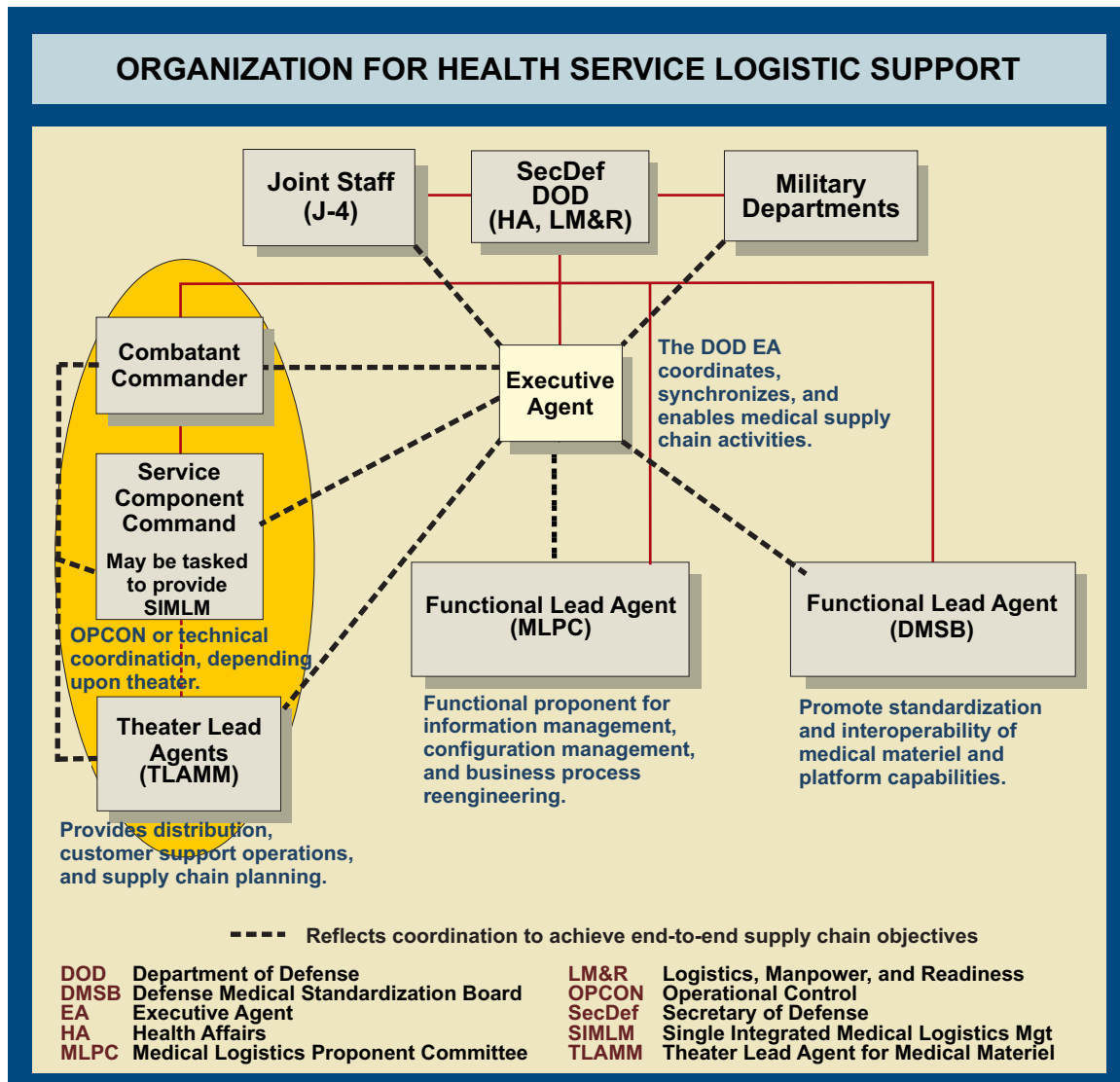


Figure C-1. Organization for Health Service Logistic Support

Services also provide the requirements data necessary to forecast and source the types and quantities of medical materiel to be procured by DLA for HSS across the full range of military operations.

c. **The CCCR** is ultimately responsible for the HSLS and the required medical materiel and equipment for their assigned and attached units.

(1) A designated combatant command surgeon advises the CCCR on all HSLS matters and provides the following HSLS functions:

(a) Prepares the detailed HSLS guidance, tasks, and joint HSLS CONOPS.

(b) Develops the theater pharmaceutical formulary and other HSS materiel policy guidance and planning factors for the CCCR, to include:

1. Preparatory requirements for pre-positioning of medical materiel, including MBCDM, medical countermeasures (e.g., antimalarial drugs), and terminal prophylaxis.

2. Theater policy for the individual issue of controlled substances, such as diazepam or morphine auto-injectors to appropriate medical personnel.

3. Theater policy for the refill of prescription medications for preexisting chronic medical conditions.

4. The management and disposal of regulated medical waste.

5. Review and recommend approval/disapproval of requests for nonstandard medical equipment beyond unit authorized allowances.

(c) Advises the CCDR on the joint application of HSLS resources to promote efficiency and minimize the HSLS footprint. This includes recommendations for establishment or designation of a TLAMM and the assignment of mission(s) for SIMLM.

(d) Maintains liaison with component surgeons and resolve HSLS conflicts surfaced by component commands.

(e) Maintains liaison with attached medical units responsible for execution of the HSLS mission(s), as well as theater HSLS organizations, to include the DLA and its regional command, TLAMM (if designated), DDOC, the joint mobility control group, and the TMLMC.

(f) Monitors HSLS support, to include status of critical and/or special interest materiel or systems, HSLS staffing, and supply chain performance.

(g) Supervises the activities of the AJBPO, if established.

(h) Advises the CCDR on the disposition of captured enemy medical materiel.

(2) The CCDR establishes capabilities for theater HSLS by requesting the operational HSLS forces required to support the HSS plan. To the extent possible, theater HSLS leverages distribution capabilities and information technology to minimize layers of storage and HSLS management, and employ HSLS capabilities that support all Service components and designated multinational partners to minimize unnecessary redundancy and promote supply chain efficiency. Theater HSLS is employed as part of the integrated HSS system typically under the management control of the senior medical commander and the oversight of the combatant command surgeon. The senior medical commander in coordination with the combatant command surgeon will recommend any reorganization of HSLS assets to the CCDR. HSLS functions are performed at every level of the HSS system and are dependent upon integrated plans and processes that are fully synchronized with theater HSS operations.

(a) First responder and FRC capabilities are the theater's most far-forward, highly disbursed, and fast-moving HSS elements. These units are very limited in the amount of materiel and equipment they carry, and are typically self-sufficient for not more than 72 hours of operations. Their primary HSLs functions are management of organic medical sets and equipment, and initiating and managing requests for replenishment or maintenance support. HSLs functions are frequently performed by clinical (non-logistics) personnel that have other primary duties. FRC also includes limited medical supply and maintenance provided by organic Service component tactical HSLs elements. Successful HSLs is reliant upon processes and supporting systems that are simple to use and reliable and upon intratheater distribution capabilities that provide time-definite delivery and timely and accurate in-transit visibility. First responder and FRC HSLs capabilities are controlled by the HSS or maneuver unit of which they are an organic part.

(b) Theater hospitalization units of HSS includes theater hospitalization as well as modular, specialty capabilities that comprise an integrated, multifunctional HSS system. It represents the most complex supply and equipment requirements for HSLs. Most of these units include organic HSLs capabilities to manage unit-level inventory and biomedical maintenance, support internal customers, and provide limited area support to external customers such as attached medical teams. These units are supported by theater-level and/or strategic HSLs units or organizations provided by the Services in response to the CCDR plan.

(c) Theater level HSLs is tailored to the mission, supported force, threat and geography of the supported theater. It is comprised of operational HSLs units requested by the CCDR and task organized within the theater HSS system to responsively and efficiently sustain all supported forces. Theater-level HSLs capabilities reach directly into the national commercial or Military Health System institutional base, and may include institutional HSLs organizations that are assigned to the theater or to a supporting CCDR. Theater HSLs units are typically under the control of the senior medical commander within a joint medical task force or Service component command tasked with providing theater HSLs to supported forces.

d. **The SIMLM** responsibility is assigned as required by a CCDR to a Service component command or JTF commander to provide medical logistics support to other Services and designated multinational partners. SIMLM is established to promote supply chain efficiency and minimize the theater medical logistics footprint. When directed, the SIMLM, in coordination with the JFS, DOD EA, and supporting TLAMM (if designated), will develop a HSLs plan and identify additional requirements necessary to provide medical logistics support to all designated customers and effectively extend HSLs into the theater in support of forward medical elements.

(1) The additional requirements may include capabilities essential to sustain an OPLAN or augment existing organizations that provide routine support to theater HSS operations in order to meet expanded mission requirements.

(2) The assignment of SIMLM is mission-specific and depends upon the composition of the supported force (e.g., one Service vs. multiple Service components) and the complexity of

intratheater distribution (e.g., that dictates the need to deploy intermediate medical storage and distribution nodes in order to meet customer requirements).

(3) The designated SIMLM may be augmented as required with HSLS capabilities provided by other Services at the direction of the CCDR, or by the other Services providing forces to the CCDR.

(4) An HSLS organization or unit of any Service may be tasked to support a SIMLM mission. The tasking should specify the scope of services provided such as customers supported and functions provided. The tasked organization or unit may be augmented and scaled to provide the capabilities required to support the specified mission. Planning and support responsibilities performed by an organization or unit performing a SIMLM mission may include:

(a) CL VIII storage and distribution, to include storage and management of critical items and other materiel of special interest to the JFS.

(b) Coordinating CL VIII support from the national-level, to include cross-docking materiel from strategic sources of supply.

(c) Monitoring the status of critical items, such as PMI and blood/blood products, and other items determined by the JTFS.

(d) Assessing CL VIII readiness and advising the JFS.

(e) Planning and synchronizing medical maintenance support, including contracted maintenance services.

(f) Planning and coordinating medical assemblage production, optical fabrication, medical gas production, and similar in-theater support.

(g) Coordinating support from foreign sources of supply and support provided to multinational partners.

(h) Planning and coordinating redeployment to include reconstitution and reutilization of assets in theater and use of material for HA or CA projects in conjunction with NGOs or HN governments.

(5) The SIMLM mission and capability will evolve in relation to the phases of a supported operation and needs of the deploying forces. Initially, SIMLM will coordinate the flow of logistic information/flow of CL VIII materiel from CONUS sources of supply and the CONUS based CL VIII national inventory control point and Service item control centers. It will also coordinate the distribution/transportation of CL VIII (A & B) materiel to US forces deployed to the operational area. As the operation continues and the theater matures, SIMLM will also maintain visibility of materiel critical to the treatment and evacuation of patients. When

appropriately equipped, SIMLM will maintain total asset visibility/ ITV of all theater CL VIII assets.

e. **DLA is the DOD EA for Medical Materiel** pursuant to DODD 5101.9. The EA supports the CCDR within the following broad operational framework:

(1) The Services organize and equip fully capable HSS forces and may be tasked to deploy Service unique HSLS forces to accomplish HSS and FHP operations in support of the CCDR.

(2) DLA provides national contracts with medical prime vendors and other commercial partners that provide access to commercially-held materiel, and use of the Defense Working Capital Fund to meet immediate inventory requirements and achieve materiel readiness in support of HSS and FHP operations.

(3) Designated lead agents provide the operational capability to execute EA strategic programs and end-to-end supply chain management in support of the CCDR. There are two types of LA:

(a) Functional LAs, such as the Medical Logistics Proponent Council and the DMSB, develop functional requirements to support best business processes and promote materiel standardization, respectively.

(b) Theater LAs are organizations designated or established to provide medical materiel distribution, customer support, and assistance the CCDR in requirements and supply chain planning in support of FHP operations.

(4) The CCDR in coordination with the DOD EA, establishes the overall medical supply chain strategy as part of the HSLS plan for Annex Q. This strategy includes the theater policy for medical requisition and materiel flow, establishment of major Class VIII distribution nodes, and assignment (as required) of a SIMLM mission and/or designation of organization(s) to serve as TLAMM. The supply chain strategy may incorporate discrete medical logistics capabilities provided by one or more Services, or the joint augmentation of medical logistics organizations to achieve required capabilities.

f. A **TLAMM** is an organization or unit designated to serve as a major theater medical distribution node and provide the face to the customer for medical logistics and supply chain management. It provides a support operations structure that has habitual relationships with medical customers, supporting medical logistics organizations, transportation and distribution managers, and the supported JFS. A TLAMM may be an existing organization that provides routine medical materiel support to theater HSS operations, or an organization that is created as required for a specific OPLAN by deployment of the necessary HSLS capabilities. It is normally operated by a Service component command as an integral part of the integrated HSS system. A TLAMM may be a military organization or unit or, under some circumstances, a contractor

operated activity. The TLAMM supports all Service components and designated multinational and/or nongovernmental customers.

(1) The TLAMM serves as the single POC between supported customers and numerous national-level industry partners. It stores and manages the distribution of medical materiel through close coordination with theater transportation and movement management activities that support the CCDR's logistics plan. It provides the intensive management required for the medical commodity.

(2) The TLAMM is normally responsible for the provision of all core medical logistics functions required to support HSS and FHP operations. These include medical supply, medical equipment maintenance, optical fabrication, assembly and fielding of medical assemblages, and management of vaccines, investigational drugs, special equipment and any other materiel subject to special interest or control by the JFS.

g. **Service medical logistics agencies** are responsible for managing medical logistics programs that support the projection and sustainment of their respective Services' operational forces. These agencies include the US Army Medical Materiel Agency, the Naval Medical Logistics Command, the Air Force Medical Support Agency, and Marine Forces Systems Command. While each of these agencies have Service-specific responsibilities and chains of command, they perform similar functions that support theater HSS operations. These include:

- (1) Forecasting and programming of Service medical materiel requirements.
- (2) Acquisition and life cycle management of medical equipment.
- (3) Managing the production and maintenance of medical assemblages.
- (4) Capturing and managing medical logistics information relative to medical assemblages and equipment.
- (5) Medical materiel fielding programs.
- (6) Management of pre-positioned unit sets and sustainment materiel.

h. A **jointly staffed medical logistics management center (MLMC)** may be employed to support execution of the HSLS plan. A MLMC is an operational HSLS unit normally assigned or attached to the senior HSS command responsible for theater HSLS support, and provides direction and oversight of theater HSLS operations. This may include management of Class VIII inventory held by operational HSLS units, monitoring of critical medical items and systems, and assessment of medical supply chain performance. The MLMC maintains close coordination with all theater HSLS units, the TLAMM, the JFS and other Service components as well as with its strategic base to facilitate effective support from national-level capabilities.

(1) An Army MLMC is an Army operational HSLS designed to provide theater-level HSLS management. It normally operates in a split-based mode, with a strategic base in CONUS and forward teams assigned or attached to a theater HSS command. At the direction of the CCDR, the MLMC forward team may be augmented with personnel from other Services to ensure joint synchronization and execution of theater HSLS support. When augmented, the MLMC forward team becomes a jointly staffed MLMC.

(2) The employment of a MLMC will be tailored to the mission. It may be incorporated into an operational HSLS unit that is designated to serve as TLAMM for a specific operation, or it may be employed separately as a subordinate organization of a HSS command.

(3) The MLMC forward team normally provides a liaison cell to the DDOC or other distribution management organization established by the CCDR to manage theater distribution. This cell remains under the control of the HSS commander, but works closely with theater distribution and movement managers to coordinate medical requirements and promote efficient and effective use of distribution resources.

(4) The MLMC provides technical direction to all operational HSLS units that comprise the theater HSLS system, to include those that fall under the operational control of subordinate HSS HQ. This is to ensure synchronization and visibility of HSLS activities throughout the theater and to ensure that supply chain management is not fragmented by HSLS unit boundaries. Its scope includes all aspects of theater materiel and medical maintenance support as well as other HSLS functions such as optical fabrication, equipment reconstitution, materiel fielding, assemblage management, and provision of medical gasses, and local contracting support for medical materiel and services. It may also plan and coordinate support from local, foreign sources of supply (when required), as well as HSLS provided to, or received from, multinational partners.

(5) The HSLS planner should address the need for early deployment of a MLMC forward team into the theater to assist the HSS commander and JFS in establishing, managing, and assessing HSLS operations in support of arriving forces.

i. DLA Commands and Agencies

(1) **The Defense Supply Center, Philadelphia (DSCP)** manages and executes national-level medical materiel acquisition and distribution programs that provide access to materiel held in commercial inventories at the supplier end of the medical supply chain. These programs include medical prime vendor, web-based ordering, and multiple forms of contingency programs with manufacturers and distributors to assure access to sufficient materiel to meet forecasted theater requirements. The DSCP also establishes national maintenance contracts for major medical equipment systems, particularly diagnostic imaging, that may be accessed by theater HSLS managers. DSCP has been delegated EA 'Execution Authority' by HQ DLA for implementation of DOD EA for Medical Materiel, serving as the DLA lead in synchronizing supply chain activities with the Services, other DLA commands, and designated LAs.

(2) **Defense distribution centers (DDCs)** provide storage and distribution of medical materiel that is held in DOD national-level inventory, as well as receipt, consolidation, and onward shipment of materiel received from commercial sources for delivery to theater HSS customers. DDCs at Mechanicsburg, PA and Hill Air Base, UT also provide “kitting” and assembly operations for the production of medical assemblages and configured supply packages in support of Service medical logistics agencies.

(3) **Defense Logistics Information Service (DLIS)** manages DOD medical logistics data, providing data products used to update medical logistics catalogs and disseminate medical logistics catalog information to DOD users. The Universal Data Repository is the primary DLIS information product used by HSLS activities.

j. **Designated functional LAs** support the development of medical logistics business processes, functional requirements, and materiel standardization necessary to promote effective and efficient supply chain support to the CCDR.

(1) **The Medical Logistics Proponent Subcommittee (MLPS)** coordinates and directs DOD medical logistics functional program management in support of business process improvement and the Defense Medical Logistics Standard Support (DMLSS) program. The MLPS provides joint oversight of functional requirements and capabilities developed for the DMLSS AIS.

(2) **The DMSB** facilitates inter-Service cooperation for the standardization of medical materiel and clinical processes in support of expeditionary and deployed medical operations. Among the DMSB products is the Joint Deployment Formulary, which is a key resource to the JFS for development of the theater formulary and planning for pharmaceutical sustainment requirements.

k. **The resourcing of medical materiel requirements** is a key factor in execution of HSLS plans, particularly with regard to the acquisition of medical materiel necessary to initially deploy HSS units, to preposition medical materiel in theater for HSS sustainment, and to conduct theater supply operations within a working capital fund. DSCP, in coordination with the Services, provides several contingency programs with distributors and manufacturers that allow the purchase of materiel for deployment and sustainment to be deferred until needed; thereby tremendously reducing the DOD’s direct investment in inventory and infrastructure. However, when this materiel is needed, resources are required to purchase materiel from commercial partners for delivery to deploying units or for pre-positioning in theater in anticipation of sustainment requirements.

(1) **Service Responsibilities.** The Services are responsible for the complete equipping and provisioning of operational forces provided to the combatant commands. This includes the funding of contingency programs that are specifically intended to provide initial operating capability for deploying units, as well as the direct purchase of materiel and equipment required by deploying forces. The inability to provide Service funding in time to fully provision deploying units has historically contributed to units arriving in theater with immediate demands for large

quantities of medical materiel, placing a burden on theater HSLS units as well as strategic and theater distribution assets.

(2) **DOD EA Responsibilities.** The DLA, as the DOD EA for Medical Materiel, is responsible for programming and providing necessary resources to support Class VIII sustainment and to secure contingency materiel at commercial sources or preposition materiel in strategic locations to support CCDR requirements. Medical materiel managed by the TLAMM will be financed and owned by the EA. The EA requirement to preposition medical materiel in theater is determined by the CCDR in coordination with the EA and supported Service component, and made a part of the negotiated PBA between the EA and the CCDR. PBAs will be established between the DLA and each CCDR, formalizing performance standards, metrics, and operational roles and responsibilities for medical supply chain support to the CCDR and HSS operations.

3. Theater-Level HSLS

a. **Theater-level HSLS** refers to the functions that manage, coordinate, and synchronize the execution of the HSLS plan in support of theater HSS operations. Theater-level HSLS typically includes support to all Service components and designated MNFs. HSLS functions are usually provided by operational HSLS units (including the MLMC) that are tailored and scaled to the mission and phase of the operation and operate in close coordination with a designated TLAMM and DDOC. Theater-level HSLS operations are usually under the control of the operational HSS HQ assigned responsibility for theater HSLS support and under the oversight of the JFS. These operations include intermediate-level medical supply operations that provide theater storage and distribution of medical materiel. Primary HSLS functions accomplished at the theater level that must be addressed in the HSS plan include:

- (1) Execution of theater preparatory tasks for HSLS.
- (2) Port operations and reception, staging, onward movement, and integration (RSOI).
- (3) Area support to forward units.
- (4) Support to theater hospitals.
- (5) Support to the maneuver force.
- (6) Support to redeployment and/or retrograde operations.

b. **Execution of Theater Preparatory Tasks for HSLS.** Typically the CCDR will develop a list of preparatory tasks that must be accomplished in preparation for anticipated operations. This list may include the pre-positioning of medical materiel and the establishment of theater HSLS capabilities necessary to support RSOI and initial entry HSS operations. Pre-positioned materiel may include stocks for initial sustainment, HSS operations during RSOI, and special medical materiel such as MBCDM, special vaccines, and other medical materiel under control of the JFS.

c. **Port Operations and RSOI.** HSS must be capable of operations immediately upon arrival of initial entry of forces (even with permissive entry); therefore, HSLS must be included in planning for port opening and early entry operations. In almost every operation, lessons learned reflect that theater HSLS units must also provide Class VIII materiel for unit shortages that were not filled prior to unit embarkation. Planning for HSLS operations during early entry/RSOI should address:

(1) Class VIII supply support to primary medical care (sick call) and area medical support in order to minimize the use of materiel from arriving units' organic medical sets.

(2) The issue of medical unit sets from pre-positioned stocks or WRM.

(3) Coordination for movement of medical materiel, to include medical unit sets, from the sea or aerial port to staging or operational areas.

(4) The reception and issue of potency dated, refrigerated, and controlled substances, including "push packages" of unit configured materiel and "just-in-time" modernization items.

(5) Storage and security of medical materiel requiring special handling, such as controlled substances, refrigerated materiel, and other items of special interest to the JFS.

(6) Priority for the filling of significant unplanned MESs or sustainment shortages.

d. **Area Support to First Responders and FRC Capabilities.** First responders and FRC capabilities usually operate throughout the theater area. These include separate medical teams, detachment and company-sized units as well as medical elements organic to operational forces operating in the theater area. HSLS support to these units is generally provided on an area basis by theater HSLS units.

e. **Support to Theater Hospitals.** Theater Hospitals present the most complex medical materiel requirements, and may consume materiel at a tremendous rate when providing trauma care in support of combat operations. Specialty care such as burn, orthopedic and neurosurgery often requires materiel and equipment that is not standard and may not have been anticipated or stocked prior to deployment. Whenever possible, theater hospitals should be located at or near APODs to facilitate PM as well as resupply, and be made direct customers of the most capable HSLS organization at the theater or the strategic level.

f. **Direct Support to the Maneuver Force.** HSLS elements organic to maneuver forces are reliant upon supply chain capabilities that are provided by HSLS organizations at the theater level. These capabilities include materiel management provided by the MLMC and TLAMM (if designated) and physical storage and distribution of theater CL VIII stocks maintained by operational HSLS units. To the extent feasible, Class VIII support to maneuver forces is provided from the highest level HSLS organization capable of meeting customer wait time (CWT) requirements using throughput distribution as far forward as possible in order to minimize the logistics burden and footprint in the theater, especially at the maneuver level.

g. **Support to Redeployment/Retrograde Operations.** The redeployment of forces presents HSLs requirements for command policy as well as HSLs operations. During prolonged operations with force rotations, redeployment/retrograde operations may occur simultaneously with RSOI during later phases of an operation.

(1) The JFS will assist the CCDR in establishing policy and procedures for redeployment processing, to include:

(a) Administration of the post deployment health survey and health counseling for redeploying personnel, to include information on the need for terminal prophylaxis and collection of unused personal medications issued in theater.

(b) Collection and appropriate disposition of medical materiel issued to individuals, to include MBCDM and drugs issues for medical countermeasures.

(c) Collection and appropriate disposition of medical materiel from units, to include materiel deemed unserviceable, excess to unit needs, or otherwise unsuitable for return to home stations.

(d) Collection and redistribution, as appropriate, for medical equipment purchased with theater funds.

(2) Theater-level HSLs units/organizations will support HSS units and elements of maneuver units for:

(a) The turn-in of pre-positioned materiel that will remain in theater to be reconstituted and returned to pre-positioned storage.

(b) The technical inspection, refurbishing and reconstitution of medical equipment and assemblages that will remain in theater as pre-positioned stocks or transferred to arriving forces.

(c) The transfer of medical materiel and/or equipment to be redistributed to arriving forces (includes “equipment-in-place” as well as retaining equipment purchased with theater funds).

h. **Time Phasing of HSLs.** The HSLs requirements and capabilities in the theater will usually change over the course of an operation, from the preparatory and early entry phases through redeployment of forces. The HSLs plan should permit flexibility to scale capabilities up or down as appropriate to adapt to HSS requirements during every phase of an operation. The flexibility to scale HSLs will be enhanced by establishing an overarching concept for theater medical supply chain management and placing theater-level HSLs capabilities under the control of a senior medical commander charged with execution of the HSLs plan. Flexibility may also be achieved by integrating support from all sources to include reachback into the HSLs plan.

(1) HSS must be available to support initial entry forces (even with permissive entry); therefore, HSLS must be planned for port opening and early entry operations. During the early phase, CL VIII sustainment may rely upon preconfigured packages shipped from the national level or pre-positioned theater stocks. Preconfigured “push packages” of CL VIII historically produce a great deal of wasted materiel, therefore, sustainment should transition as quickly as possible to line item requisitions. HSLS capabilities will build in the theater with the arrival of forces sufficient to ensure effective support of HSS operations.

(2) As communications and movement capabilities mature, theater HSLS should be able to leverage more reliable distribution capabilities to satisfy most customer orders from theater or even from strategic-level stocks. The HSLS footprint should be driven by CWT; that is, HSLS capabilities should be positioned in the supply chain to be able to deliver the support required within a time-definite standard set in the HSLS plan and theater PBAs.

(3) Maturing theater communications and distribution channels may allow the HSLS footprint to be reduced to achieve greater efficiency. To the extent possible, customer orders should be filled from the highest level of HSLS that meets customer requirements. Some functions may also be able to transition from military to contract or civilian capabilities, while remaining under the oversight of the HSS system. Plans to ‘right-size’ the theater HSLS footprint will be developed by the HSS commander charged with executing the HSLS plan with the oversight of the JFS.

(4) During retrograde operations, HSLS capabilities may have to be increased to effectively manage additional work associated with recovery, inspection, refurbishment and/or packing for shipment or return to WRM storage.

4. Distribution of Medical Materiel

a. **DLA and USTRANSCOM** share responsibility for orchestrating effective supply chain support to the CCDR and collaborating in the development of strategic distribution processes and movement programs.

b. **Medical supply chain management** is characterized by substantial integration with the health care sector of the national industrial base and by the intensive management of medical requirements and supply chain activities by HSLS managers within the theater HSS system. The HSS system does not own or manage the transportation resources used to distribute medical materiel, which typically flows through the same distribution channels and is subject to the same movement controls as all other classes of supply. HSLS managers must work closely with the movement control elements at all levels to make the most effective use of transportation resources to meet HSS requirements.

c. **National-level distribution of medical materiel** is primarily accomplished by commercial partners, including medical prime vendors, manufacturers, and other third-part medical distributors delivering materiel directly to the requesting customer. Medical prime vendors typically deliver materiel from regional distribution centers to each requesting medical facility using owned or leased transportation

assets. The local purchase of materiel that is not available through DSCP prime vendor or web-based ordering systems is managed by the individual medical facility, with materiel typically delivered to the forward operating base destination.

d. **Strategic distribution to overseas theaters** is primarily accomplished through commercial tenders arranged by DLA in coordination with USTRANSCOM. These commercial carriers pick up materiel daily from the prime vendor distribution facility for delivery to the designated TLAMM supporting the theater. Materiel shipped from other commercial partners is delivered to designated military or commercial distribution centers for onward transportation to the supported theater by either military or commercial carrier. In either case, the TLAMM receives and either stores or reconfigures materiel for further shipment to the customer through intratheater channels.

e. **Intratheater distribution** is reliant upon transportation capabilities provided by military ground and/or tactical aircraft or contracted commercial carriers under the control of the DDOC and movement management elements within the theater. HSLS units do not provide transportation of materiel. Priorities for movement of CL VIII material is established along with all other commodities by the CCCR and supported maneuver commanders. The TLAMM and other theater HSLS units coordinate the movement of CL VIII shipments with the DDOC. HSLS managers must recognize that, historically, CL VIII has had a lower priority for movement than other commodities; therefore, supply chain activity and the medical materiel status of HSS units must be closely monitored so that movement managers can make informed decisions on the optimum use of transportation resources, and the JFS can assess the impact of supply chain capabilities upon HSS operations.

f. **Special considerations** for storage and distribution of medical materiel. These requirements will pose special challenges during early operations when HSLS units and storage capabilities are limited and distribution channels are immature:

(1) **Temperature Sensitivity.** Most pharmaceuticals and many medical-surgical items are sensitive to temperature extremes (most require storage between 5-30° Centigrade (C)/41-86° Fahrenheit). Most laboratory reagents and vaccines as well as all whole blood and blood products require refrigeration or packaging that maintains temperature with a specified range. This poses a challenge for storage at operational HSLS units as well as distribution nodes in regions where the ambient temperatures may destroy the effectiveness of unprotected medical materiel. Technologies that monitor the temperature that medical materiel are exposed to during transit also require special quality control procedures by HSLS personnel to interpret, report, and act upon the information provided.

(2) **Storage and Shipping.** Most operational HSLS units have very limited environmentally controlled storage. Shipping materiel that needs thermal management will require insulated containers as well as sources of wet and/or dry ice. Planning for HSLS operations, especially in extreme climates, must address these needs for environmental protection of materiel in storage and in transit. Planning considerations include:

(a) Buildings of opportunity, especially for the pre-positioning of inventory for theater sustainment.

(b) The local leasing of commercial refrigeration trailers or warehouse units (with the necessary power for their operation).

(c) Tents, military vans, or similar temporary structures. However, planning should include the provision of air conditioners or environmental control units along with the additional power generators or hookups to local power grids.

(d) The availability of HSLS personnel appropriately trained in packing procedures for wet and dry ice shipments (improper packing has destroyed many medical shipments).

(e) The training of HSLS personnel in the quality control procedures used for shipments monitored with temperature sensing technology.

(3) **Controlled Substances.** Narcotics and other controlled substances are subject to specific physical security, inventory management, and issue control procedures established by federal statute and/or as Service regulations. HSLS planning must include the provision of appropriately secure storage, the availability of appropriately trained HSLS personnel to serve as controlled substances custodian, and theater policies for the issue of controlled substances, to include issues to individual first responders.

(4) **Distribution Expeditors.** Medical materiel frequently becomes frustrated or backlogged at intermediate distribution nodes. HSLS planning should consider the placement of small teams of medical logistics specialists at critical or problematic nodes to assist transportation personnel in identifying medical materiel and resolving issues that prevent its onward movement. They would also ensure that action is taken to prevent its deterioration due to lack of refrigeration or environmental protection, and assist distribution managers in locating and expediting materiel that must be managed by exception.

(5) **Low Volume Shipments.** CL VIII sustainment shipments for most HSS customers typically are relatively low weight/cube. This poses a challenge because aerial ports try to make maximum use of aircraft capacity, leading to CL VIII materiel being held until there is sufficient volume to justify an aircraft. This increases CWT and increases the risk that medical materiel will be lost or will deteriorate while being held pending movement. HSLS planning should work closely with the DDOC and aerial port managers, especially for remote/dispersed customers, and establish CWT standards. Consideration should also be given to commercial tenders with carriers that will deliver materiel within established standards.

(6) **Commercial Tenders.** The use of commercial carriers, both air and ground, may provide an effective means of meeting the distribution requirements for some customers or types of shipments, such as refrigerated or high priority items being managed by exception. However, commercial carriers also may pose additional challenges related to customs processing and cost. HSLS planning must work closely with the DDOC to ensure awareness of customer requirements and to develop distribution strategies that meet HSS requirements of units that are not well served by routine movement plans.

(7) **Customs Clearance.** Cargo and personnel arriving in theater by commercial transportation are usually subject to processing through local customs. Customs processing can delay the availability of materiel and also be subject to additional fees, depending upon agreements between the host government and US forces. Theater HSLS planning should address customs procedures for each country within the operational area and include guidance in the medical annex to the applicable OPLAN.

(8) **Hazardous Materiel.** HSLS planning must address the storage and movement of hazardous substances, such as compressed gasses (including oxygen), certain disinfectants, radiographic chemicals, alcohols and other laboratory products. Planning must include the provision of materiel safety data sheets and protective clothing/equipment for HSLS personnel as well as appropriate storage facilities and containers/placards for shipment. HSLS unit training must include the certification of personnel to sign movement documentation for hazardous cargo. HSLS planners and commanders at all levels must understand that safety and regulatory requirements are not waived for most military operations, especially at the theater level, and violations can be a source of friction with a HN as well as unnecessary risk to US personnel.

5. Information Management

a. **The theater medical information program (TMIP)** provides the suite of DOD standard applications that support theater HSS operations. These including medical C2, health care delivery, patient tracking, and medical logistics and blood management. TMIP applications are fielded and maintained by each Service.

b. **The DMLSS program** provides the DOD standard applications for medical logistics in both institutional and operational environments, integrating national and operational-level business processes, medical information management, and medical information technology. The MLPS, under the direction of ASD(HA), is the functional proponent for the DMLSS Program to promote business process innovations that increase the efficiency and effectiveness of medical logistics support of HSS across the full range of military operations. The DMLSS applications that support HSLS are found at all echelons of theater HSS and enable end-to-end management of HSLS processes. These include:

(1) **DMLSS release 3.0** provides medical supply, medical equipment management and maintenance, assembly management, facility management, and customer support functions for theater HSS units.

(2) **DMLSS Customer Assistance Module (DCAM).** DCAM provides a simple, laptop-based tool for customer order management for tactical HSS units. DCAM provides tactical customers with a ‘store and forward’ capability when communications are not available.

(3) **Theater Enterprise Wide Logistics System (TEWLS).** TEWLS is the DMLSS solution for theater-level CL VIII supply chain management. TEWLS integrates CL VIII storage and

distribution operations in all theater HSLS units under the management of the MLMC, and provides linkage with national-level commercial sources.

(4) **Joint Medical Asset Repository (JMAR).** JMAR is a web-based data repository that provides worldwide asset visibility for medical materiel.

c. **Communications.** HSLS is highly dependent upon reliable and timely data and voice communications to exchange information among customers, HSLS units, commercial suppliers, and transportations systems. Theater HSLS operates primarily a non-secure environment; however, some customers (such as Special Forces) and processes (such as joint movement requests) require access to secure communications. A lack of communications connectivity has been frequently cited in past ‘lessons learned’ as a major factor when supply chain performance has not met customer requirements. HSLS planning must address the need for reliable data connectivity for HSLS customers and organizations, especially during the earliest stages of theater operations before theater communications capabilities are fully mature. HSLS planners must coordinate closely with their J-6 and understand the communications plan for the operation. HSLS issues that should be considered include:

(1) HSS customers’ ability to communicate requirements and receive status.

(2) HSLS units’ ability to communicate with customers as well as supporting theater and national-level organizations.

(3) HSLS units’ ability to share requirements and movements information with distribution management organizations, and provide situational awareness to logistics and/or C2 systems.

(4) Information security, to include negotiation of firewalls.

(5) The requirement and/or use of nonstandard communications capabilities, such as satellite communications for HSS/HSLS.

(6) Training, fielding and in-theater support for hardware and applications.

6. Medical War Reserve Materiel

a. **WRM Requirements.** The DOD programs and maintains WRM in order to achieve flexibility and reduce reaction time for sustainment of forces for operations across a spectrum of regional contingencies. CCDRs determine operational requirements based upon planning scenarios approved in the Defense Planning Guidance. The Services, in coordination with DLA, compute war reserve requirements necessary to meet DOD approved operational requirements. WRM requirements are programmed and met through five basic strategies:

(1) Pre-positioned unit sets are Service-managed packages of unit allowances of materiel and equipment that are strategically pre-positioned in order to be rapidly available for operational requirements.

(2) Standing stocks are WRM stocks pre-positioned in or near a theater of operations to last until resupply at wartime rates is established.

(3) Swing stocks are WRM stocks positioned ashore or afloat for meeting requirements of more than one contingency and/or more than one theater of operations.

(4) Industrial-based contingency programs leverage commercial capacity to meet computed requirements with minimum direct DOD investment.

(5) Inventory-based contingency programs provide national stocks of selected medical items. DLA also manages a strategic program to maintain an industrial base capability for the production of military-unique medical products for chemical defense.

b. **Service WRM Programs.** Each Service computes, programs, funds, and manages Service-specific programs to meet planned operational requirements for medical materiel. Service programming includes pre-positioned unit sets and WRM stocks to provide initial operating capability for their operational forces.

(1) **Army.** The Army pre-positioned stock (APS) program is comprised of 3 major components: pre-positioned brigade and unit sets; pre-positioned operational project stock; and pre-positioned sustainment stock. APS is stored at strategic land based locations and aboard pre-positioned ships. Packages of potency-dated supplies are also provided through vendor managed inventory (VMI) programs to provide full unit operational capability and initial sustainment upon activation.

(2) **Navy.** The Fleet Hospital Program provides pre-positioned unit sets stored at strategic locations, and provides packages of potency-dated supplies through VMI programs to provide full operational capability and initial sustainment upon activation.

(3) **Air Force.** Starter and resupply stocks are maintained at OCONUS medical treatment facilities and other strategic locations. VMI programs for selected materiel provide full operational capability upon activation. Deployed Air Force medical units use Expeditionary Medical Logistics, a 'reachback' system of support, for sustainment of early-deployed USAF platforms until the TLAMM becomes fully operational.

(4) **Marines.** USMC units are supported by the maritime pre-positioning ships squadrons.

c. **Commercially-based Contingency Programs.** To the extent possible, DLA manages commercially based contingency programs with numerous manufacturers and distributors to meet medical WRM requirements. DLA commercial contingency programs include prime vendor

“surge” capabilities, stock rotation contracts, corporate exigency contracts, and VMI. These programs are especially useful in reducing the need to maintain potency-dated materiel in WRM programs and providing flexibility to purchase materiel that more closely matches the operational need of a specific mission at the time it is needed. However, these programs also increase the need to carefully plan and time the purchase and distribution of contingency materiel from commercial sources in order to assure its delivery into the theater when and where it is needed.

d. **Implications for HSLS Planning.** The availability of medical materiel is critical to the success of the HSS mission. HSLS planners must understand the CCDR’s operational requirements and how WRM programs will be applied to meet those requirements. They also must understand the extent to which commercially-based contingency programs are being relied upon to provide initial operating capability and sustainment, and how that impacts upon the need for strategic lift to assure timely delivery. This requires close coordination with the TLAMM as well as with the DDOC and CCDR’s J-4 staff. Planning considerations must include:

- (1) Adequate pre-positioned unit sets and standing WRM stocks to meet operational requirements.
- (2) TPFDD plans to support the execution of the HSS plan.
- (3) TPFDD plans to provide sufficient HSLS capability to receive, store, and begin distribution operations in support of the HSS plan.
- (4) Adequate storage to receive swing stocks or other materiel from contingency programs, especially for refrigerated materiel and controlled substances.

7. Medical Equipment Maintenance Considerations

a. **Role of Biomedical Maintenance.** Biomedical equipment maintenance is a core function of HSLS and critical to HSS operations. Health care delivery at every level of the HSS system is highly reliant upon specialized equipment requiring service and repair that can only be provided by appropriately trained BMETs. Medical equipment technology is characterized by increasing technological sophistication, greater integration with information technology, and rising sensitivity to the balanced delivery of electrical power. Efforts by the Services to standardize both equipment and BMET training have increased HSS capabilities for joint interoperability and support and provided technicians that are exceptionally versatile in supporting the technology demands of HSS. In addition to the maintenance and repair of medical equipment, these demands include the set up and distribution of power, the networking of equipment with information systems, the production of medical gasses, and the fielding and training of clinical personnel in new equipment technology.

b. **Biomedical Maintenance Capabilities.** The effective treatment of injured patients cannot tolerate interruption in the availability of essential medical equipment. The cost, complexity and multiplicity of medical equipment items as well as the dispersion of HSS units in the theater make simple exchange of unserviceable equipment an unrealistic basis for maintaining equipment operational availability. HSLS

planners must understand the organic BMET capabilities of HSS units and ensure that biomedical equipment maintenance capabilities at the theater level are appropriately scaled to adequately support the HSS plan and CONOPS.

(1) At forward locations, BMET capabilities are limited to first response diagnosis, component exchange, and relatively simple repair.

(2) Theater hospitalization capabilities normally have a biomedical maintenance shop capable of providing unit-level maintenance and repair of organic equipment. Limitations may exist with highly specialized systems used in laboratory and diagnostic imaging services.

(3) Theater HSLs capabilities are provided by the TLAMM and/or operational HSLs units employed as part of the theater HSS system. These organizations have personnel and expertise to provide support HSS units on a direct support or area basis, to maintain theater equipment assets for equipment exchange, to calibrate highly sophisticated equipment such as anesthesia machines and imaging systems, and to manage critical repair parts needed to maintain equipment used in the theater. Theater biomedical maintenance functions include both shop operations and the provision of contact teams to support forward units, and manage/coordinate contractor support provided by theater or national-level contracting activities.

(4) National-level biomedical maintenance capabilities are provided by the Services' medical logistics agencies and by DSCP, all of which have a close, habitual working relationship. National capabilities include equipment acquisition and integrated logistics support, Service-level maintenance operations (that also support new equipment acquisition and fielding), coordination with original equipment manufacturers (OEMs) and third party maintenance vendors, and provision of national contracts and/or one-time contracts for maintenance and repair services. The medical logistics agencies also are able to project biomedical equipment maintenance assistance teams into the theater at the request of the CDR.

c. **Biomedical Equipment Maintenance, SIMLM, and TLAMM.** Under SIMLM, the CDR may direct one Service to provide theater biomedical equipment support to all supported Service components, and direct other Services to provide BMET augmentation necessary to accomplish this mission if required. This provides the HSS commander with a single support organization for all theater medical logistics as well as a single POC for national-level support agencies. While biomedical equipment maintenance is not a responsibility of DLA, the theater-level HSLs organizations that may be designated as TLAMM normally provides all core HSLs functions, to include biomedical equipment maintenance. Therefore, organizations designated as TLAMM will normally provide theater-level biomedical equipment maintenance as well as medical supply chain management and other HSLs functions directed by the CDR.

d. **Other Considerations for Biomedical Equipment Maintenance.** The concept of support for theater biomedical equipment maintenance should be scaled to meet HSS requirements with the smallest possible theater footprint. SIMLM may be employed to reduce theater redundancy and more efficiently synchronize the use of HSLs resources, including medical maintenance. Theater and national-level capabilities may be employed when possible to provide

necessary services when and where needed, particularly as the theater matures, distribution channels become stable, and force protection allows greater use of contract or other national-level support.

(1) When supporting a SIMLM mission, the TLAMM would provide all HSS components with on-site contact team support for equipment calibration and repairs as well as medical equipment for maintenance exchange, critical repair parts stockage, and coordinating contract support when required.

(2) Many US medical equipment manufacturers have foreign distributors and service engineers to support those distributors. Equipment manufacturers' web sites usually list their worldwide service networks. When available, theater contracting activities may be able to negotiate as-required service agreements with local or regional distributors.

(3) DSCP provides national contracts with the OEMs and 3rd party vendors for the repair of major medical end items, especially for diagnostic imaging modalities. Equipment or components can be returned to contractor facilities, or in some cases the contractor may provide a service technician to a site in theater. When a technician is provided, the theater must provide travel clearance and ensure that CCCR requirements for predeployment processing and individual protection are met.

8. Threat of Chemical, Biological, Radiological, or Nuclear Weapons

a. **HSLS Considerations.** The threat of CBRN weapons against US forces constitutes a tremendous HSS planning challenge. Planned medical countermeasures range from the routine management of medical materiel used for individual protection to planning responses for events that may produce catastrophic numbers of casualties. The level of investment in materiel and other countermeasures for anticipated CBRN CM will depend upon the CCCR's assessment of the threat and directives for planning and materiel readiness. HSLS considerations may include:

- (1) Management of MBCDM.
- (2) CM sets.
- (3) Disruption of distribution channels.
- (4) Threats to HSS units.
- (5) Reconstitution of HSLS capabilities.
- (6) Partnership with other Federal agencies.

b. **Medical Biological, Chemical Defense Materiel.** The HSLS plan may have to provide theater storage for individual MBCDM and provisions for its rapid distribution. These include military-unique auto-injectors for chemical agent antidotes and pre-positioned stocks of antibiotics for various possible biological agents. CCCR guidance will specify the conditions for its issue, particularly the issue of pyridostigmine bromide tablets and controlled substances (diazepam auto-injectors).

Provisions may also have to be made for the issue of MBCDM to contractors, embedded reporters, and other non-DOD personnel.

c. **CM Sets.** The HSS plan may require theater storage and plans for distribution of preconfigured packages of medical materiel developed for CBRN response. Information on the composition of CM sets and their availability should be coordinated through the TLAMM and the Service medical logistics agencies.

d. **Disruption of Distribution Channels.** Threat employment of CBRN may make targeted distribution nodes unusable and destroy medical materiel in storage or in-transit. HSLs managers must work closely with the DDOC and other movement control activities in adjusting the flow of medical materiel, and be prepared to use asset and in-transit visibility tools to assess the impact on medical assets if distribution nodes are compromised.

e. **Threats to HSS Units.** Threat forces may introduce chemical or biological agents into water sources, foodstuffs or other supplies used by theater hospitals. HSS personnel must be prepared to protect themselves, patients, medical equipment and supplies throughout the operational area. This includes the physical security of units stocks of water, food and supplies, stockage or access to prepackaged (sealed) foodstuffs and bottled water, and close coordination with managers of other supply classes.

f. **Reconstitution of HSLs Capabilities.** Threat employment of CBRN may require the reconstitution of HSS capabilities. This could involve the release of medical equipment items being held by the TLAMM or other HSLs units, or the fielding of new equipment sets from WRM or national sources.

g. **Partnership with other Federal Agencies.** DLA, as the DOD EA, coordinates with Federal agencies that maintain strategic capabilities for CBRN CM. These include the Department of Veterans Affairs, the Department of Health and Human Services, and the CDC. Strategic assets include the National Strategic Stockpile, which is comprised of caches of medical materiel strategically pre-positioned in the US, as well as materiel maintained through VMI programs. The possible employment of these resources to meet urgent DOD requirements, or the employment of DOD personnel to assist non-DOD personnel in delivery/distribution in support of a national response to a CBRN event, is a new dimension to the range of military operations. HSLs planners would coordinate materiel management issues through the TLAMM, if the CCDR is directed by the President or SecDef to support or obtain support from non-DOD agencies

9. Other HSLs Planning Considerations

a. **Foreign Sources of Materiel.** The JFS and HSLs planner must be aware that there are DOD policy limitations that may constrain the use of non-FDA approved pharmaceuticals and medical devices. This issue must be addressed whenever the local purchase of medical materiel is considered. This may occur when urgent needs cannot be met in time by distribution from approved sources, or needed materiel is only available from foreign sources. An example of materiel

only available from foreign sources is antivenin for snakebites or stinging animals that only exist in those regions.

b. **Commercial Packaging and Marking.** Nearly all CL VIII supplies and equipment are commercial, nonstandard products obtained by Service HSLS organizations through DLA acquisition programs directly from commercial sources. These acquisition programs leverage commercial best business practices that impose few government-unique requirements on commercial partners in the fulfillment of DOD orders. Commercial suppliers use their own methods for product ID and packaging that, in many cases, do not meet all Defense Transportation System (DTS) requirements for the labeling of packages destined for DOD customers. When such packages are routed through DTS distribution hubs, they frequently become frustrated.

(1) HSLS managers should monitor distribution hubs for backlogs of frustrated CL VIII shipments and consider assigning a medical logistic liaison to critical hubs to serve as medical freight expeditors, if the situation warrants.

(2) HSLS planners should coordinate with the TLAMM to route shipments from commercial vendors in CONUS through designated commercial activities serving as a “medical air bridge”. These are prime vendors under contract with DLA to be consolidation points for medical shipments originating from other industry sources. These consolidated shipments are then moved with prime vendor shipments to the TLAMM for further handling and distribution in theater.

(3) Commercial suppliers are required to appropriately package and label shipments that have special handling requirements due to their fragility, need for temperature control, or hazardous properties. Improper marking may pose a risk to DOD transportation or logistics personnel, and/or lead to product deterioration in transit. HSLS managers who receive material not properly packaged or marked should submit discrepancy reports through theater channels for corrective action with the industry source.

c. **Captured Medical Materiel.** Captured medical materiel will not be used for treatment of US personnel without specific approval of the command surgeon. After clearance for safety and potential military medical intelligence exploitation, captured medical supplies and equipment may be used to treat EPWs and detainees, and to provide HA for indigenous populations. Medical materiel is protected by the Geneva Conventions from intentional destruction.

d. **Disposal of Medical Materiel.** The collection and disposal of excess and unserviceable medical materiel can be a major challenge, especially during the retrograde/redeployment portion of an operation. The HSS plan must include command policy for reporting, handling, and disposition of excess or unserviceable medial materiel, to include approved methods for its destruction.

(1) Serviceable medical materiel can be returned to stock or redistributed by the TLAMM or other theater HSLS units.

(2) Serviceable and unserviceable pharmaceuticals may be able to be returned through the TLAMM to commercial companies under contract with DSCP that in many cases return funds to DOD as credit.

(3) Serviceable excess materiel may be made available to HN or NGOs for HA if this consistent with CCDR policy and direction. This normally requires coordination by the HSLP and JFS with the command CA and SJA as with the DLA, which has responsibility for reutilization and disposal of DOD property.

(4) The local destruction of excess or unserviceable materiel must comply with HN laws and DOD policy. The HSLS planner should coordinate with the command ESO as well as supporting engineer and contracting officer.

e. **HSLS Support to Contractors.** HSS and HSLS planners must understand the CCDR's responsibility and policy for medical support to contract personnel operating in the operational area. This population frequently has health requirements that are not typically found in the military forces. Specific issues that directly affect HSLS support include the provision of prescription refills for chronic conditions and the provision of prescription eyewear. It may also include direct HSLS to medical services provided by contract companies for their personnel in theater.

APPENDIX D BLOOD MANAGEMENT

1. The Armed Services Blood Program

a. **General.** Established by the ASD(HA), the Armed Services Blood Program (ASBP) provides transfusion products when required to US forces worldwide. Tri-Service cooperative efforts between the Army, Navy, and Air Force enable blood and blood products to be collected, tested, processed, and shipped to military MTFs throughout the world. The planning and execution for the effective management of blood and blood products is a continuing, dynamic process requiring a coordinated, highly responsive system that extends from CONUS to the battlefield. The various aspects of this coordination are depicted in Figure D-1.

b. The Armed Services Blood Program Office

(1) The ASBPO is chartered by DOD to coordinate the provision of blood products throughout the Services to meet medical requirements during national emergencies and overseas military operations. The ASBPO coordinates implementation of the ASD(HA) policies and DOD procedures for the ASBP. The ASBPO is under the policy guidance of the ASD(HA).

(2) The ASBP shall adhere to ASD(HA) policies, and meet FDA regulations published in the Code of Federal Regulations and follow the procedures of the American Association of Blood Banks (AABB) as established in Army Technical Manual 8-227-3, Navy Medicine (NAVMED) P-5101, Air Force Manual (AFMAN) 41-119. CJCS reviews and provides guidance on all matters pertaining to blood support in joint operation planning and execution as well as activation of the ASBPO for contingencies and war. The ASBPO:

(a) Coordinates and monitors the blood programs of the US Army, Navy, and Air Force and that of each geographic combatant command.

(b) Coordinates standardization of policies through the ASD(HA) for the operation of the Services' blood programs to collect and manufacture blood and blood products.

(c) Coordinates the development and submission of specifications on the essential characteristics of required blood program equipment to the DMSB.

(d) Performs liaison with other federal, civilian, allied, and coalition agencies concerning blood-related matters.

(e) Directs the Services, upon mobilization or during periods of increased blood needs for contingency operations, to meet required quotas of blood or blood products to be shipped to designated Armed Services Whole Blood Processing Laboratories (ASWBPLs).

(f) Establishes shipment requirements for liquid and frozen blood products from ASWBPLs in support of the geographic combatant commands.

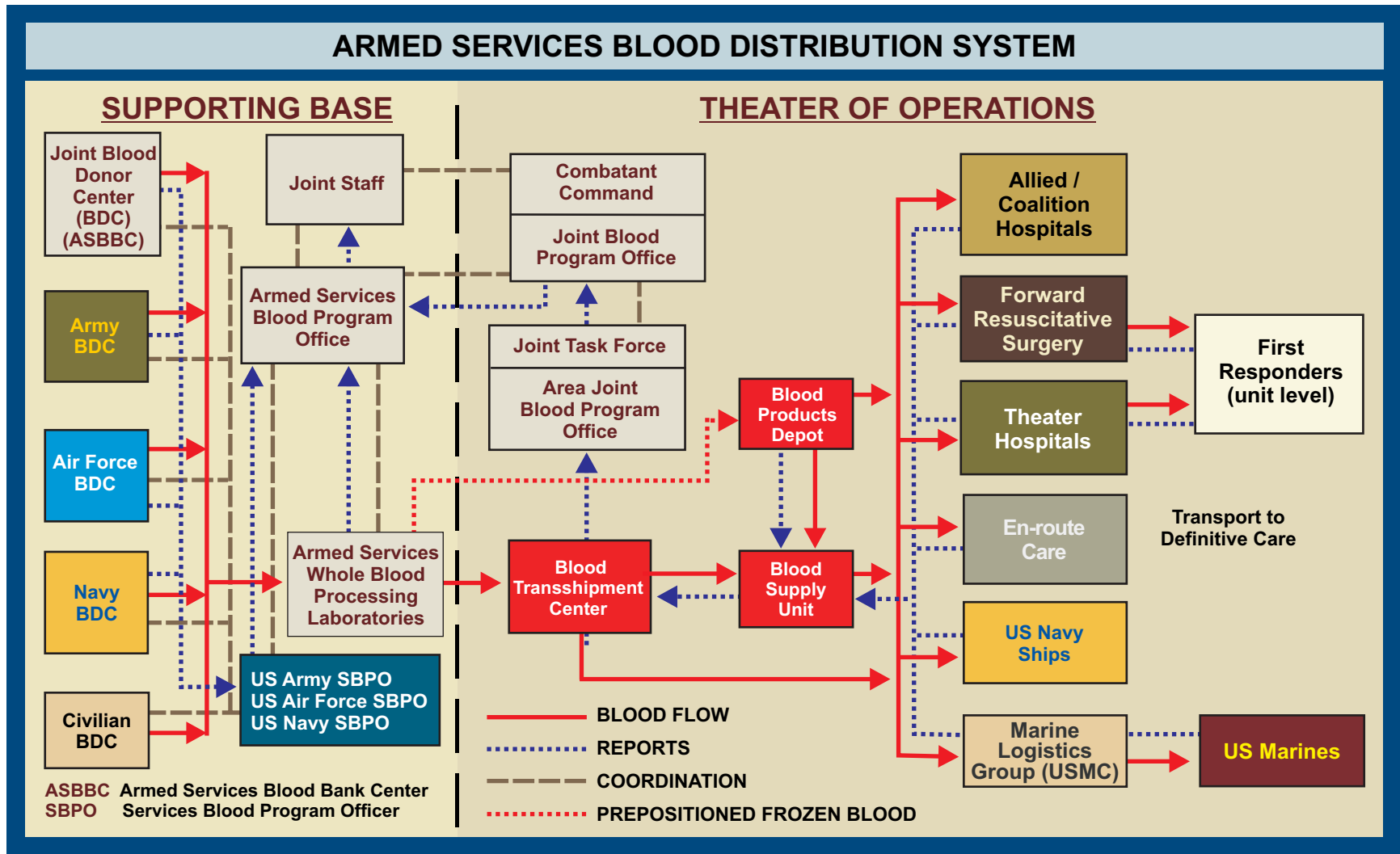


Figure D-1. Armed Services Blood Distribution System

c. **Service Blood Programs.** The Army, Navy, and Air Force maintain separate blood programs to meet normal peacetime requirements. To meet ASBP contingency requirements, the Services direct expansion of their BDCs to rapidly increase their blood collecting capabilities. Additional responsibilities of the Services with regard to the ASBP are described in DODD 6000.12, *Health Services Operations and Readiness*, and DODI 6480.4, *Armed Services Blood Program (ASBP) Operational Procedures*.

d. **Combatant Commands.** Each geographic combatant command's JBPO serves as the Class VIIIb manager. The JBPO coordinates blood products requirements of the theater's capabilities with the ASBPO.

(1) **Joint Blood Program Office.** The JBPO is under the staff supervision of the geographic combatant command surgeon. This office is responsible for the joint blood program management in the theater of operations. The organization of the JBPO depends on the overall command mission. Personnel are assigned from all Service components, as necessary, to meet the blood operational requirements. The JBPO:

(a) Advises the geographic combatant command surgeon on all matters pertaining to theater blood management activities. This shall include the development of the CONOPS for the blood program and the writing of the supporting OPLANs using command mobilization planning factors. Mobilization planning factors will include the establishment and coordination of an AJBPO, as necessary.

(b) Evaluates the AJBPO, BDC, BPD, BTC/TBTC, and BSU to ensure that personnel, equipment, and resource requirements are addressed in the geographic combatant command OPLANs, as well as compliance with policies, standards, and regulations of the ASBPO, the FDA, and the AABB. Evaluation of the BDC, BPD, BTC/TBTC, and BSU may be accomplished via an AJBPO.

(c) Provides managerial and technical oversight of all DOD military blood activities within the AOR, to include the coordination of Service component blood programs, blood product requirements, and capabilities within the theater of operations.

(d) Maintains direct liaison with the ASBPO.

(e) Plans and executes joint blood program exercises.

(f) Assess risk of potential diseases on deployed troops and the impact on donor populations upon redeployment.

(2) **Area Joint Blood Program Office.** The geographic combatant command surgeon may direct the establishment of one or more AJBPO(s) to provide regional blood management in the theater. The AJBPO may be established upon activation of a JTF as outlined in the respective OPLAN or OPORD. The functions of an AJBPO are similar to a JBPO, but in a limited geographical area. The AJBPO:

(a) Coordinates blood requirements and distribution of blood and blood products to support all the BSU and MTFs in the AJBPO area regardless of Service component. This includes defining the distribution system for blood and blood products at all levels, from the supporting BTC or BSU/blood supply detachment (BSD) down to the MTF.

(b) Evaluates BDC, BPD, BTC/TBTC, BSU, and MTF transfusion services within the operational area to ensure the requirements of the JBPO are supported or addressed in the geographic combatant command and/or JTF OPLAN.

2. Blood Support in the Taxonomy of Care Capabilities

a. **Blood Distribution System.** Blood and blood products (CL VIIIb) are more than just another commodity of medical supply. Blood is a living tissue and, as such, requires handling by individuals specially trained in blood movement and storage.

(1) Blood support in a theater of operations containing actual combat operations is a dynamic and ever-evolving process, heavily influenced by:

- (a) Stringent storage and handling requirements.
- (b) Inventory management constraints.
- (c) Limited potency periods.
- (d) Available technology.
- (e) Evolving transportation systems and routes.

(2) To be successful, blood support must be an organized and cooperative effort on the part of health service logisticians, laboratory and blood bank personnel, transportation personnel, and primary health care providers.

(3) Theater blood support during wartime is provided to US military facilities and, as directed, allied, coalition military and indigenous civilian medical facilities.

(4) Theater blood support may consist of a combination of liquid and frozen blood components. The actual amount of liquid and frozen blood components is determined by the urgency of need and availability of resources within the theater of operations.

(5) Blood services in a theater of operations containing actual combat operations consist of a combination of operational capabilities. Of importance are the following:

- (a) Receiving blood components from the supporting base.
- (b) Moving, storing, and distributing blood components to primary users.

(c) Storing, processing, and distributing previously frozen blood components pre-positioned within the theater.

(d) Emergency collecting of whole blood in the theater of operations. (This procedure should be used only as a last resort when no fully tested blood products are available.)

(6) The Armed Services Blood Distribution System from the supporting base to the MTF is depicted in Figure D-1. The JBPO or AJBPO will be responsible for the Joint Blood Distribution System within their geographic area. The JBPO works for the combatant command surgeon. The AJBPO, when formed, establishes blood support for the JTF. The AJBPO mission is based on a geographic area as well as a specific command. Therefore, AJBPO shall plan and train for joint operations and shall coordinate with the JBPO for all blood operations. Geographic combatant command, subunified command and JTF OPLANs will include projected blood requirements developed by the MAT. These requirements are documented in Appendix 2 of Annex Q, *Medical Services to the Unified Command OPLAN* as prescribed in CJCSM 3122.03B, *Joint Operation Planning and Execution System Vol II, Planning Formats*.

(7) Theater MTFs will:

(a) Maintain an amount of blood products on hand necessary to meet operational requirements, yet minimize waste due to out-dating. Some MTFs have limited capability to collect whole blood in emergencies. This practice is not encouraged, however, since the MTF does not have the capability to perform serological testing of these units for infectious diseases, and the hemostatic benefits of whole blood are limited to 24 hours. Transfusion, and subsequent patient follow-up, of untested (non-FDA licensed) blood must be performed IAW ASD(HA) policy. Key points include:

1. The necessity of transfusing untested (non-FDA licensed) blood must be fully documented in the patient's medical record.

2. Patients shall have a pre-transfusion blood sample collected and submitted for base-line serologic testing.

3. Patients must be tested at 3, 6, and 12 month post-transfusion intervals.

4. All testing must be completed and documented in the patient's medical record.

(b) Submit required BLDREPs to their supporting BSU, as designated by the JBPO or AJBPO. This BSU/BSD may be from any Service component. In certain joint operations, such as joint response contingencies, MTFs may deploy with blood if a requirement to use blood prior to establishment of the resupply chain is anticipated. In this case, the Service-specific SBPO should be notified to coordinate the provision of the necessary blood products prior to the unit's deployment.

(8) A **BSU** can usually support several MTFs depending on the operation, and may include supporting forces afloat. The JBPO determines the number of MTFs that a BSU supports. The mission of the BSU is to receive, store, process, and distribute blood products to its supported MTFs, collect whole blood on an emergency basis and perform limited testing. A BSU:

- (a) Is responsible for maintaining a minimum of a 100% resupply of the blood products based on its supported MTF requirements or as designated by the JBPO. Maximum storage capacity is 3,600 red blood cells (RBCs).

- (b) Is deployable with blood products when the operation involves immediate conflict.

- (c) Is tailored to force packages for contingency operations.

- (d) Can be tasked by the GCC to manage a BPD or BTC/TBTC.

- (e) Can provide a consolidated BLDREP (from its supported MTFs) to the AJBPO or JBPO, as required.

(9) The **BPDs** have been built into some geographic combatant commands to provide frozen blood products such as frozen RBCs, fresh frozen plasma (FFP), cryoprecipitate and frozen platelets. (NOTE: the FDA has not licensed frozen platelets.)

- (a) Are pre-positioned to offset strategic shortages of blood products during the initial stages of an operation until the liquid RBC units can be shipped into the theater.

- (b) Provide frozen blood products to ships offshore.

- (c) Have the capabilities to thaw and distribute frozen products as well as deglycerolize RBCs.

- (d) Issue blood and blood products to BSU, as directed by the JBPO.

- (e) Act as a BSU and distribute blood and blood products to MTFs.

- (f) Provide required BLDREP to their respective AJBPO or JBPO.

(10) GCCs are responsible for ensuring that BPDs are maintained, manned, equipped, and supplied during peacetime operation.

(11) The BTC/TBTCs are managed by the USAF at various airfields. They receive blood products from the ASWBPL, or other BTC/TBTCs, store, re-ice and distribute the products to other BTC/TBTCs, BSUs, or MTFs when required. They provide required blood reports to their respective AJBPO or JBPO. The TBTC may be airlifted to designated airports or landing

zones to maximize blood distribution and to provide for transshipment operations not otherwise available in theater.

(a) The current configuration of the BTC/TBTC provides a maximum storage of 7,200 RBCs.

(b) The goal of the BTC/TBTC is to maintain 50% of the established inventories of its supported BSUs.

b. **Available Blood Products.** Figure D-2 provides a summary of the blood products now available to the theater, as well as the taxonomy of care capability at which they are generally provided. *This figure is a guideline only.* Products may be pushed down to lower care capabilities if the proper staffing and equipment are available for storage, transport and use of the products.

(1) The storage temperature for liquid RBCs is 1 to 6° Centigrade (C). During transport from one facility to another, the shipping temperature of RBCs is 1 to 10° C.

(2) Fresh frozen plasma is stored at -18° C or colder. Once FFP is thawed, it must be transfused within 24 hours. When shipping FFP, it must be kept in the frozen state using dry ice or a system that can sustain a -18° C temperature or colder.

(3) Platelets are stored at 20-24° C with continuous agitation. The temperature during shipment must remain as close to 20-24° C as possible. The maximum time that platelets can be stored without agitation is 24 hours.

(4) Cryoprecipitate is stored at -18° C or less.

(5) Hemoglobin based oxygen carriers are stored according to manufacturer's guidance. This product is still pending FDA licensure.

3. Planning for Effective Blood Management

a. **Coordination.** Continuous planning for mobilization, combat operations, and other contingencies enables the Services to rapidly respond to situations requiring blood support.

(1) A coordinated effort between the theater JBPO, the theater plans/operations officer, and transportation officer is required for successful planning. The JBPO must be integrated early into the planning process. Operation plans dictate blood management strategy. Some issues include:

(a) Will blood be required immediately upon arrival of the combat units?

(b) Should blood be brought into the AOR with the initial medical units?

BLOOD BANK PRODUCTS AND PROCEDURES BY TREATMENT LEVEL

TREATMENT LEVEL	AVAILABLE BLOOD PRODUCTS	ABO & Rh GROUP	TRANSFUSION SERVICE PROCEDURES	MAXIMUM STORAGE CAPACITY	BLOOD SUPPLIER
FIRST RESPONDERS (L1)	HBOC ¹	NONE	NONE	NONE	NONE ³
FORWARD RESUSCITATIVE SURGERY (L2)	RED BLOOD CELLS (RBCs)	O Rh+/-	NONE	50 UNITS RBC PER MED FLD REFRIGERATOR	BSU, BTC or MTF
<u>THEATER HOSPITALS (L3)</u>					
Combat Support Hospital (CSH)	RBCs	O, A, B Rh+/-	ABO/Rh type and group on patient and donor RBCs. ² Immediate spin crossmatches	480 Units: CSH/FH 90 Units: EMEDS+25 500 Units: LHD/LHA 2000 Units: /Hospital Ships	BSU or BTC
Fleet Hospital (FH)	FROZEN/DEGLYCEROLIZED RBCs	O Rh+/-	N/A	950 Units: LHA/LHD 2850 Units: Hospital Ships	BSU or BPD
Expeditionary Medical Support (EMEDS)+25	FRESH FROZEN PLASMA	O, A, B Rh+/-	N/A	20 UNITS	BSU or BTC
Ships	CRYOPRECIPITATE	O, A, B Rh+/-	N/A	20 UNITS	BSU or BTC

1. AVAILABILITY PENDING FOOD AND DRUG ADMINISTRATION LICENSURE

2. NOT NECESSARY IF ARMED SERVICES WHOLE BLOOD PROCESSING LABORATORIES HAS VERIFIED THE ABO GROUP

3. RED BLOOD CELLS CAN BE SUPPLIED FROM HIGHER LEVELS VIA SPECIAL CONTAINERS

Definitive care in CONUS medical treatment facility or other medical center with broad transfusion medicine capabilities

BPD Blood Products Depot

BSU Blood Supply Unit

BTC Blood Transshipment Center

MTF Medical Treatment Facility

Figure D-2. Blood Bank Products and Procedures by Treatment Level

(c) Will there be multinational operations and will the JBPO be responsible for blood requirements of MNFs?

(d) Do the storage capabilities of the BTC/TBTCs, BSU, and BPDs support the blood product requirements?

(e) Will BPD capabilities to deglycerolize frozen RBCs meet blood requirements prior to shipments of liquid RBCs from the supporting base?

(f) Are transportation assets readily available for emergency blood product distribution?

(g) Where will the main supply routes be?

(h) Where will the strategic and tactical supply and air evacuation routes and aerial ports be located?

(2) The locations of the BTC/TBTCs are dependent upon the location of the air terminals and operational necessity. Depending upon the requirements within the geographic combatant command, the BTC/TBTC needs to be able to appropriately manage a varied throughput of blood products. Current capacity is 7,200 RBCs/day. The JBPO and/or AJBPO must provide the BTC/TBTC personnel with their supported blood program elements, types, DOD activity address codes (AACs), and location of MTFs within the area of operation in order to allow proper distribution planning.

(3) Timely communication with the next higher echelon of support usually ensures that adequate supplies of blood and blood products are available.

b. Blood Planning

(1) **Product Availability.** Liquid RBCs and FFP are available for use. Platelets may be available if supporting MTFs possess the necessary apheresis equipment. Theater blood policy will dictate availability of products.

(2) **Shipping Red Blood Cells.** Subject to availability, RBCs shipped from CONUS are packed with the unit group and type distributions as determined by the JBPO and ASBPO.

(3) **Blood Planning Factors.** Blood planning factors are programmed by the MAT to help the JBPO and the geographic combatant command determine the estimated requirements. Subsequently used by the respective combatant command medical planners to generate daily blood product requirements for the theater of operations.

NOTE: Assets to meet anticipated EPW, civilian, and valid allied or coalition personnel workload must be included in the TPFDD as documented IAW CJCSM 3122.03B, *Joint Operation Planning and Execution System Vol II, Planning Formats*. Additionally, a 5-day safety factor will normally

be added to blood requirements in the combat zone, operations zone I to take into account LOC disruption, damage, and in-transit spoilage.

(4) **Blood Support to Rhesus Factor (Rh) Patients.** Eighty to 90% of all blood supplied to all levels of care will be Rh positive. Ten to 20% will be Rh negative. This is in keeping with the levels as found in the donor population within the US. Rh negative RBCs will be provided to both Rh negative female and male patients. In the event that there is not enough Rh negative blood to meet all of the needs, transfusing Rh positive RBCs to Rh negative patients becomes an **EMERGENCY REQUIREMENT** in saving the patient's life and should be thoroughly documented in the patient's medical record.

(5) **Pre-Positioned Frozen Blood Products.** Frozen RBCs are pre-positioned at various locations within the geographic combatant commands. These pre-positioned products are intended as a stop gap to ensure blood products are available at the onset of hostilities until the CONUS blood system is fully activated and shipping products into theater. To ensure rotation of frozen RBC inventory stocks, the use of deglycerolized RBCs must be incorporated routinely into available MTF blood inventories. Dyglycerolized RBCs have a 24-hour expiration; 72-hours during wartime with JFS authorization.

(6) **Armed Services Blood Program Office Reaction Time.** The reaction time of the ASBPO or other supporting JBPO must be considered. Optimally, receipt by the requesting command of blood or blood products for sustainment of operations should take approximately 72 hours depending on flight arrangement. Within some geographic combatant commands, BPDs with pre-positioned frozen blood products have been constructed to provide blood products in anticipation to receiving liquid blood products from CONUS. There are also limited blood donor operations outside the United States, which will be able to provide products prior to receiving them from CONUS. This is especially important in theaters where the command anticipates short notice or no notice of impending combat operations where large numbers of casualties can be expected. Most MTFs should plan to keep a 3-day supply of blood and blood products on hand based on the requirements. Most BSUs should have a 100% replacement goal. Realistically, a planner may expect a 4 to 5-day resupply response time from outside the theater dependent upon at least two factors:

(a) Availability of air transportation.

(b) Location of the operational needs.

(7) **RBCs Shelf Life.** Currently, the health service personnel can expect RBCs to be at least 10 – 14 days old upon receipt. This is due in part to increased FDA testing requirements on all blood donors. Another factor is the resupply times from CONUS. This will be based upon the current requirements with the theater of operations. Blood collected in CPDA-1 (a citrate, phosphate, dextrose, and adenine-formula 1; an anticoagulant preservative solution) and stored at 1° to 6°C expires 35 days after collection. Blood collected in additive solutions (AS-1, AS-3, AS-5) have an extra 7 days of shelf life for a total of 42 days after collection. Extended storage solutions currently in research and development will soon allow for even greater storage periods.

(8) **Needs for Intelligence.** The best source for operational information is the J-3. The J-2 can facilitate the best current intelligence be provided to assist the JBPO. Once located in the AOR, it is necessary for the JBPO to maintain current information on the combat situation and on the anticipated actions of friendly and adversary forces. The best sources of this information are the joint force intelligence officer and the operations officer. As required, the JBPO can anticipate increasing requirements for the AOR as a whole, or he may reallocate resources within the AOR to support specific operations.

- (a) How much blood is in the command?
- (b) Where is it concentrated?
- (c) Is the blood where it is most likely needed?

c. Host-Nation Support

(1) **Host-Nation Blood Bank Support.** The JBPO should coordinate with the J-4 to determine whether existing bilateral and/or multilateral agreements are in place for HN blood bank support. Medical intelligence and the ASBPO will provide additional information upon which to base a decision on the comparability of HN blood with reference to required FDA level of blood testing and the willingness and ability of the HN to provide blood bank support. This support could take the form of blood products such as platelets, additional refrigerators in local hospitals or hotels, ice-making capability, or sources for dry ice to store FFP or frozen RBCs.

(2) **Obtaining Alternative Ice Sources.** Blood distribution assets and MTFs must develop alternative sources for ice and refrigeration in case of equipment failure. These alternative sources can include other military units in the area or HN sources.

d. Logistical Considerations of Blood Support

(1) After the decision has been made on where to locate the blood distribution units and the CONOPS for blood support has been established, plans must be coordinated to effect the timely distribution of blood and blood products throughout the theater of operations. Prior planning must be accomplished with the JMC to establish procedures for the emergency movement of blood. Specific information required when shipping blood by air includes weight, whether wet or dry ice is required, number of units, number of boxes and DOD AAC of receiving facility.

(2) After transportation requirements and priorities have been established, planning consideration must be given to maintaining adequate levels of emergency blood collection and basic testing supplies for the planned operational scenario. If the Army is the dominant user, a MEDLOG battalion will usually be augmented to perform CL VIIIA management functions and assume the role of the SIMLM for the AOR. MTF coordination with the SIMLM is imperative. The SIMLM will have LNOs from supported Services to assist in coordinating logistic support requirements during joint or combined operations. Examples of required supplies include:

- (a) Blood typing system (ABO) grouping and Rh typing antiserum/gel cards.
- (b) Test tubes.
- (c) Blood shipping boxes and labels.
- (d) Plastic bags.
- (e) Adequate supply of ice for maintenance of required blood temperature during transit.

4. Blood Report

a. **Purpose of Standardized Blood Reporting.** The purpose of the standardized BLDREP is to enable the JBPO to effectively manage blood and blood products, project blood requirements, request blood, report blood inventories, and provide information on the overall blood element operations of all Service components in the theater of operations. The JBPO will establish the report format and reporting frequencies based upon operational factors. Examples of BLDREPs are shown in Figure D-3 and Figure D-4.

b. Blood Reporting

(1) Each facility with blood products will submit required BLDREPs to the next higher organization as follows.

(a) MTF (lowest level with blood) to BSU/BPD. For first responder capability and FRC capability units, the JBPO may direct that the report be sent to the supporting theater hospitalization capability MTF.

(b) BSU (to include roll up of all MTF's), BPD, and BTC to AJBPO, if established, or directly to JBPO if no AJBPO.

(c) AJBPO (to include roll up of all lower reporting facilities) to JBPO.

(d) JBPO to ASBPO.

(2) The time of reporting should be determined by the supported commander, but should be a consistent time each day.

(3) The following minimum information is required as part of the BLDREP.

(a) Number of blood components by ABO and Rh.

(b) Number of RBCs due to expire within next 7 days by ABO and Rh.

BLOOD REPORT

Spreadsheet Example

MTF											Date:		
Red Blood Cells													
	O+	O=	A+	A=	B+	B-	AB+	AB=	Total				
Total Count													
< 7 days to exp													
Frozen Red Cells													
	O+	O=	Total										
Fresh Frozen Plasma													
	O	A	B	AB	Total								
Total													
Quarantined													
OTHER													
	O	A	B	AB	Total								
Total													
Quarantined													
Transfused Units													
	O Pos	O Neg	A Pos	A Neg	B Pos	B Neg	AB Pos	AB Neg	Unknown	Total			
RBC													
FFP													
PLT													
Total Count													
Patient Data													
UNIT #	EXP Date	Product ABO/Rh	Product Type	Transfusion Date	Patient's Name		FMP/SSN	Nationality	Patient's ABO/Rh	Sex	Note		

Figure D-3. Blood Report

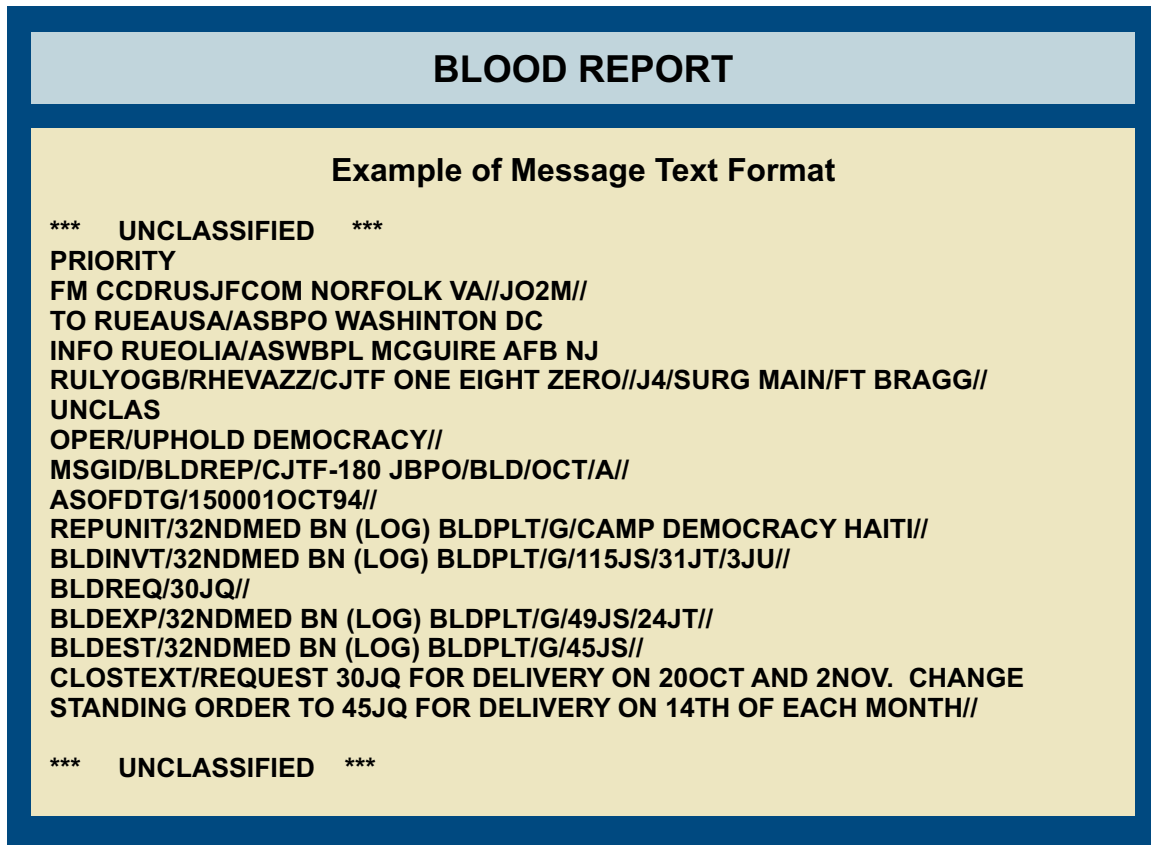


Figure D-4. Blood Report

(c) Number and type of components transfused since last report by ABO and Rh. MTFs should also include patient transfusion data.

(d) Immediate requirements with required delivery date.

(e) Seventy-two hour projected estimated need.

(f) Blood components shipped by ABO and Rh and receiving location as well as all flight information (classification will be set by the geographic combatant command).

(g) Calculated days of supply as determined by the JBPO.

(4) The JBPO will establish the BLDREP format. One method is spreadsheet sent via e-mail (see Figure D-3). Another method is message text format sent through current military message programs such as the Global Command and Control System (see Figure D-4). Voice messages may also be used.

(5) BLDREPs should be classified at the lowest level possible. Any report with consolidated/roll-up data and flight information may be classified SECRET.

(6) The theater blood program manager may assign brevity codes and designate specific lines to be utilized in the required reporting.

(7) Requests for RBCs should normally be based on a random distribution of blood groups and types (that is, 40 percent O positive; 10 percent O negative; 35 percent A positive; 5 percent A negative; 8 percent B positive; and 2 percent B negative). At theater hospitalization and definitive care capabilities, group and type-specific RBCs should be transfused whenever possible. First responder and FRC capabilities will require Group O RBCs only. Upon activation, each MTF should request a base load of blood components.

c. Transmission of the Blood Report

(1) **Method.** The method of BLDREP transmission will be by means designated by the JBPO. The method should be outlined in the Annex Q, Appendix 2.

(2) **Frequency.** The JBPO will determine the frequency of MTF reporting. Key factors in determining frequency include the type and/or level of military operation and the rate of blood product transfusions. This should be detailed in the Annex Q, Appendix 2.

d. Blood Report Policies

(1) Information copies should be kept to a minimum and be specifically required by the respective OPLAN. Increased quantities of information copies overload the message channels.

(2) All BLDREPs should be classified at the lowest level required to meet operational constraints. Generally, data from individual MTFs will be UNCLASSIFIED. As reports are consolidated and sent upward, the classification may be changed to SECRET.

(3) The addressee will normally be the next higher organization level with whom the reporting unit (originator) is authorized direct communication: MTF to blood supplier; blood supplier to AJBPO (if established); blood supplier to JBPO (if AJBPO not established); BTC to JBPO (if AJBPO not established); AJBPO to JBPO (if AJBPO is established); JBPO to ASBPO (see Figure D-1).

e. Blood Shipment Report (BLDSHIPREP)

(1) BLDSHIPREPs are used within the ASBP to report blood shipments.

(2) Like the BLDREP, the format and means of transmission will be determined by the current operation. The JBPO, ASBPO, and the ASWBPL will make this determination.

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APPENDIX E

INTELLIGENCE SUPPORT TO HEALTH SERVICE SUPPORT

1. Aspects of Medical Intelligence

a. HSS planners and providers must consider the entire scope of the threat to effective HSS support. Intelligence support to HSS must address all aspects of the threat. Considerations range from the potential impact of enemy combat operations on HSS personnel, LOCs, and materiel, to the types of weapons (and their consequent health effects) that may be employed against friendly forces, as well as other health and environmental threats. Continuous coordination by HSS planners with the command J-2 is a key element in the effort to maintain awareness of the threat.

b. Medical intelligence is that intelligence produced from the collection, evaluation, and analysis of information that includes the medical aspects of foreign areas that have an immediate or potential impact on policies, plans, and operations. The AFMIC, located at Fort Detrick, Maryland, has the sole responsibility within the DOD for producing finished intelligence on foreign military and civilian medical capabilities, infectious diseases and environmental health risks, and scientific and technical developments in biotechnology and biomedical subjects of military importance. AFMIC is the sole producer of medical intelligence for the Defense Intelligence Agency. Medical intelligence includes only finished intelligence products produced by an authorized intelligence agency such as AFMIC through the intelligence process. Medical intelligence data is critical in enabling HSS to provide the CJTF with early warning of biological warfare attacks, as well as prompt detection and identification of biological attacks or naturally-occurring disease outbreaks. To develop medical intelligence, information is gathered, evaluated, and analyzed on the following subjects:

(1) Endemic and epidemic diseases, public health standards and capabilities, and the quality and availability of health services. Medical intelligence data concerning endemic and epidemic disease rates in the JOA is required to establish a medical surveillance baseline. HSS must establish baseline rates of disease and illness to detect deviations that warrant a timely investigation to determine if the increase is due to biological warfare agent attacks or naturally occurring disease outbreaks. This is accomplished through medical surveillance.

(2) OEH threats present in the JOA.

(3) Health service logistics, to include blood products, MTFs, and the number of trained health service logistics personnel.

(4) The location, specific diseases, strains of bacteria, lice, mushrooms, snakes, fungi, spores, and other harmful organisms (toxic flora and fauna).

(5) Foreign animal and plant diseases, especially those diseases transmissible to humans.

(6) Health problems relating to the use of local food and water supplies.

(7) Medical risks and effects of CBRN agents and recommendations for countermeasures.

(8) The possible casualties that can be produced by newly developed foreign weapon systems.

(9) The health and fitness of the enemy's force and his use of antidotes and immunizations.

(10) Areas of operations (such as altitude, extremes of temperature, and difficult terrain [swamps, mountains, deserts, or urban]) that in some way may affect the health of the command or the conduct of HSS operations.

(11) Detectors and sensors for personnel, environmental and specimen-based analysis to use scientific biological, chemical and electromagnetic, acoustic, and visual technologies to aid in the detection and/or ID of threats.

(12) Use of Informatics. All source/open source data mining, correlation and nodal analyses to identify and tie together events of HSS significance. These sources include but are not limited to information about industrial products, imports, exports, travel and shipping, financial transactions, news, web sites, databases, and intelligence reports. It is possible that the informatics' analysis of industries, transport, and sales of precursor or finished products result in a threat posture that may require action or countermeasure.

2. Significance of Medical Intelligence

a. At the strategic level, the objective of medical intelligence is to contribute to the formulation of national and international policy. The policy will be predicated in part on foreign military and civilian capabilities of the medical or biological scientific community.

b. At the operational level, the objective of medical intelligence is to develop HSS strategies that:

(1) Detect and/or identify the medical threat.

(2) Counter the medical threat.

(3) Are responsive to the unique aspects of a particular theater.

(4) Enable the commander to conduct his operation.

(5) Conserve the fighting strength of friendly forces.

3. Sources of Medical Information

a. The first place to search for information is in the office of the combatant command surgeon with geographic responsibility for the area into which the JTF is being deployed. The combatant command surgeon's preventive medicine officer should be intimately familiar with the region's medical threats. If the preventive medicine officer does not have specific information right at his/her fingertips, he or she probably has access to a library of applicable medical threat data, in addition to what is available from AFMIC.

b. The **AFMIC** produces a wide range of publications that can assist the in developing a military intelligence preparation of the battlespace. Five important publications that a JTFS may find useful are the Disease and Environmental Alert Reports, the Medical Capabilities Studies, the World-Wide Medical Facilities Handbook, the Special Series documents, and the Weekly Wire (a periodic message update of worldwide medical concerns). Additionally, AFMIC has published much of its unclassified information on a multi-platform compact disc (CD) titled "Medical Environmental Disease Intelligence and Countermeasures." The Navy Environmental Health Center, USACHPPM, US Army Medical Research and Materiel Command, and others can be of tremendous assistance in identifying and analyzing threats in an AOR. This information is also available at AFMIC's websites: SECRET Internet Protocol Router Network (SIPRNET) <http://www.afmic.dia.smil.mil> and the Non-Secure Internet Protocol Router Network (NIPRNET) <http://mic.afmic.detrack.army.mil/>.

c. There are numerous sources of medical information. The **Defense Pest Management Information Analysis Center** of the Armed Forces Pest Management Board is one. This organization publishes an excellent series of disease vector ecology profiles on many foreign countries and regions of the world. The profiles include information regarding disease risks, infectious agents, modes of transmission, geographic and seasonal incidence, and prevention and control recommendations. Some of its other publications are also available online. A CD of operational entomology references is also available.

d. A second resource is the **Navy Preventive Medicine Information System (NAPMIS)**. NAPMIS maintains up-to-date information like disease risk assessment profiles and disease vector risk assessment profiles. The Navy also operates regional naval environmental and preventive medicine units that publish periodic fleet public health bulletins and provide assistance throughout the world.

e. A third publication of value is the quarterly Communicable Disease Report published by the **Walter Reed Army Institute of Research (WRAIR)**. It identifies disease outbreaks worldwide. Additionally, WRAIR quickly responds to ad hoc queries and provides timely regional medical assessments.

f. A third military source is the **US Army Research Institute of Environmental Medicine (USARIEM)**. USARIEM publishes an excellent series of "deployment manuals" which address soldier health and performance in a wide variety of environments.

g. Still other sources of medical information are available from agencies external to DOD. **DOS** publishes Background Notes, a series of publications on selected countries and regions.

h. The **CDC** publishes *Health Information for International Travel*, a document often referred to as the “Yellow Handbook,” which identifies current vaccination requirements, immunization and prophylaxis recommendations, and regional health threats. This information is also accessible online at <http://www.cdc.gov/travel/>.

i. **The World Health Organization (WHO)** publishes Vaccination Certificate Requirements and Health Advice for International Travel, a document that is similar to the Yellow Handbook. WHO also publishes the Weekly Epidemiological Record.

APPENDIX F

CASUALTY PREVENTION

1. Introduction

a. FHP provides the conceptual framework for optimizing health readiness and protecting Service members from all health threats associated with military service. Casualty prevention, the second pillar of FHP, seeks to prevent casualties from environmental, occupational, operational, nuclear, biological, and chemical warfare threats.

b. An effective fit and healthy force provides the JFC with forces capable to withstand the physical and mental rigors associated with combat and other military operations. The ability to remain healthy and fit in the deployed setting despite being subjected to a multitude of health threats is a force multiplier for commanders. It reduces the logistic support tail required to sustain the fighting force by decreasing the need for medical care and for replacement personnel. During deployment, the enemy and the “total” environment both generate threats to the forces. The adversary threat produces most combat-related casualties commonly called BIs, while the total environment threat produces DNBI casualties. DNBIs historically have accounted for three-quarters or more of battlefield admissions (69 percent in Vietnam, over 95 percent in World War II and Somalia).

c. Prevention of DNBI casualties requires unwavering command emphasis at every level or it will fail. Success is dependent on all program facets from ensuring bed nets are provided to the force to environmental and disease surveillance programs in the operational area. Although historical data indicates contaminated food or water, disease vectors, or climatic conditions pose the greatest risk to forces, environmental, industrial, and occupational exposures remain a risk of equal importance.

d. Casualty prevention is a continuous life-cycle process conducted during pre-deployment, deployment, and post-deployment phases. Comprehensive, continuous deployment health surveillance, including collection, analysis, and recording of objectively determined occupational and environmental monitoring data and when possible, actual exposure levels, is necessary to identify these non-enemy threats, which can dramatically affect the health of deployed personnel.

2. Deployment Health Surveillance

a. Deployment health surveillance is the routine, standardized tracking of disease and injury incidence in meaningful rates, initial analyses and response at the unit level, and data-driven corrective actions taken at all levels. Deployment health surveillance requires standardization of methods, rates, data, and communication across Services. Effective surveillance relies on collection and recording of health care, personnel, environmental, and operations data. Analysis requires data to be accurate and linked to appropriate information systems, including daily Service member location information to enable integration of that data and assignment of exposure to specific personnel. Support automation and data collection should begin at the lowest echelon possible.

b. Deployment health surveillance is activities critical to FHP, which include identifying the PAR; identifying and assessing potential OEH hazards, documenting OEH and CBRN risks and exposures; using specific risk management countermeasures; monitoring real time health outcomes (medical surveillance); and reporting of DNBI and BI rates and other measures during deployments in a timely manner. Routine shipboard operations that are not anticipated to involve field operations ashore are exempt from deployment health surveillance requirements except when the potential health risks indicate actions necessary beyond the scope of normal shipboard occupational health programs. DODI 6490.3, *Deployment Health Surveillance and Readiness*, and USD(P&R) memorandum, “Enhanced Post-Deployment Health Assessments,” lists the mandatory requirements for pre- and post-deployment assessments. Commanders are highly encouraged to accomplish deployed health surveillance activities for operations, which may fall outside the current deployment definition, including CONUS response. If the duration of deployment is uncertain, then the surveillance requirements described in CJCS Memorandum (MCM) 0006-02 and USD(P&R) memorandum (pre- and post-deployment health assessments, health readiness, and DNBI reporting) will be met. The USACHPPM is the repository for deployment health surveillance data and reports. All deployment medical surveillance data will be forwarded to USACHPPM’s Army Medical Surveillance Activity to assist in managing the Defense Medical Surveillance System. All OEH surveillance data and reports will be forwarded to the USACHPPM Risk Management Division which manages the defense-wide deployment OEH surveillance data repository USACHPPM will ensure permanent archival of these data and reports and make it available integration with DOD health information systems.

3. Identifying Preventable Threats and Implementing Countermeasures

a. Preventive medicine competencies and training must elicit continuous command interest to ensure support for deployment operations. CCDRs must ensure preventive medicine supplies and equipment are provided and maintained to support implementation of their prevention responsibilities. Additionally, they should maximize the use of joint training to exploit existing tri-service environmental health, occupational health, and preventive medicine expertise.

b. Preventive medicine training should become an integral part of predeployment preparations. Wide dissemination of any preventive medicine knowledge gained during deployment will prove invaluable in sustaining the health of the force and in preparing for future deployments. Creation of a universally accessible repository of DNBI data will enable access to valuable lessons learned, which must be considered for future deployments. These data should be used to develop models and scenarios for various deployments to identify and assess the preventable threats during predeployment planning and to use in exercise play.

c. Preventive medicine units need three kinds of equipment: automated information support systems, equipment designed for rapid detection and on-the-spot evaluation of environmental and biologic threats, equipment designed to collect and measure biological vector activities, and personal protective equipment and transportation. Access to essential deployable computer systems with environmental exposure data, unit locations, and movement information is critical.

d. Preventive medicine teams should be highly mobile, light, rugged, and have easy to use, and whenever possible direct reading sampling and analysis equipment to maximize the ability of preventive medicine teams to do accurate and timely baseline, routine, and incident-specific OEH sampling. The teams will also continue to collect samples of potentially hazardous materials for any laboratory analysis and threat assessment that must be provided by joint theater health surveillance laboratories deployed to the operating theater. DOD also needs an integrated health management system to capture and maintain required health, environmental, and biological information to support preventive medicine operations during deployment.

e. All required medical equipment and supplies (mosquito bed netting and poles, permethrin treated-uniforms; etc.) to support FHP must be issued or made available in theater for all deploying personnel.

f. All required individually issued nuclear, biological, and chemical medical defense items to support FHP must be issued and documented in the individual's medical record.

4. Infectious Disease Prevention

a. Infectious disease threats, based upon current medical intelligence, must be identified during the pre-employment period. Diseases such as acute respiratory infection and diarrheal diseases are of great concern, particularly when many troops are brought together in staging areas. It is important to monitor health to gauge the predeployment health status of units and to identify preexisting (base-line) health characteristics of individuals. Unit health status is a measure of unit readiness. The ID of preexisting health characteristics ensures that individuals who should be classified non-deployable are identified before deployment. Infectious diseases should be prioritized and monitored according to the threat each poses to the fighting force and the achievement of the force's mission. Countermeasures should be employed according to this established risk management process.

b. During deployment, vigilant monitoring of medical diagnoses, and of DNBI reporting categories and rates (e.g., sick calls, outpatient treatment, and hospital admissions) as well as surveillance of disease carrying vectors and existing local pathogens is required for effective planning and refinement of countermeasures to infectious disease. Furthermore, development of enhanced DNBI predictive models based on historical data, type of deployment, location of deployment, duration of deployment, and level of support are highly recommended.

c. Throughout the deployment life cycle, potential and emerging infectious diseases need to be addressed in a timely manner. Appropriate infectious disease countermeasures must be implemented, particularly in the following areas:

- (1) Food and water vulnerability.
- (2) Waste disposal.
- (3) Control of disease carrying vectors.

(4) Personal protection measures (i.e., immunizations, chemoprophylaxis, insect repellents, and uniforms impregnated with preventive compounds). Infectious disease resulting from deployment may not be immediately apparent upon an individual's return, and previously deployed individuals may develop chronic conditions years after return. Returning Service members require post-deployment health debriefings, post deployment health assessments, serum collections, and when indicated, referral for clinical evaluations to screen for infectious diseases and other development related health conditions acquired during deployment. Members returning from deployment are required to complete a post-deployment assessment survey. The post-deployment assessment survey serves as a tool to evaluate the member for any infectious diseases, injuries, and other medical conditions obtained during deployment.

d. When directed, all Service members returning from theater will participate in necessary diagnostic/vaccination/chemoprophylaxis programs to minimize the threat and extent of post-deployment illness. All therapies will be posted to the individual's treatment record and to the greatest extent possible to their electronic prescription profile.

5. Mental Health Casualty Prevention

a. Mental health problems and appropriate medical intervention throughout all phases of deployment are critical to mission success. Individuals identified at high risk for developing mental health problems are often associated with dual-Service member families, use of psychoactive medications, frequent disciplinary problems, and domestic problems. Units at high risk include those anticipating a highly intense combat mission; a CBRN warfare threat; a long deployment; and units with poor morale and unit cohesion including units that have recently had a change in command. Several factors may signal a developing mental health problem. Four key indicators are increased use of health services, use of medication, disciplinary problems, and increased absences.

b. Mental health intervention may be critical to mission success. Preventive interventions for individuals and units include:

- (1) Voluntary and command-referred counseling.
- (2) Family support services.
- (3) Support from family and friends through available media.
- (4) Activation of an existing spouse support network.
- (5) Personnel input into rest and recuperation (R&R) policies and schedules.
- (6) Critical incident stress debriefings.

c. Historically, post-deployment mental health interventions for personnel returning from theater have remained a low priority. To change this, the stigma of mental health interventions

must be minimized. Educational briefings aimed at mitigating the stress and anxiety that often follow a unit's return from theater are suggested. Those briefings may address personal finances, combat stress prevention, repatriation issues, general mental health issues (e.g., stress indicators and stress reduction), R&R suggestions, and positive information regarding the accomplishment of mission objectives.

6. Disease Nonbattle Injury Prevention

a. OEH surveillance is a key component of deployment health surveillance and contributor toward DNBI prevention.

b. Environmental and occupational monitoring for chemical, biological, and physical hazards such as indigenous communicable diseases, vectors, toxic industrial materials, field sanitation problems, and unsafe food and water is a continuous process over the entire deployment life cycle. During the predeployment phase, the intelligence preparation of the battlefield must take into account the available strategic and operational medical intelligence pertaining to the operational environment in order to identify and protect against expected hazards that may be encountered.

c. For example, bioassays for depleted uranium and lead are approved to assess human exposures during or after deployment and combat operations. Monitoring different types of health conditions should be prioritized according to likely and/or detrimental exposures. Occupational health and occupational medicine specialists should be available for consultation to assess potential toxic exposures in real time and identify and execute appropriate countermeasures.

d. Environmental threats are likely to vary considerably according to each deployment. Continuous reassessment of environmental threats helps ensure that commanders understand current risks and applicable countermeasures. Assessment methods require constant refinement and improvement to diagnose threats accurately and develop preventive interventions. To assess any threat accurately, vigilant objective documentation of all toxic agents with linkage to short term health outcome data is required for both near real time and retrospective analyses. Immediate analysis and feedback are essential to rapid threat intervention. Joint epidemiological activities will require use of central data collection, analysis, and storage locations.

e. Exposures to toxins present during the deployment phase may be assessed by employing the use of approved biomarkers either during or post-deployment depending on the persistence of the biomarker. When warranted, post-exposure biomonitoring may be conducted and compared with a pre-exposure baseline. Exposure to environmental toxins may have short- or long-term effects. Long-term medical follow-up surveillance and care will be provided to individuals experiencing chronic conditions related to any documented environmental exposures.

f. Effective and comprehensive casualty prevention among all combat and support personnel will also depend on the ability of CCDRs to ensure that occupational safety and health measures are rigorously adhered to whenever practical. While occupational safety is a commander's responsibility, the medical community plays a crucial role in reducing preventable losses by

developing mishap prevention measures, life support research and development, and materiel or doctrinal development to support the protection and performance of all deployed service members.

7. Nonbattle Injury Prevention

a. FHP calls for the anticipation and prevention of injuries likely to impede the attainment of mission objectives or result in hospitalization or predispose to recurrent injury. This ID should use all available sources of health information, including finished intelligence to determine high-risk threats. Personnel at high risk of suffering NBIs include individuals:

(1) With preexisting conditions (such as illnesses, injury profiles, past injuries, inadequate physical conditioning).

(2) Participating in high-risk activities (such as sports with a high rate of physical contact).

(3) Participating in unfamiliar activities (such as manual material handling in preparation for deployment).

b. Other recognized hazards to personnel health include:

(1) Motor vehicle accidents.

(2) Heat and cold injuries.

(3) Fatigue and stress illness.

(4) Physical overtraining.

(5) Hazardous noise levels.

c. Both common and deployment specific threats can be addressed by training provided before and during deployment, adequate lighting and work conditions for assigned tasks, proper clothing and equipment, and amelioration of fatigue or stress experienced by personnel.

d. Physical overtraining, lack of physical fitness, and participation in contact sports are major contributors to NBI. To minimize injuries resulting from overtraining or a lack of physical fitness, a baseline fitness program for gradual conditioning must be implemented. Sports that involve a high risk of injury should be limited or their threat otherwise minimized through use of protective equipment or with rule changes to minimize harmful contact. Occupational hazards are another major cause of injury. These hazards can be minimized through the use of ergonomically appropriate lifting and packing techniques, enforcement of work-rest cycles, and training to avoid injuries likely to occur during a Service member's career.

e. Estimating probable NBIs requires historical data on deployed personnel. The use of a theater trauma register is valuable in ensuring that data documenting the circumstances leading to injury are recorded. Once entered into the registry, epidemiological analysis of the data can take place and countermeasures established for those injuries which are numerous and/or severe. Historical NBI data should be used to develop casualty prevention simulation models for Service operational training exercises.

f. NBIs can significantly impair the achievement of mission objectives. To prevent this, a risk management plan must emphasize general safety practices aimed at greatly reducing NBIs during the deployment cycle.

8. Operational Risk Management

a. Risk management is an essential element of military doctrine. Uncertainty and risk are part of all military operations. A time-tested principle of success in joint operations is taking bold, decisive action, and a willingness to identify and control or accept the associated risk. Risk is the probability and severity of failure or loss from exposure to various hazards. Carefully determining the hazards, analyzing and controlling the hazards, and formulating and executing a risk management plan to mitigate known or anticipated hazards contributes to the success of the application of military force.

b. Risk management is the process used by decision makers to reduce or offset risk. The risk management process provides leaders and individuals a systematic mechanism to identify and choose the optimum COA for any given situation. Risk management must become a fully integrated element of planning and executing an operation. The operational risk management (ORM) process is applicable to all levels of military operations from strategic to tactical. Commanders are responsible for the routine application of risk management in the planning and execution phases of all missions, whether they are combat or support operations.

c. Four principles govern all actions associated with risk management. These continuously employed principles are applicable before, during, and after all tasks and operations. The four principles are:

- (1) Accept no unnecessary risk.
- (2) Make risk decisions at the appropriate level.
- (3) Accept risk when benefits outweigh the costs.
- (4) Integrate ORM into Service doctrine and planning at all levels.

d. ORM is a continuous process designed to detect, assess, and control risk while enhancing performance and maximizing combat capabilities. ORM provides the basic structure for the detection, assessment, and ultimate sustained control of risk while enhancing performance and

maximizing combat capabilities. Individuals at all levels, identify and control hazards through the ORM process. Figure F-1 shows an ORM process chart with six steps. The six steps are:

(1) **Identify the Hazard.** A hazard can be defined as any real or potential condition that can cause mission degradation, injury, illness, death to personnel, or damage to or loss of equipment or property. Experience, common sense, and specific risk management tools help identify real or potential hazards.

(2) **Assess the Risk.** The hazard assessment step is the application of quantitative or qualitative measures to determine the possibility of loss or injury associated with a specific hazard. This process defines the probability and severity of a mishap that could result from the hazard based upon the exposure of personnel or assets to that hazard.

(3) **Analyze Risk Control Measures.** Investigate specific strategies and tools that reduce, mitigate, and eliminate the risk. Effective control measures reduce or eliminate one of the three components probability, severity, or exposure) of risk.



Figure F-1. Six-Step Process of Operational Risk Management

(4) **Make Control Decisions.** Decision makers at the appropriate level choose the best control combination of controls based on the analysis of overall costs and benefits.

(5) **Implement Risk Controls.** Once control strategies have been selected, an implementation strategy needs to be developed and then applied by management and the work force. Implementation requires commitment of time and resources.

(6) **Supervise and Review.** Risk management is a process that continues throughout the life cycle of the system, mission, or activity. Leaders at every level must fulfill their respective roles in assuring controls are sustained over time. Once controls are in place, the process must be periodically reevaluated to ensure their effectiveness.

9. Health Risk Communication

Effective health risk communication is essential to casualty prevention including threat ID, predeployment health debriefings and any medical follow-up indicated. All significant risks must be clearly and accurately communicated to deploying Service members and to the chain of command. Command emphasis is an integral part of injury prevention. Commanders should receive feedback throughout the deployment life cycle from preventive medicine staff regarding preventable threats and countermeasures. Medical staff should ensure that the range of preventable threats is prioritized and commanders are made aware of the risks that could affect operations. Health care personnel should be given all available information to enable them to deliver high quality care to individuals during deployment and upon their return from theater. It is essential that DOD, the Department of Veterans Affairs, and civilian health care providers be alerted to possible diseases that may have been contracted by deployed personnel. Candid information concerning actual and probable DNBIs resulting from a deployment should be provided to all appropriate individuals.

10. Battle Injury Prevention

Although disease and nonbattle injuries have historically caused most hospital admissions from the battlefield or other deployed operational settings, battle injuries remain very significant because of their severity. Services' medical personnel provide support for prevention of BI casualties by anticipating and preparing to counter the adverse medical effects of the enemy's operational threats.

11. Conclusion

The second pillar, casualty prevention, protects the healthy and fit Service member from environmental, occupational, and operational threats. DNBIs historically account for the majority of battlefield admissions. Individual Service members and commanders accomplish DNBI prevention through actions. Medical personnel including those in the medical intelligence community identify potential threats, develop COAs, and advise commanders of the risks and

the recommended countermeasures, communications techniques and practices when informing commanders and Service members of the risks and measures to be followed to eliminate or reduce the risks.

APPENDIX G

PATIENT AREA RECEPTION PLANS

1. Purpose

The purpose of this appendix is to provide guidance to assist the Federal coordinating center (FCC) in developing patient reception SOPs and maintaining the support of hospitals and area agencies for the assigned patient reception areas (PRAs) plan.

2. Responsibilities

The FCC director is responsible for ensuring the development, exercise, and evaluation of local PRA plans. The FCC area coordinator assists the FCC director, ensuring that a patient reception team (PRT) is developed for each PRA and that each PRT remains viable through training and exercises. The FCC coordinator maintains contact with appropriate authorities in each PRA, and includes contact information in each PRA plan. The FCC coordinator notifies all agencies involved as soon as activation of the FCC geographical AOR is anticipated.

3. Plan Development

The development of local plans is critical if NDMS is to be a viable national system to support the local communities. The key to success is the thoroughness and effectiveness of local level planning. Each local community in which the NDMS is organized is unique. The degree of sophistication of current community contingency/disaster planning and the availability of local resources that can be incorporated into the PRA plan will vary among communities. Each PRA plan must be tailored to its community; thus local planning cannot be accomplished without the support, involvement, and coordination of the local areas medical community. Most communities have an airport disaster plan or a similar MASCAL incident plan. In many instances, this can be used as a basis for the PRA plan. In fact, it is advisable that the PRA plan be based on existing plans where possible. In few circumstances is it envisioned that a PRA plan would have to be developed from the ground up. At a minimum, the same people and organizations that developed existing emergency response plans should help develop and manage the PRA plan. Each PRA plan should address the following areas:

a. Concept of Operations

- (1) Provide a concise mission statement.
- (2) Define the geographic PRA of responsibility.
- (3) Briefly define the roles and responsibilities of principle agencies, teams, and individuals.
- (4) Identify any applicable references, including the NRP as well as any applicable state and local disaster plans.

(5) Identify applicable state and local governmental and nongovernmental bodies, including local emergency medical system agencies.

(6) Identify primary and alternate airfields, rail and bus terminals or other local identified patient reception sites.

(7) Identify local resources for transporting patients.

(8) Identify local resources for definitive medical treatment.

b. PRA Activation

(1) Define the processes for NDMS activation of the local PRA.

(2) Define the local processes for alerting and augmenting the FCC staff.

(3) Define the processing and provide a checklist for notifying local agencies of activation.

c. FCC Operations

(1) Define FCC staff roles, responsibilities, and shift schedules.

(2) Define FCC internal communications, logs, reports, etc.

(3) Define control of access to the FCC.

d. Bed Availability Reporting

(1) Provide definitions of terms, including a list of medical categories.

(2) Define the processes for collecting at the local level initial and recurring bed reports, including “throughput.”

e. Medical Regulating and Patient Evacuation to the PRA

(1) Define the role of the DOD GPMRC.

(2) Define the processes and procedures for coordinating PM missions between GPMRC and the FCC AOR.

f. Patient Reception and Staging

(1) Describing the local patient reception site(s). Patients arriving from distant disaster sites or from military contingencies will generally be received at a single reception site in the

PRA (e.g., an airfield, rail or bus terminal). The site should facilitate the off-loading of patients, the immediate evaluation and triage of patients, and the staging of litter and ambulatory patients prior to transport to local medical facilities. Close coordination is required with DOD, civil airport authorities, emergency medical services (EMS) providers, city emergency planners and other agencies and organizations as appropriate to ensure access to the site, adequate staffing, security, environmental control (heat, water, light), provision of food and drink, and communications.

(2) Define the roles and responsibilities of a PRT. The PRT is a multifunction group and consists mainly of clinical staff, but should also include appropriate support from medical administration and communications personnel, logistics personnel, and people acting as litter bearers and drivers. The team leader can be a physician or other person with appropriate medical expertise. This team can be based out of a federal facility (Veterans Administration [VA] or DOD) or comprised of volunteers from community organizations. Disaster medical assistance team staffs make exceptional PRT members if they are available to the FCC. Local EMS volunteers who perform dispatch and ambulance transportation can also be helpful.

g. Transportation

(1) Define resources, procedures, and contact information to obtain vehicles, drivers, and other personnel to transport patients from the reception site(s) to local NDMS member hospitals. It is important that all vehicles be assessed for their patient carrying capability, inventoried, and tabulated in the patient transportation plan. Additionally, coordinate in advance with the authorities providing the vehicles and personnel for transportation. Military vehicles that are scheduled to move to an overseas theater of operations early in mobilization, or are committed to a potential military mobilization effort, should not be included as patient transportation assets during military contingencies. Resources might include:

- (a) Ambulances, other vehicles and personnel from local EMS.
- (b) Military, VA, and/or local hospital ambulances and ambulance buses.
- (c) Commercial, governmental, or other vehicles available that are wheelchair accessible or otherwise configured to accommodate litter patients.
- (d) Other commercial vehicles (e.g., airport limousines or buses).
- (e) Military and other governmental general use trucks, vans, school buses, etc.

(2) Define the roles, processes and procedures for managing and tracking the use of local transport resources.

(3) Identify primary and alternate routes from the patient reception site(s) to local medical facilities. Ensure advance coordination with local law enforcement agencies is made in the event that traffic control and additional security are needed.

h. Patient Administration

(1) Define the roles and responsibilities of the FCC area coordinator. The FCC area coordinator assumes administrative responsibility for patients. This responsibility begins upon a patient's arrival and continues until the patient is transferred to a gaining facility and/or returned home or, in the case of military patients, returned to the responsible Service personnel system for processing and assignment to a military unit or discharge from active duty, as appropriate.

(2) Define the roles and responsibilities of the GPMRC liaisons, if available, and military patient administration team, if available.

(3) Identify current contact information for each participating NDMS hospital.

(4) Define the roles and responsibilities of each participating NDMS hospital. The medical staff of that hospital will accomplish the patients' day-to-day medical management and care. The hospital will provide medical care using their own procedures and forms. NDMS member hospitals should provide information to the FCC coordinator, to include a daily admission and disposition list (indicating the expected length of stay) and a narrative summary upon discharge of the patient.

(5) Define the roles, processes, and procedures for tracking patients in the PRA. Ensure that the following information is included in the tracking system adopted by the FCC:

(a) Patient name.

(b) Social security or other ID number.

(c) Medical regulating/diagnostic category.

(d) Type of patient (i.e., directly injured/victimized by disaster or relocated/displaced by the disaster).

(e) Home address (if available).

(f) Next of kin, address, and telephone number (if available).

(g) Admitting hospital, admission date, address, POC, and telephone number for inpatients.

(h) Local domicile (e.g., hotel or shelter), address, POC, and telephone number for outpatients.

(6) Define policies and procedures for disposition of records. The FCC area coordinator generally retains patient data for the minimum period required by statutory law, but never less than one year after the last patient has been returned home. The FCC director will submit

records to a central repository. All appropriate patient confidentiality procedures, including protection of social security numbers, must be followed.

i. Patient Discharge and Return

- (1) Define roles and responsibilities for individual patient discharge planning.
- (2) Define the processes and procedures for transporting patients who require continuing medical treatment.
- (3) Define the processes and procedures for transporting patients who do not require continuing medical treatment.

j. Financial Claims Processing

- (1) Define basic procedures for data collection, claims processing, and reimbursement.
- (2) Define roles and responsibilities of the FCC coordinator and NDMS participating hospitals.

k. Training and Exercises

- (1) Identify the requirements and objectives for annual training of individuals.
- (2) Identify the requirements and objectives for annual training of teams.
- (3) Identify the requirements and objectives of annual comprehensive PRA exercises.

l. Public Relations and Media Information

- (1) Identify local media resources.
- (2) Define rules, limitations, and processes for preparing information for release.
- (3) Identify local agencies and individuals authorized to release information.

m. Communications

- (1) Identify primary and alternate means of communication, and provide a detailed contact list for the following:
 - (a) The FCC.
 - (b) Appropriate HQ elements or agencies.

- (c) GPMRC.
 - (d) Local authorities and agencies.
 - (e) Patient reception site authorities.
 - (f) PRTs.
 - (g) Patient transport agencies.
 - (h) All local participating NDMS hospitals.
 - (i) Others as required.
- (2) Provide an inventory of primary and alternate communications equipment and supplies.

APPENDIX H

GENEVA CONVENTION INFORMATION

1. General

a. The conduct of armed hostilities is regulated by law of armed conflict (LOAC). This law is derived from two principal sources:

(1) Lawmaking treaties or conventions (such as The Hague and Geneva Conventions).

(2) Custom (practices which by common consent and long-established uniform adherence has taken on the force of law).

b. Under the US Constitution, treaties constitute part of the Supreme Law of the Land, and thus must be observed by both military and civilian personnel. The unwritten or customary LOAC is part of international law. As such, it is binding upon the United States, citizens of the United States, and other persons serving the United States.

2. The Geneva Conventions

a. The US is a party to numerous conventions and treaties pertinent to warfare. Collectively, these treaties are often referred to as The Hague and Geneva Conventions. Whereas the Hague Conventions concern the methods and means of warfare, the Geneva Conventions concern the victims of war or armed conflict. The Geneva Conventions are four separate international treaties, signed in 1949. The Conventions are very detailed and contain many provisions, which are tied directly to the HSS mission. These Conventions are titled:

(1) *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (Geneva I or GWS).*

(2) *Geneva Convention for the Amelioration of the Condition of the Wounded, Sick, and Shipwrecked Members of the Armed Forces at Sea (Geneva II or GWS Sea).*

(3) *Geneva Convention Relative to the Treatment of Prisoners of War (Geneva III or GPW).*

(4) *Geneva Convention Relative to the Protection of Civilian Persons in Time of War (Geneva IV or GC).*

b. All HSS personnel should thoroughly understand the provisions of the Geneva Conventions that apply to medical activities. Violation of these Conventions can result in the loss of the protection afforded by them. Medical personnel should inform the tactical commander of the consequences of violating the provisions of these Conventions. The consequences can include the following:

- (1) MEDEVAC assets subjected to attack and destruction by the adversary.
- (2) HSS capability degraded.
- (3) Captured medical personnel becoming POWs rather than retained personnel. They may not be permitted to treat fellow prisoners.
- (4) Loss of protected status for medical unit, personnel, or evacuation platforms (to include aircraft on the ground).

3. Protection of the Wounded, Sick, and Shipwrecked

a. The essential and dominant idea of the GWS is that the combatant who has been wounded or who is sick, and for that reason is out of the combat in a disabled condition, is from that moment protected. Friend or foe must be tended with the same care. From this principle, numerous obligations are imposed upon parties to a conflict.

b. **Protection and Care.** Article 12 of the GWS imposes several specific obligations regarding the protection and care of the wounded and sick.

(1) The first paragraph of Article 12, GWS, states “Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances.”

(a) The word “respect” means “to spare, not to attack,” as explained in the International Committee of the Red Cross’s (ICRC’s) *Commentary, I Geneva Convention* and “protect” means “to come to someone’s defense, to lend help and support.” These words make it unlawful to attack, kill, ill-treat, or in any way harm a fallen and unarmed adversary combatant who has ceased to fight. At the same time, these words impose an obligation to come to the combatant’s aid and give the combatant such care as the combatant’s condition requires.

(b) This obligation is applicable in all circumstances. The wounded and sick are to be respected just as much when they are with their own Service or in no man’s land as when they have fallen into the hands of the adversary.

(c) Combatants, as well as noncombatants, are required to respect the wounded. The obligation also applies to civilians; Article 18, GWS, specifically states: “The civilian population shall respect these wounded and sick, and in particular abstain from offering them violence.”

(d) Military personnel who are at sea and are wounded, sick or shipwrecked, by whatever cause, are entitled to the same respect and protection.

(e) The GWS does not define what “wounded or sick” means, nor has there ever been any definition of the degree of severity of a wound or a sickness entitling the wounded or

sick combatant to respect. Any definition would necessarily be restrictive in character and would thereby open the door to misinterpretation and abuse. The meaning of the words “wounded and sick” is thus a matter of common sense and good faith. It is the act of laying down of arms because of a wound or sickness, which constitutes the claim to protection.

(f) The benefits afforded the wounded and sick extend not only to members of the armed forces, but to other categories of persons as well, classes of whom are specified in Article 13, GWS. Even though a wounded person is not in one of the categories enumerated in the Article, we must still respect and protect that person. There is a universal principle that says that any wounded or sick person is entitled to respect and humane treatment and the care, which his condition requires. Wounded and sick civilians have the benefit of humanitarian safeguards. It is the best practice to treat all sick or wounded adversary citizens as detainees, entitled to treatment, until their status can be determined otherwise.

(2) The second paragraph of Article 12, GWS, provides that the wounded and sick “...shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria...”

(a) All adverse distinctions are prohibited. Nothing can justify an adversary in making any adverse distinction between wounded or sick who require his attention, whether they are friend or foe. Both are on equal footing in the matter of their claims to protection, respect, and care. The foregoing is not intended to prohibit concessions, particularly with respect to food, clothing, and shelter, which take into account the different national habits and backgrounds of the wounded and sick.

(b) The wounded and sick shall not be made the subjects of biological, scientific, or medical experiments of any kind that are not justified on medical grounds and dictated by a desire to improve their condition.

(c) The wounded and sick shall not willfully be left without medical assistance, nor shall conditions exposing them to contagion or infection be created.

(3) The only reason that can justify priority in the order of treatment are reasons of medical urgency. This is not so much an exception to the principle of equality of treatment of the wounded as it is recognition of the legitimacy of triage. So long as adversary patients are triaged on an equal footing with allied patients, triage is justified. An adversary can never refuse to care for adversary wounded on the pretext that his adversary has abandoned them without medical personnel and equipment.

(4) Paragraph 5 of Article 12, GWS, provides that if we must abandon wounded or sick, we have a moral obligation to, “as far as military considerations permit,” leave medical supplies and personnel to assist in their care. This provision is in no way bound up with the absolute obligation imposed by paragraph 2 of Article 12 to care for the wounded.

c. **Adversary Wounded and Sick.** The protections accorded the wounded and sick apply to friend and foe alike without distinction. Certain provisions of the GWS, however, specifically concern adversary wounded and sick. There are also provisions in the GPW, which because they apply to POWs generally, also apply to adversary wounded or sick.

(1) Article 14 of the GWS states that the wounded and sick of a belligerent who are captured have the status of POWs. However, that wounded adversary is also a person who needs treatment. Therefore, a wounded adversary who falls into the hands of an adversary who is a Party to the GWS and the GPW, such as the US, will enjoy protection under both Conventions until his recovery.

(2) Article 16 of the GWS requires the recording and forwarding of information regarding adversary wounded, sick, or dead.

(3) When intelligence indicates that large numbers of EPWs may result from an operation, medical units may require reinforcement to support the anticipated additional EPW patient workload.

d. **Search for and Collection of Casualties.** Article 15 of the GWS imposes a duty on combatants to search for and collect the dead and wounded and sick as soon as circumstances permit. It is left to the tactical commander to judge what is possible and to decide to commit his medical personnel to this effort. If circumstances permit, an armistice or suspension of fire should be arranged to permit this effort.

e. **Assistance of the Civilian Population.** Article 18, GWS, addresses the civilian population. It allows military authorities to ask the civilians to collect and care for wounded or sick of whatever nationality. This provision does not relieve the military authorities of their responsibility to give both physical and moral care to the wounded and sick. The GWS also reminds the civilian population that they must respect the wounded and sick, and in particular, must not injure them.

f. **Adversary Civilian Wounded and Sick.** Certain provisions of the GC are relevant to the HSS mission.

(1) Article 16 of the GC provides that adversary civilians who are “wounded and sick, as well as the infirm, and expectant mothers shall be the object of particular protection and respect.” The Article also requires that, “as far as military considerations allow, each Party to the conflict shall facilitate the steps taken to search for the killed and wounded (civilians), to assist...other persons exposed to grave danger, and to protect them against pillage and ill-treatment [emphasis added].”

(a) The “protection and respect” to which wounded and sick adversary civilians are entitled is the same as that accorded to wounded and sick adversary military personnel.

(b) While Article 15 of the GWS requires Parties to a conflict to search for and collect the dead and wounded and sick members of the armed forces, Article 16 of the GC states that the Parties must “facilitate the steps taken” in regard to civilians. This recognizes the fact that saving civilians is the responsibility of the civilian authorities rather than of the military. The military is not required to provide injured civilians with medical care in a combat zone. However, if we start providing treatment, we are bound by the provisions of the GWS.

(2) In **occupied territories**, the Occupying Power must accord the inhabitants numerous protections as required by Part III, Section III, GC. The provisions relevant to medical care include the:

(a) Requirement to bring in medical supplies for the population if the resources of the occupied territory are inadequate.

(b) Prohibition on requisitioning medical supplies except for use by occupation forces and administration personnel unless the requirements of the civilian population have been taken into account. Fair value must be paid for the requisitioned goods.

(c) Duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health, and hygiene in the occupied territory.

(d) Requirement that medical personnel of all categories be allowed to carry out their duties.

(e) Prohibition on requisitioning civilian hospitals on other than a temporary basis and then only in cases of urgent necessity for the care of military wounded and sick and only so long as suitable arrangements are made for the civilian patients in due time. Prohibition on requisitioning the material and stores of civilian hospitals so long as they are necessary for the needs of the civilian population.

(f) Requirement to provide adequate medical treatment to detained persons. Requirement to provide adequate medical care in internment camps.

4. Protection and Identification of Medical Personnel

a. Article 24 of the GWS provides special protection for “Medical personnel *exclusively engaged* in the search for, or the collection, transport, or treatment of the wounded or sick, or in the prevention of disease, [and] staff *exclusively engaged* in the administration of medical units and establishments . . . [emphasis added].” Article 25 provides limited protection for “Members of the armed forces *pecially trained* for employment, should the need arise, as hospital orderlies, nurses, or auxiliary stretcher-bearers, in the search for or the collection, transport, or treatment of the wounded and sick . . . *if they are carrying out these duties at the time when they come into contact with the enemy or fall into his hands* [emphasis added].”

b. **Protection.** There are two separate and distinct forms of protection.

(1) The first is protection from intentional attack if medical personnel are identifiable as such by an adversary in a combat environment. Normally this is facilitated by medical personnel wearing an arm band bearing the distinctive emblem (a red cross or red crescent on a white background), or by their employment in a medical unit, establishment, or vehicle (including medical aircraft and hospital ships) that displays the distinctive emblem. Persons protected by Article 25 may wear an armband bearing a miniature distinctive emblem only while executing medical duties.

(2) The second protection provided by the GWS pertains to medical personnel who fall into the hands of the adversary. Article 24 personnel are entitled to “retained personnel” status. They are not deemed to be POWs, but otherwise benefit from the protections of the GPW. They are authorized to carry out medical duties only, and “shall be retained only in so far as the state of health . . . and the number of POWs require.” Article 25 personnel are POWs, but shall be employed to perform medical duties in so far as the need arises. They may be required to perform other duties or labor, and they may be held until a general repatriation of POWs is accomplished upon the cessation of hostilities.

c. **Specific Cases.** Personnel assigned to medical units fall into the category identified in Article 24 provided they meet the “exclusively engaged” criteria of that article. While it is not a violation of the GWS for Article 24 personnel to perform nonmedical duties, it should be understood, however, that Article 24 personnel lose their protected status under that article if they perform duties or tasks inconsistent with their noncombatant role. Should those personnel later take up their medical duties again, a reasonable argument might be made that they cannot regain Article 24 status since they have not been exclusively engaged in medical duties and that such switching of roles might at best cause such personnel to fall under the category identified in Article 25.

(1) Article 24 personnel who might become Article 25 personnel by virtue of their switching roles could include the following:

(a) A medical company commander, executive officer, or a physician detailed as convoy march unit commander with responsibility for medical and nonmedical unit routes of march, convoy control, defense, and repulsing attacks.

(b) Helicopter pilots who are permanently assigned to a dedicated medical aviation unit to fly MEDEVAC helicopters, but fly helicopters not bearing the red cross emblem on standard combat missions during other times.

(2) The GWS does not itself prohibit the use of Article 24 personnel in perimeter defense of nonmedical units such as logistics areas or base clusters under overall security defense plans, but the policy of DOD is that Article 24 personnel will not be used for this purpose. Adherence to this policy should avoid any issues regarding their status under the GWS due to a

temporary change in their role from noncombatant to combatant. Medical personnel may guard their own unit without any concurrent loss of their protected status.

d. **Identification Cards and Armbands.** Medical personnel who meet the “exclusively engaged” criteria of Article 24, GWS, are entitled to wear an armband bearing the distinctive emblem of the Red Cross and carry the medical personnel ID card authorized in Article 40, GWS (in the US Armed Services, DD Form 1934). Article 25 personnel and medical personnel serving in positions that do not meet the “exclusively engaged” criteria of Article 24 are not entitled to carry the medical personnel ID card or wear the distinctive emblem armband. Such personnel carry a standard military ID card (DD Form 2A) and, under Article 25, may wear an armband bearing a miniature distinctive emblem when executing medical duties.

5. Protection and Identification of Medical Units, Establishments, Buildings, Materiel, and Medical Transports

a. **Protection.** There are two separate and distinct forms of protection.

(1) The first is protection from intentional attack if medical units, establishments, or transports are identifiable as such by an adversary in a combat environment. Normally, this is facilitated by medical units or establishments flying a white flag with a red cross and by marking buildings and transport vehicles with the distinctive emblem.

(a) It follows that if we cannot attack recognizable medical units, establishments, or transports, we should allow them to continue to give treatment to the wounded in their care as long as this is necessary.

(b) All vehicles employed exclusively on medical transport duty are protected on the battlefield. However, if they fall into enemy hands they are subject to the law of war. Medical vehicles being used for both military and medical purposes, such as moving wounded personnel during an evacuation and carrying retreating adversaries are not entitled to protection.

(c) Medical aircraft, like medical transports, are protected from intentional attack, but with a major difference — they are protected only “while flying at heights, times, and on routes specifically agreed upon between the belligerents concerned,” (Article 36, GWS). Such agreements may be made for each specific case or may be of a general nature, concluded for the duration of hostilities. If there is no agreement, flights over enemy or enemy-occupied terrain receive no special protection.

(d) Article 37, GWS specifies that “medical aircraft of Parties to the conflict may fly over the territory of neutral Powers, land on it in case of necessity, or use it as a port of call.” The medical aircraft will “give the neutral Powers previous notice of their passage over the said territory and obey all summons to alight, on land or water.” The aircraft will be “immune from attack only when flying on routes, at heights and at times specifically agreed upon between the Parties to the conflict and the neutral Power concerned.” It further states that “the neutral Powers

may, however, place conditions or restrictions on the passage or landing of medical aircraft on their territory, so long as those conditions or restrictions apply equally to all Parties of the conflict.”

(e) According to GWS Sea, Article 28, should fighting occur on board a warship, the sick-bays shall be respected and spared as far as possible. Sick-bays and their equipment shall remain subject to the laws of warfare, but may not be diverted from their purpose so long as they are required for the wounded and sick. Nevertheless, the commander into whose power they have fallen may, after ensuring the proper care of the wounded and sick who are accommodated therein, apply them to other purposes in case of urgent military necessity.

(f) According to GWS Sea, Chapter III, hospital ships may not be attacked or captured, provided their names and descriptions have been provided to the adversary at least ten days before they are deployed. Hospital ships lose protection if they are used for any military purpose or commit acts harmful to the adversary. Possession of secret codes for radios or other means of communication by a hospital ship is considered an act harmful to the adversary, but US policy has been to equip its hospital ships with encrypted communication in order to allow for communication between the hospital ship and other naval vessels or commands.

(g) The second paragraph of Article 19 GWS imposes an obligation upon commanders to “ensure that the said medical establishments and units are, as far as possible, situated in such a manner that attacks against military objectives cannot imperil their safety.” Hospitals should be sited alone, as far as possible from military objectives. The unintentional bombardment of a medical establishment or unit due to its presence among or in proximity to valid military objectives is not a violation of the GWS. Legal protection is certainly valuable, but it is more valuable when accompanied by practical safeguards.

(2) The second protection provided by the GWS pertains to medical units, establishments, materiel, and transports that fall into the hands of the adversary.

(a) Captured mobile medical unit materiel is to be used first to treat the patients in the captured unit. If there are no patients in the captured unit, or when those who were there have been moved, the materiel is to be used for the treatment of other wounded and sick persons.

(b) Generally, the buildings, materiel, and stores of fixed medical establishments will continue to be used to treat wounded and sick. However, after provision is made to care for remaining patients, tactical commanders may make other use of them. All distinctive markings must be removed if the buildings are to be used for other than medical purposes.

(c) The materiel and stores of fixed establishments and mobile medical units are not to be intentionally destroyed, even to prevent them from falling into adversary hands.

(d) Medical transports that fall into adversary hands may be used for any purpose once arrangement has been made for the medical care of the wounded and sick they contain. The distinctive markings must be removed if they are to be used for nonmedical purposes.

(e) A medical aircraft is supposed to obey a summons to land for inspection. If it is performing its medical mission, it is supposed to be released to continue its flight. If examination reveals that an act “harmful to the enemy” (for example, if the aircraft is carrying munitions) has been committed, it loses the protections of the Conventions and may be seized. If a medical aircraft makes an involuntary landing, all aboard, except the medical personnel (who will be retained personnel), will be POWs. A medical aircraft refusing a summons to land does so at its own risk and is a lawful target.

b. **Identification.** The GWS contains several provisions regarding the use of the Red Cross emblem on medical units, establishments, and transports (the ID of medical personnel has been previously discussed).

(1) Article 39 of the GWS reads as follows: “Under the direction of the competent military authority, the emblem shall be displayed on the flags, armlets, and on all equipment employed in the Medical Service.”

(a) There is no obligation of an adversary to mark his units with the emblem. Sometimes a commander may order the camouflage of his medical units in order to conceal the presence or real strength of his forces. The adversary must respect a medical unit if he knows of its presence, even one that is camouflaged or not marked. The absence of a visible Red Cross emblem, however, coupled with a lack of knowledge on the part of the adversary as to the unit’s protected status, may render that unit’s protection valueless.

(b) The distinctive emblem is not a red cross alone; it is a red cross on a white background. Should there be some good reason, however, why an object protected by the Convention can only be marked with a red cross without a white background, adversaries may not make the fact that it is so marked a pretext for refusing to respect it.

(c) Some countries use a red crescent on a white background in place of a red cross. This emblem is recognized as an authorized exception under Article 38, GWS. Although not specifically authorized as a symbol in lieu of the Red Cross, enemies of Israel in past wars have recognized the red Star of David and have afforded it the same respect as the Red Cross. This showed compliance with the general rule that the wounded and sick must be respected and protected when they are recognized as such, even when not properly marked.

NOTE: The Geneva Conventions authorizes the use of the following distinctive emblems on a white background: Red Cross; Red Crescent; and Red Lion and Sun. In operations conducted in countries using an emblem other than the Red Cross on a white background, US personnel must be made aware of the different official emblems. US forces are legally entitled to only display the Red Cross. However, commanders have authorized the display of both the Red Cross and the Red Crescent to accommodate HN concerns and to ensure that confusion of emblems would not occur. Such use of the Red Crescent must be of a smaller size than the Red Cross.

(d) The initial phrase of Article 39 shows that it is the military commander who controls the emblem and can give or withhold permission to use it. He is at all times responsible

for the use made of the emblem and must see that it is not improperly used by the troops or by individuals.

(2) Article 42 of the GWS specifically addresses the marking of medical units and establishments.

(a) “The distinctive flag of the Convention shall be hoisted only over such medical units and establishments as are entitled to be respected under the Convention, and only with the consent of the military authorities.” (Paragraph 1, Article 42, GWS) Although the Convention does not define “the distinctive flag of the Convention,” what is meant is a white flag with a red cross in its center. Also, the word “flag” must be taken in its broadest sense. Hospitals are often marked by one or several Red Cross emblems painted on the roof. Finally, the military authority must consent to the use of the flag (see the above comments on Article 39) and must ensure that the flag is used only on buildings entitled to protection.

(b) “In mobile units, as in fixed establishments, [the distinctive flag] may be accompanied by the national flag of the Party to the conflict to which the unit or establishment belongs.” (Paragraph 2, Article 42, GWS) This provision makes it optional to fly the national flag with the Red Cross flag. It should be noted that on a battlefield, the national flag is a symbol of belligerency and is therefore likely to provoke attack.

NOTE: There is no such thing as a “camouflaged” Red Cross. When camouflaging a medical unit or ambulance, either cover up the Red Cross or take it down. A black cross on an olive drab or any other background is not a symbol recognized under the Geneva Conventions.

6. Loss of Protection of Medical Establishments and Units

Medical assets lose their protected status by committing acts “harmful to the enemy.” (Article 21, GWS.) A warning must be given to the offending unit and a reasonable amount of time allowed to cease such activity.

a. **Acts Harmful to the Adversary.** The phrase “acts harmful to the enemy” is not defined in the Convention, but should be considered to include acts the purpose or effect of which is to harm the adversary, by facilitating or impeding military operations. Such harmful acts would include, for example, the use of a hospital as a shelter for able-bodied combatants, as an arms or ammunition dump, or as a military observation post. Another instance would be deliberately locating a medical unit in a position where it would impede an adversary attack. Treating wounded and sick military personnel is not considered an act “harmful to the enemy” for purposes of the Convention.

b. **Warning and Time Limit.** The adversary has to warn the unit to put an end to the harmful acts and must fix a time limit on the conclusion of which he may open fire or attack if the warning has not been complied with. The phrase “in all appropriate cases” recognizes that there might obviously be cases where no time limit could be allowed. A body of troops approaching a hospital and met by heavy fire from every window would return fire without delay.

c. **Use of Smoke and Obscurants.** The use of smoke and obscurants during MEDEVAC operations for signaling or marking landing zones does not constitute an act harmful to the adversary. However, employing such devices to obfuscate a medical element's position or location is tantamount to camouflaging; it would jeopardize its entitlement privilege status under the GWS.

7. Conditions not Depriving Medical Units and Establishments of Protection

a. Article 22 of the GWS reads as follows: "The following conditions shall not be considered as depriving a medical unit or establishment of the protection guaranteed by Article 19, that the:

(1) Personnel of the unit or establishment are armed, and that they use the arms in their own defense, or in that of the wounded and sick in their charge.

(2) Absence of armed orderlies, the unit or establishment is protected by a picket or by sentries or by an escort.

(3) Small arms and ammunition taken from the wounded and sick and not yet handed to the proper service, are found in the unit or establishment.

(4) Personnel and materiel of the veterinary service are found in the unit or establishment, without forming an integral part thereof.

(5) Humanitarian activities of medical units and establishments or of their personnel extend to the care of civilian wounded or sick."

b. These five conditions are not to be regarded as acts harmful to the adversary. These are particular cases where a medical unit retains its character and its right to immunity, in spite of certain appearances that might lead to a contrary conclusion or, at least, created some doubt.

(1) **Defense of Medical Units and Self-defense by Medical Personnel.** A medical unit is granted a privileged status under LOAC. This status is based on the view that medical personnel are not combatants and that their role in the combat area is exclusively a humanitarian one. In recognition of the necessity of self-defense, however, medical personnel may be armed for their own defense or for the protection of the wounded and sick under their charge. To retain this privileged status, they must refrain from all aggressive action and may only employ their weapons if attacked in violation of the Conventions. They may not employ arms against adversary forces acting in conformity with LOAC and may not use force to prevent the capture of their unit by the adversary (it is, on the other hand, perfectly legitimate for a medical unit to withdraw in the face of the adversary). Medical personnel who use their arms in circumstances not justified by the law of land warfare expose themselves to penalties for violation of the LOAC and, provided they have been given due warning to cease such acts, may also forfeit the protection of the medical unit or establishment which they are protecting.

(a) Medical personnel may carry only small arms, such as rifles or pistols or authorized substitutes.

(b) The presence of machine guns, grenade launchers, booby traps, hand grenades, light antitank weapons, or mines (regardless of the method by which they are detonated) in or around a medical unit or establishment could seriously jeopardize its entitlement to privileged status under the GWS. The **deliberate arming** of a medical unit with such items could constitute an act harmful to the adversary and cause the medical unit to lose its protection, regardless of the location of the medical unit.

(2) **Guarding Medical Units.** As a rule, a medical unit is to be guarded by its own personnel. However, it will not lose its protected status if the guard is performed by a number of armed military personnel. The military guard attached to a medical unit may use its weapons, just as armed medical personnel may, to ensure the protection of the unit. But, as in the case of medical personnel, the armed personnel may only act in a purely defensive manner and may not oppose the occupation or control of the unit by an adversary who is respecting the unit's privileged status. The status of such armed personnel is that of ordinary members of the armed forces. The mere fact of their presence with a medical unit will shelter them from attack. In case of capture, they will be POWs.

(3) **Arms and Ammunition Taken from the Wounded.** Wounded persons arriving in a medical unit may still be in possession of small arms and ammunition, which will be taken from them and handed to authorities outside the medical unit. Should a unit be captured by the adversary before it is able to get rid of these arms, their presence is not of itself cause for denying the protection to be accorded the medical unit under the GWS.

(4) **Personnel and Materiel of the Veterinary Corps.** The presence of personnel and materiel of the Veterinary Corps with a medical unit is authorized, even where they do not form an integral part of such unit.

(5) **Care of Civilian Wounded or Sick.** A medical unit or establishment protected by the GWS may take in civilians as well as military wounded and sick without jeopardizing its privileged status. This clause merely sanctions what is actually done in practice.

8. Medical Care for Retained and Detained Personnel

Definitions

a. The term **detainee** refers to any person captured or otherwise detained by an armed force.

b. The term, **retained personnel** is defined as "Enemy personnel who come within any of the categories below are eligible to be certified as retained personnel.

- (1) Medical personnel exclusively engaged in the:
 - (a) Search for, collection, transport, or treatment of the wounded or sick.
 - (b) Prevention of disease.
 - (c) Staff administration of medical units and establishments exclusively.
- (2) Chaplains attached to enemy armed forces.
- (3) Staff of national Red Cross societies and other voluntary aid societies duly recognized and authorized by their governments. The staffs of such societies must be subject to military laws and regulations.”

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APPENDIX J

MEDICAL ASPECTS OF REINTEGRATION

1. General

The purpose of this appendix is to describe medical processing of recovered isolated US military, DOD civilian and DOD contractor personnel who have been POWs, were held hostage by terrorists, were detained in peacetime by a hostile foreign government, were evading enemy capture, or were otherwise missing. The objective of medical reintegration is to provide returnees with appropriate and complete medical evaluation and treatment, to establish a detailed medical record for future reference, to maintain or restore dignity, and to facilitate readjustment to society. JP 3-50, *Personnel Recovery*, refers to reintegration as one of the five execution tasks of personnel recovery (PR): report, locate, support, recover, and reintegrate.

a. Reintegration is a critical, straightforward task that allows DOD to gather necessary tactical and strategic survival, evasion, resistance, and escape (SERE) information while protecting the health and well-being of returned isolated personnel. Qualified SERE and intelligence debriefers who gather information from recovered isolated personnel, SERE psychologists who assist the recovered isolated personnel to decompress and reintegrate to their unit, family and society, **and qualified medical personnel** who care for the physical well being of returned isolated personnel are key to the successful accomplishment this task.

b. The combatant command's PR directive, the OPLAN/OPORD, and PR CONOPS should specify the required PR debrief and reintegrate (D&R) teams and their composition and responsibilities. The JFC's PR D&R team chief will be responsible for the promulgation and execution of the D&R plan and the oversight of, and assistance to, component PR D&R teams. The joint personnel recovery center (JPRC) should coordinate all joint requirements necessary to conduct D&R phases I and II (as described below). The scope and complexity of the process will vary depending on the classification of the recovered isolated personnel (i.e., survivors and evaders may require less debriefing and psychological attention than captives, detainees, and POWs) and their physical and mental condition. **Medical stability is the top priority of all debriefing and reintegration processes**, but gathering time sensitive information that has the potential to save others during on-going hostilities can be equally important in some circumstances. **Medical personnel must have an understanding of the operational needs of the debriefing and reintegration process** so they can help and not hinder this important process.

2. Debrief and Reintegrate Process

D&R is a process that consists of five essential steps. Medical and psychological personnel are responsible for three of those steps. The medical community must remember that D&R is an operational mission. The medical community supports this mission by assuring the health and well-being of the returned isolated individuals.

a. **Medical Stabilization.** Returning isolated individuals should receive a comprehensive medical triage and any medical treatment necessary to medically stabilize the returnee should be conducted.

b. **Tactical Debriefing.** Tactical debriefs are designed to obtain specific time sensitive information that has the potential of saving lives in the on-going operational environment. Information such as the location of other isolated individuals or position and strength of enemy forces can have significant impact if the information can be gathered and distributed in a timely manner.

c. **Medical Treatment.** After the tactical debriefing is completed, necessary medical treatment becomes the number one priority. In-depth debriefing may continue, but medical treatment takes precedence.

d. **Debriefing.** The debriefs are designed to obtain specific information regarding the experience of recovered isolated personnel. Intelligence and SERE debriefs may run separately or concurrently as dictated by mission circumstances, but must be coordinated with one another and deconflicted with ongoing medical treatment needs.

e. **Reintegrate.** Reintegration begins at the moment the recovered individual enters US control and continues until a final disposition of duty status. This task is primarily focused on the decompression of the recovered isolated personnel and is monitored or conducted by a SERE psychologist certified by Joint Personnel Recovery Agency. Decompression is a critical element that can prevent psychological damage to the recovered isolated personnel and the loss of accuracy in recalling critical intelligence and operational information. The SERE psychologist:

(1) Provides an explanation of the D&R procedures to include the behavioral assessment.

(2) Conducts a behavioral assessment and addresses critical elements of capture, detention/captivity, long-term evasion, and liberation in terms of their impact on the adjustment of recovered isolated personnel.

(3) Monitors and coordinates all aspects of the D&R task, to ensure the health and stamina of recovered isolated personnel are maintained.

(4) Provides the behavioral assessment of the recovered isolated personnel to the D&R team leader who makes the recommendation on disposition (i.e., return to duty or continue to next phase) to the component commander.

3. Debrief and Reintegrate Phases

a. **Phases.** D&R is normally conducted in three phases, the first two are directed by the CCCR in coordination with the Services, and the final phase is conducted by the Services in CONUS. Phase I encompasses the process of transporting the recovered isolated person to a

safe area to conduct initial debriefing and reintegration. Phase I will end with the recovered isolated personnel being returned to duty or recommended for Phase II. Phase II encompasses the transition from Phase I to a theater treatment and process facility and further SERE and intelligence debriefings and/or decompression treatment. Phase II will end with the recovered isolated personnel being released to duty or recommended for Phase III.

(1) **Phase I** is a component responsibility and managed by the PR coordination cell. All isolated personnel must undergo Phase I. Based on the D&R team chief's recommendation and theater guidance, the component commander should have the authority to reintegrate isolated personnel to their DOD duties or transfer them to the next phase. Phase I can begin as soon as the recovered isolated personnel are in the care of the component's D&R team and must be accomplished as soon as possible. The D&R team chief will determine the most appropriate place and means to accomplish Phase I. Based on the CCCR's guidance, and component requirements, Phase I will normally consist of:

- (a) Immediate medical attention.
- (b) An intelligence debrief to collect any appropriate tactical/perishable intelligence and/or any appropriate isolated personnel ID and status information.
- (c) Information debriefs necessary to collect perishable SERE information and determine whether recovered isolated personnel can be returned to duty or require additional time for decompression and medical treatment.
- (d) The component D&R team chief recommends the disposition of the recovered isolated personnel to the component. This should be done after consultation with medical authorities and the SERE psychologist.

(2) **Phase II** will be conducted at the theater designated facility (this is usually a regional hospital) where the recovered isolated personnel will receive more structured SERE and intelligence debriefings, medical attention, and the decompression process will begin in earnest. Phase II should be managed by the JPRC and executed by the CCCR's designated joint D&R team. The theater D&R team should have Service component representation to keep component commanders informed on the status of their recovered isolated personnel. After completion of the gathering of time sensitive information medical and mental health needs take top priority in the D&R process.

- (a) The D&R team chief will ensure coordination with other members of the CCCR's staff who are involved in the administrative processing of the recovered isolated personnel or require proprietary debriefings (or they may be part of the team). The D&R team chief will be charged with prioritizing and monitoring, in coordination with the SERE psychologist and medical authorities, all D&R and other reintegration processes to prevent confusing the recovered isolated personnel or damaging their mental health.

(b) An inherent, and critical part of the reintegration process are the decompression protocols. The long-term successful reintegration of recovered isolated personnel into military and social/civil environments is directly affected by proper decompression. Protocols have been established to maximize the benefit of decompression and, at the very least under “normal” conditions, require a minimum of 72 hours to be effective. Deviating from established protocols can have a severe impact and, under certain circumstances, create permanent psychological trauma to the recovered isolated personnel. From past detention incidents, this trauma has manifested itself in recovered isolated personnel separating themselves from military Service, having dysfunctional family relationships, and, in severe cases, committing suicide.

(c) Phase II is where reintegration with family members may begin initially with contact by telephone. Rarely is there any benefit for family members to travel to Phase II locations. In fact, until decompression/debriefing is complete, the primary concern of recovered isolated personnel is the objective assessment of how they conducted themselves while isolated — they have a need to know the answer to “did I conduct myself well and with honor?”

(d) The D&R team chief determines the completion of Phase II and recommends the disposition of the recovered isolated personnel to the respective component commander or CCCR. The decision is made to either return the recovered isolated personnel to their DOD duties or transfer them into Phase III where the recovered isolated personnel will come under the control of their respective Service in CONUS.

(3) **Phase III.** Phase III begins with the transition of the recovered isolated personnel to a Service designated CONUS location. A designated personal escort, PA representative, physician, chaplain, and SERE psychologist normally will accompany the recovered isolated personnel. Phase III does not have a prescribed time limit and depends on coordinated needs of the Service, SERE and intelligence debriefers, medical needs and the SERE psychologist.

b. **Process Flexibility.** Though conducted by phase, the critical tasks within each phase are not necessarily conducted sequentially or on a rigid time schedule. Latitude and flexibility remain with the component commander to accomplish D&R within the context of ongoing military operations.

For more information on debriefing and reintegration see JP 3-50, Personnel Recovery.

4. Challenges During Debriefing and Reintegration

The greatest challenge during D&R is when well-intended actions are implemented without understanding their full ramifications. These actions may impact the reintegration of recovered isolated personnel into a healthy family, social, and professional life. The following are some of the common ways that senior executives have negatively impacted the reintegration process while trying to be helpful.

a. **Overwhelming the Recovered Isolated Personnel with a Show of Support.** Regardless of how well they performed during isolation, all recovered isolated personnel are in a mild state

of shock when they return and need time to regroup. Parades, bands, media events, ceremonies, and celebrations have their place but not during the early stages of D&R. These types of activities serve to increase the state of shock of recovered isolated personnel and usually end up overwhelming them and complicating the reintegration process.

b. **Awarding Medals too Early.** Expediting medal processing is not recommended as it takes time for recovered isolated personnel to work through the intensity of their emotional reactions to the isolating event. Medals that are given while recovered isolated personnel are still struggling with intense emotional reactions complicates the D&R process and in many cases isolates/alienates recovered isolated personnel from unit members.

c. **White House and Command Presentations/Visits.** Attempts to honor recovered isolated personnel with high level visits serve necessary political purposes but are not in the best interest of the recovered isolated personnel if conducted during the early stages of D&R. Recovered isolated personnel will remember these events as positive if they are conducted at the proper time and IAW the wishes of the recovered isolated personnel. Brief telephone calls may be appropriate during early stages if coordinated with the D&R team.

d. **Transporting Families to Phase I and Phase II Locations.** Families are an essential part of reintegration. Introducing families too early not only complicates the reintegration process but it is harmful to long-term family relationships. Recovered isolated personnel try to protect families from the horrors of their ordeal while family members tend to overwhelm recovered isolated personnel and do not allow them time to decompress. Recovered isolated personnel should be allowed to make telephone contact with families during the early stages of the reintegration process. Family reunions are more appropriate when the D&R process is nearing completion or when recovered isolated personnel return to CONUS.

5. Follow-Up

SERE psychologists should follow-up with recovered isolated personnel, as needed, for at least one year. All POWs are eligible for follow-up medical and psychological services at the Robert Mitchell Center for Repatriated POW Studies. Intelligence organizations may require follow-up contact with recovered isolated personnel to pursue additional intelligence requirements, particularly to support investigations of unresolved POW and/or missing in action incidents.

6. Specific Operational Medical Duties

Medical personnel play a key role in the successful debriefing and reintegration of returned isolated personnel. The SERE psychologists duties are well defined, require specialized training, and are described in detail in other DODI 2310.4, *Repatriation of Prisoners of War (POW), Hostages, Peacetime Government Detainees and Other Missing or Isolated Personnel*, JP 3-50, *Personnel Recovery*, and in specific theater plans. This section describes some of the medical responsibilities during D&R operations.

a. **Medical Triage and Evaluation.** Many recovered isolated personnel have been through physically traumatic experiences such as plane crashes, or armed conflict and require immediate hands-on medical triage/evaluation and treatment for life threatening injuries/conditions. Often, in the excitement of recovering an isolated person medics will look at the returnee and if there are no obvious injuries they will ask, “Are you okay?”, however, a hands-on medical evaluation is necessary to prevent missing serious medical conditions that may go undetected in a returnee suffering from shock.

b. **Medical Evacuation.** Isolated personnel are often evacuated through established MEDEVAC systems. It is essential that individuals who are isolated together remain together throughout the D&R process, this includes MEDEVAC transportation if possible. It is essential that all recovered isolated personnel are initially MEDEVAC to the same facility. Nonessential personnel should not be allowed on any MEDEVAC transportation. If nonessential personnel must be on the same transportation they should not have any interaction with returnees. At times debriefers and SERE psychologists will travel with the returnees, these individuals should be considered essential personnel.

c. **Return to Duty Recommendation.** Not all recovered isolated personnel will require Phase II and III. Often definitive medical care will take place at the forward location. The lead medical person is responsible to consult with the operational debriefing and reintegration team chief and the SERE psychologist in making return to duty recommendations.

APPENDIX K

HEALTH SERVICE SUPPORT PLANNING CHECKLISTS

SECTION A. HEALTH SERVICE SUPPORT CHECKLIST FOR CIVIL SUPPORT OPERATIONS

1. General Mission Analysis Considerations

a. What type of operation is being considered?

(1) Is the joint operation a civil support mission? If it is a civil support operation, is the mission DSCA?

(a) Is the DSCA mission for disaster response non-CBRN, or domestic CBRN CM?

(b) Is the DSCA mission military assistance to civil law enforcement agencies for counter drugs, national special security event, combating terrorism or maritime security operations?

(2) Will the supported population for the operation comprise of federal agency employees, government contractors, nongovernmental organization personnel (American Red Cross workers/volunteers), and/or civilian personnel (victims and rescuers)?

(3) Will HSS units provide HSS only to military personnel deployed in support of the operation or will care be provided to the civilian population?

(4) Has a determination regarding eligibility for care for nonmilitary personnel been established?

b. What agencies are involved in the operation?

(1) What agency has the primary responsibility for the operation?

(2) Will the military chain of command be organized as a JTF?

(3) What is the HSS capability of participating agencies?

(4) Will civilian or interagency HSS facilities be utilized (clinics, health centers, or hospitals)?

(a) What capabilities do they possess?

(b) Will they require augmentation by military medical personnel?

(c) Can HSS resources be shared?

c. How is the operation being funded?

(1) What agency has primary responsibility for funding the operation?

(2) Are there restrictions on the use of certain funds?

(3) What record keeping is required to ensure reimbursement?

(4) What military funds will be utilized to sustain HSS?

d. How will the credentialing and scope of practice for medical professionals be managed?

(1) How will military health care professionals that augment civilian MTFs in the JOA be credentialed? And, will there be limits to their scope of practice?

(2) Will nonmilitary health care professionals be authorized to assist or augment JTF MTFs in the JOA?

(a) If yes, how will they be credentialed?

(b) Will there be limits to their scope of practice?

e. What is the terrorist threat in the JOA?

2. Preventive Medicine Considerations

a. What is the medical threat within the JOA?

(1) What are the endemic or epidemic disease threats?

(2) Are there hazardous flora and fauna in the JOA?

(3) What are the environmental and occupational health threats?

(4) Is there a threat from the potential use of CBRN warfare agents?

b. Will there be clinical and environmental laboratory support for the diagnosis of diseases?

(1) What laboratory capabilities will medical units deployed during the operation possess?

(2) If laboratory capability is not sufficient in the JOA, where will this support be obtained?

(3) Are civilian laboratories available in the JOA to process laboratory specimens required to diagnosis disease?

c. Will laboratory support provide for the ID and confirmation of biological and chemical warfare agents and support selected biomonitoring requirements?

(1) Will there be a laboratory in the JOA with the capability and certification to test and provide field confirmation of suspected biological and chemical agents?

(2) If this capability is not available in the JOA, how will this support be obtained?

(3) How will the chain of custody be maintained for these biological and chemical specimens?

(4) Will laboratory support be available in the JOA to support any in-theater biomonitoring requirements for the documentation of selected exposures to chemical warfare agents or environmental agents?

d. Will there be requirements for pest management operations in the JOA?

e. Will the lead federal agency require military augmentation for food, water, air, and general sanitation inspections in the JOA?

3. Health Service Support Facilities and Hospitalization Considerations

a. What MTFs and HSS resources are planned for the JOA?

(1) What is the total number of medical and surgical beds and ancillary support services required for the mission?

(2) Will organic dental resources be deployed?

(3) Where will dental resources be located?

(4) Where will pharmacy resources be located?

b. How will MTFs and HSS resources document the furnished medical/dental care?

c. What HSS resources are already in the JOA? And what are their capabilities?

(1) What are the total number of military, VA, and NDMS MTFs in the JOA?

- (a) What is their medical and surgical bed holding capabilities?
- (b) What is the scope of their ancillary service support capability?
- (c) What are their bed surge capabilities at designated intervals?
- (d) Will these MTFs require medical augmentation for the operation/scenario?
- (2) What are the names and locations of supporting NDMS FCCs in the JOA?
- (3) What are the total numbers and capabilities of non-NDMS participating civilian medical treatment facilities in the JOA?
- (4) What is the throughput capacity for the patient reception areas in the JOA?
- (5) Will patients require further evacuation for definitive treatment?

d. During disaster relief operations, what mental health support will be available for victims, caregivers, and rescuers?

- (1) Will the JTF be required to provide mental health support to other agencies and individuals supporting the operation?
- (2) Will civilian mental health organizations be available to provide support to victims, caregivers, and rescuers?

e. Will interpreters be available as required, to translate patient complaints to attending medical personnel?

f. What mental health intervention support will be available should a terrorist incident occur?

4. Medical Regulating and Evacuation Considerations

- a. What infrastructure is available for patient evacuation?
- b. What capabilities exist within the JOA's patient reception areas to include: airfields/landing sites, air/local ground transportation assets, and patient staging areas?
- c. Will numbers of casualties or the event require formal activation of NDMS within/outside the JOA?
- d. How will patients be regulated within and if necessary, outside the JOA?

(1) Will casualties go to the same treatment facility or will they be dispersed among various facilities in the JOA?

(2) Who will perform the medical regulating function?

e. Who will be responsible for MEDEVAC support?

f. How will MEDEVAC support be requested?

(1) Will communications interoperability and capability issues exist between the evacuation platforms and the medical regulating authority?

(2) How will the supporting MEDEVAC unit be contacted?

(3) What type of MEDEVAC request format will be required?

(4) Will medical regulating support be required at the staging areas? And if so, will GPMRC provide augmentation support?

g. How will PMIs be handled?

h. Will a PMI center be established?

i. Will a PMI pool be established to facilitate the immediate exchange and resupply of PMIs?

j. Will a process be established at strategic PM hubs to recover PMIs and return them to the PMI pool?

k. When a PMI is recovered, will a technical inspection and maintenance be performed on all PMIs prior to their return to the PMI pool to ensure they are in issue-ready condition?

l. Will a procedure be established that will facilitate the inclusion of PMI exchange requests with the MEDEVAC requests so that the correct PMI can be replaced when the patient is transferred through the MEDEVAC system?

5. Health Service Logistics Considerations

a. What is the source of CL VIII materiel?

(1) Will CL VIII be obtained through conventional military channels?

(2) Will CL VIII resupply be obtained through military channels?

(3) What is the funding source for use of military CL VIII materiel?

(4) Will they be provided by other federal agencies?

(5) Will donated medical items be used in disaster relief operations?

(6) If donated items are to be used, what agency will be responsible for receiving, storing, repackaging, and distributing these items? Will this be accomplished by another federal agency? Or, will the JTF be responsible for this mission?

b. Will blood and blood products be required by the mission?

(1) How will blood support be requested?

(2) Who will have primary responsibility for providing blood support to the operation?

(3) If the JTF is tasked/authorized to provide blood products to the operation, will the Red Cross be responsible for blood product distribution in the JOA?

c. Has the CDRR designated a theater LA for medical materiel for the operation?

d. How will medical equipment maintenance and repair be accomplished?

(1) What HSS capability can be organized to provide this support?

(2) Where will units providing this support be located?

(3) Is this support available within the JOA?

(4) Can this support be contracted?

6. Veterinary Service Considerations

a. Will MWDs, other government-owned animals, or civilian work dogs be used during the operation?

(1) What is the MWD population to be supported?

(2) Will augmentation of veterinary medicine personnel be required for the operation?

(3) Will veterinary medicine personnel be required to provide care and treatment of other government-owned animals, and civilian work dogs such as search and rescue dogs?

b. Where will supporting veterinary medicine facilities be located?

c. How will animals requiring evacuation be managed?

- (1) Will transportation assets (ground/air) be designated for animal evacuations?
- (2) Will dog handlers accompany MWDs during evacuations?
- (3) If handlers are unable to accompany animals, can they be sedated before evacuation?

d. What are the zoonotic disease threats to MWDs and government-owned animals in the JOA?

e. What are the immunization requirements for MWDs and government-owned animals deploying in the JOA?

f. Will there be a requirement for animal control assistance (strays and ill)?

g. Will there be a requirement for food processing and distribution site assistance?

7. Medical Communications Considerations

a. What is the medical communications system and intelligence plan in the JOA?

b. Can the medical C2 elements communicate with all critical parties?

SECTION B. HEALTH SERVICE SUPPORT CHECKLIST FOR STABILITY OPERATIONS

8. General Mission Analysis Considerations

a. What type of operation is being considered?

(1) Is it a noncombatant evacuation operation (NEO), disaster relief, FHA or peace operations?

(a) If NEO is anticipated, has a contact list to include phone numbers of embassy health officials been established?

(b) Is NEO permissive or non-permissive, and how best can it be supported?

(c) What are the numbers and demographics of noncombatants and how many are known to require medical care? Are there high-risk individuals?

(d) What is the physical location of the noncombatants and is there a published plan addressing their collection prior to evacuation?

(e) Are there any civilian casualty projections for the NEO?

- (f) What is the MEDEVAC policy for NEO casualties?
 - (g) What nations are available to provide support for an evacuation?
 - (h) What will be done with pets brought to evacuation control points?
 - (i) Has the DOS authorized pets to accompany NEO evacuees? And, will the FDA or other agency prohibit any animals from entry into the US? Can pets be evacuated to another country that has a US military installation?
 - (j) If it is a disaster relief, humanitarian assistance or peace enforcement operation, will action be unilateral or multinational? What are potential countries? And, what type of HSS will they provide?
 - (k) If mission is a disaster relief, HA, or peace enforcement operation, what type of military forces may be used to resolve the crisis or conflict, and how might they best be supported medically?
 - (l) If it is a NEO, disaster relief, HA, or peace enforcement operation, what other resources are available (CA, ICRC, interagency community, etc.) to share additional medical information about the threat, crisis, conflict, or region?
- (2) Will the supported population for the operation comprise of federal agency employees, government contractors, nongovernmental and international organization personnel (American Red Cross workers/volunteers, United States Agency for International Development [USAID] workers), allied forces, and/or civilian personnel (foreign nationals, victims and rescuers)?
- (3) Will JTF HSS units provide medical care only to personnel deployed in support of the operation or will care be provided to the civilian population?
- (4) Has a determination regarding eligibility for care and PM for nonmilitary or allied forces personnel been established?
- (5) Are there specific cultural, religious, or social considerations, which may impact HSS?

b. How is the operation being funded?

- (1) Are there restrictions on the use of certain funds?
- (2) What record keeping is required to ensure reimbursement?

c. What agencies are involved in the operation?

- (1) What agency has the primary responsibility for the operation?
- (2) Will the military chain of command be organized as a JTF?
- (3) Will SOF operate in the JOA during the operation?
- (4) What is the HSS capability of participating agencies?
- (5) Will civilian or interagency HSS facilities be utilized (clinics, health centers, or hospitals)?
 - (a) What capabilities do they possess?
 - (b) Will they require augmentation by military medical personnel?
 - (c) Can HSS resources be shared?
 - (d) How will medical credentials and reimbursements be managed?

d. What is the terrorist threat in the JOA?

e. How will MTF and HSS resources document the furnished medical care?

9. Preventive Medicine Considerations

a. What is the medical threat within the JOA?

- (1) What are the endemic or epidemic disease threats?
- (2) Are there hazardous flora and fauna in the JOA?
- (3) What are the environmental and occupational health threats?
- (4) Is there a potential health threat from the CBRN warfare agents? (Obtain threat data from operational threat assessment.)
- (5) If the operation is allied or MNF based, do all allied or MNF member's health screening process meet the multinational task force requirements?
- (6) Are immunizations, chemoprophylaxis, or antidotes available to counter the disease threat?

b. Where will troops be billeted?

(1) Will troops be billeted in military facilities, housed in makeshift facilities or in a field environment?

(2) Have site surveys been conducted for areas to be occupied by JTF forces?

(3) If a site survey was conducted, were any areas determined to be hazardous due to sewage overflow, vector borne, or other arthropod infestation, or soil contaminated by toxic industrial material? And, can adverse environmental conditions at the site be corrected?

(4) Will there be requirements for pest management operations where troops will be billeted?

(a) Will aerial spray missions be required?

(b) Will rodent control operations be required?

(5) What sources of water are available to JTF personnel?

(a) What water sources are to be used during the operation?

(b) What established water systems are within the JOA?

(c) Are streams, lakes, ponds, reservoirs, or other natural sources available?

(d) If water is available, will the water require treatment prior to consumption?

(6) What personal protective equipment and supplies are required for the operation?

(7) Have JTF personnel received personal protective measures training?

(8) Will JTF personnel require acclimation to the environment within JOA? And, will work/rest cycles be required to assist with acclimation to the JOA?

(9) What are the deployment health surveillance requirements and for whom are they indicated?

(10) Have the required deployment health surveillance programs been established for pre-, during-, and post-operations?

c. Will there be laboratory support for the diagnosis of diseases?

(1) What laboratory capabilities will medical units deployed during the operation possess?

(2) If laboratory capability is not sufficient in the JOA, where will this support be obtained?

(3) Are civilian laboratories available in the JOA to process laboratory specimens required to diagnosis disease?

d. Will laboratory support provide for the ID and confirmation of biological and chemical warfare agents and support selected biomonitoring requirements?

(1) Will there be a laboratory in the JOA with the capability and certification to test and provide field confirmation of suspected biological and chemical agents?

(2) Will laboratory support be available in the JOA to support any in-theater biomonitoring requirements for the documentation of selected exposures to chemical warfare agents or environmental agents?

(3) If this capability is not available in the JOA, how will this support be obtained and documented in the individuals' medical record?

(4) How will the chain of custody be maintained for these biological and chemical specimens?

e. How will medical waste be collected and disposed?

f. How will wastewater be managed and disposed?

g. Are refugee and displaced civilians anticipated?

(1) Are sufficient sanitation facilities planned and available to support refugees and supported civilian populations?

(2) Are sufficient preventive medicine resources planned and available to support refugees and displaced civilians?

(3) How will coordination with international organizations be handled (e.g., UN High Commissioner for Refugees, International Organization for Migration)?

(4) Has coordination with CA personnel been established?

(5) How will unaccompanied minors be managed?

(6) If a child requires evacuation, will the child's parent and/or other family members be allowed to travel with the child?

10. Health Service Support Facilities and Hospitalization Considerations

a. What medical treatment facilities and HSS resources will be in the theater/JOA?

- (1) What is the total number of medical and surgical beds and ancillary support services required for the mission?
- (2) Will organic dental resources be deployed?
- (3) Where will dental resources be located?
- (4) How will dental patients be evacuated for emergency and essential comprehensive treatment?
- (5) What dental conditions will necessitate the evacuation of patients from the theater?
- (6) Will a preventive dentistry program be implemented for JTF forces in the theater?
- (7) What is the plan for providing prescription refills of maintenance?

b. What HSS resources are already in the JOA? And what is their capability?

- (1) What is the total number of medical and surgical beds and ancillary support services?
- (2) Will additional HSS facilities be phased into the JOA as the operation progresses and the theater matures?
- (3) Will patients require further evacuation for definitive treatment?
- (4) What are the capabilities of HN and friendly neighboring nations HSS facilities? And can they be utilized as a shared resource?
- (5) Are organic dental resources deployed with the HSS resource?

c. Will non-US physicians and nonmilitary physicians be permitted to treat patients in a US medical treatment facility in the JOA?

d. If non-US physicians and nonmilitary physicians are permitted to treat patients in a US medical treatment facility, who will provide credentialing?

e. Has a formulary been established for prescription drugs?

- (1) Does it include medications for diseases endemic to the operations area?

(2) Does the formulary include medications that may be required for HA and disaster relief operations?

(3) Does the formulary include medications in forms usable for infants and children?

(4) Have off-the-shelf options for medications for HA been considered (e.g., WHO emergency health kits)?

f. During disaster relief operations, what mental health support will be available for victims, caregivers, and rescuers?

(1) Will the JTF be required to provide mental health support to other agencies and individuals supporting the operation?

(2) Will civilian and/or NGO mental health be available to provide support to victims, caregivers, and rescuers?

g. Will interpreters be available as required, to translate patient complaints to attending medical personnel?

h. What mental health intervention support will be available should a terrorist incident occur?

i. What JTF HSS facilities will be designated for the care of detainees?

11. Medical Regulating and Evacuation Considerations

a. What is the theater PM policy?

b. What infrastructure is available for patient evacuation?

c. What airfields are available for intratheater and intertheater AE?

d. How will patients be regulated?

(1) Will casualties go to the same treatment facility or will they be dispersed among various facilities in the JOA?

(2) Who will perform the medical regulating function?

e. Who will be responsible for MEDEVAC support?

f. How will MEDEVAC support be requested?

(1) Will communications interoperability and capability issues exist between the evacuation platforms and the medical regulating authority?

(2) How will the supporting MEDEVAC unit be contacted?

(3) What type of MEDEVAC request format will be required?

g. Will an AELT and AEC be activated for the operation?

h. Will a JPMRC be activated for the operation?

(1) How will PMIs be handled?

(2) Will a PMI center be established?

(3) Will a PMI pool be established to facilitate the immediate exchange and resupply of PMI?

(4) Will a process be established at strategic PM hubs to recover PMIs and return them to the PMI pool?

(5) When PMIs are recovered, will a technical inspection and maintenance be performed on all PMIs prior to their return to the PMI pool to ensure they are in issue-ready condition?

(6) Will a procedure be established that will facilitate the inclusion of PMI exchange requests with the MEDEVAC requests so that the correct PMI can be replaced when the patient is transferred through the MEDEVAC system?

i. Will a MASF be established for staging patients awaiting MEDEVAC aircraft?

(1) Once patients have arrived at the MASF, how long can they be held?

(2) If a patient's flight is cancelled, who will pick up the patients and sustain them until the next scheduled flight?

(3) If a patient is on medical equipment, will there be an exchange of medical equipment or the equipment remain with the patient?

(4) What HSS capability will be established at the APOD or airfield to receive incoming patients and prepare them for further evacuation to the next echelon of care?

(5) If patients are to be moved to a CRTS, are AE personnel qualified for deck landing?

j. Are high capacity air ambulance operations anticipated for MEDEVACs?

- (1) What will be the requirements for commencing these operations?
- (2) Will USAF CCATTs be employed?

12. Health Service Logistics Considerations

a. What is the source of CL VIII materiel?

- (1) Will CL VIII be obtained through conventional military channels?
- (2) Will CL VIII resupply be obtained through military channels?
- (3) What is the funding source for use of military CL VIII materiel?
- (4) Will they be provided by other federal agencies?
- (5) Will donated medical items be used in disaster relief and HA operations?
- (6) If donated items are to be used, what agency will be responsible for receiving, storing, repackaging, and distributing these items? Will this be accomplished by another federal agency or NGO? Or will the JTF be responsible for this mission?

b. Will blood and blood products be required by the mission?

c. Has the CDRR designated a theater LA for medical materiel for the operation?

d. Will HSS logistics forward distribution teams (FDTs) be considered for SPOD, APOD, forward operating bases, intermediate staging bases, and forward staging bases?

e. How will medical equipment maintenance and repair be accomplished?

- (1) What HSS capability can be organized to provide this support?
- (2) Where will units providing this support be located?
- (3) Is this support available within the JOA?
- (4) Can this support be contracted?

13. Veterinary Service Considerations

a. Will MWDs, other government-owned animals, or civilian work dogs be used during the operation?

- (1) What is the MWD population to be supported?
 - (2) Will augmentation of veterinary medicine personnel be required for the operation?
 - (3) Will veterinary medicine personnel be required to provide care and treatment of other government-owned animals, and civilian work dogs such as search and rescue dogs?
 - (4) Will veterinary medicine personnel be required to provide care and humanitarian treatment for animals owned by the local populace?
- b. Will veterinary medicine personnel be required to provide care and humanitarian treatment for animals owned by the local populace?**
- c. Will animal husbandry programs be established and/or supported during the operation?**
- d. How will animals requiring evacuation be managed?**
- (1) Will transportation assets (ground/air) be designated for animal evacuations?
 - (2) Will dog handlers accompany MWDs during evacuations?
 - (3) If handlers are unable to accompany animals, can they be sedated before evacuation?
- e. What are the zoonotic disease threats to MWD and government-owned animals in the JOA?**
- (1) Will zoonotic disease surveillance be conducted?
 - (2) Will epidemiological investigations be conducted when outbreaks of transmissible diseases occur?
 - (3) What coordination is required with the HN and/or national contingents?
- f. What are the immunization requirements for MWDs and government-owned animals deploying in the JOA?**
- g. Will there be a requirement for food processing and distribution site assistance?**
- h. How will rations operations be conducted?**
- (1) Will food be procured from local sources?

(2) Will personnel subsist on meals ready to eat or will other types of rations be available?

(3) Is there a requirement to inspect food for wholesomeness and quality and food sources for hygiene and safety?

14. Medical Communications Considerations

a. **What is the medical communications system and intelligence plan?**

b. **Can the medical C2 elements communicate with all critical parties?**

15. Medical Civil-Military Operations

a. **General Planning Considerations**

(1) Will medical personnel conduct or support CMO?

(2) What is the political-military desired end-state?

(3) How will MCMO support the commander's intent and the desired political-military end-state?

(4) Who has the CJTF designated as the lead for MCMO? CA? JTF surgeon? How will CA and JTFS efforts be coordinated?

(5) What medical resources does CA have?

(6) Does MCMO interfere with the traditional HSS mission?

(7) Has the CJTF been advised of the capabilities/limitations and major issues involved in the medical civil-military support operation?

(8) How will the JTF best support the HN if HN does not have a clear long-term strategy?

(9) What other USG agencies are involved? Who is "supported" and who is "supporting"?

(10) What multinational agencies are active in the JOA?

(11) What NGOs and IGOs are active in the JOA?

(12) What is the role of other USG and multinational agencies? Are projects better performed by one of these agencies?

(13) Have all restraints and constraints under Title 10 and related DODDs and DODIs been fulfilled?

(14) Has the independence/impartiality/neutrality of the NGO/IGO community been acknowledged/respected to allow for the mutual exchange of information?

b. How will MCMO/activities be coordinated?

(1) Have liaisons with CA personnel been established?

(2) Has a CMOC been established? And, has a medical LNO to the CMOC been appointed?

(3) What other civil-military coordination mechanisms are present (UN's on-site operations coordination center, humanitarian operations center etc.)? And, do they have medical working groups?

(4) Have projects been coordinated with information operations and the media?

(5) Has coordination with civil engineers been considered for water/sanitation projects?

(6) Have existing projects of other agencies been taken into account, to avoid duplication of effort?

(7) Have HA, HCA, HAP-EP, and HA (other) missions been coordinated with DOS and HN?

c. Are CJTF resources adequate to conduct MCMO?

(1) Does the medical force have the right training/resources/personnel/equipment to conduct MCMO (e.g., training in CMO, information operations, civil-military/interagency relations, HA, traditional medicine, cultural issues, language skills and appropriate medical subspecialties [public health, pediatrics, tropical medicine, geriatrics])?

(2) Do medical personnel have training or experience in CMO (language/cultural skills, civil-military/interagency/humanitarian training or experience)? And, does the JTF have the appropriate personnel to conduct MCMO (public health, pediatrics, adequate number of female providers, etc.)?

(3) Will other MNF nations conduct or support medical civil-military support operations?

(4) Do projects detract from the MNF's mission of providing security for other humanitarian actors to work ("humanitarian space")?

(5) What equipment will be required for the mission (vehicles, radios, specialized equipment for public health, and equipment for pediatric and geriatric care)?

(6) Who will provide security?

(7) Who will provide translation and interpretation support?

(8) If the decision is made to emphasize capacity-building projects for the HN, have off-the-shelf courses for this purpose been considered (Defense Institute for Medical Operations, Defense Medical Training Institute, etc.)?

(9) Have local resources been used to the maximum extent possible?

(10) What funding sources will be used? Title 10 HCA, HA, HAP-EP? Overseas humanitarian disaster and civic aid? Central Emergency Revolving Fund (UN) (CERF)? Or other funding source?

(11) What are the restraints/constraints of each funding source?

d. Has a needs assessment preceded MCMO?

(1) What other assessment and surveys by other agencies have been accomplished?

(2) Has the HN been involved in the assessment process?

e. Will there be an equal exchange of information with agencies/NGOs and IGOs?

(1) Will the JTF share information that does not compromise force protection, but may be useful to civilian agencies?

(2) Have efforts been made to avoid unnecessarily classifying information that may be useful to partner agencies and nations? And, has this been discussed with the JTF J-2?

f. Have HN issues been adequately considered?

(1) Will the HN be considered the lead? And, the JTF the supporting element?

(2) Will projects enhance the legitimacy of the HN?

(3) Will projects boost the population's confidence in the HN?

g. How will projects be selected?

(1) Will projects emphasize capacity building (developing medical societies, training public health personnel, etc.)?

(2) Have local cultural and religious issues been considered (including traditional medicine, female providers for female patients, etc.)?

(3) How will MCMO projects be tracked?

(4) How will locations of projects be listed and standardized? Map grid references? Street addresses?

h. What standard of care will apply if medical care is delivered to civilians? The HN? International consensus standards? Has the HN been involved in this decision?

i. What measures of effectiveness will be used?

j. Have all potential negative effects of MCMO been considered?

(1) How will parallel medical systems be avoided?

(2) How will dependency be avoided?

(3) How will duplication of effort be avoided?

(4) What long-term impact will the projects have?

(5) What is the potential economic impact of medical civil-military support operations/activities (i.e., direct food aid may cause market prices to drop and discourage agriculture)?

(6) Do projects raise unrealistic expectations in the HN population?

(7) Does the activity distort the distinction between civilian and military agencies?

(8) Will projects be sustainable by the HN, UN, or other agencies?

(9) Who will provide follow-up and continuity of care if direct patient care activities are rendered?

(10) What is the plan to transition responsibility for public health and other medical projects back to the HN or other appropriate authority (UN, multinational JTF, etc.)?

SECTION C. HEALTH SERVICE SUPPORT CHECKLIST FOR MULTINATIONAL OPERATIONS

16. General Mission Analysis Considerations

a. What type of operation is being considered?

- (1) If it is stability operations, is it disaster relief, FHA, or peace operations?
 - (a) If it is a disaster relief, FHA, or peace operations, will action be unilateral or multinational? What are potential countries? And, what type of HSS will they provide?
 - (b) If mission is a disaster relief, FHA, or peace operation, what type of military forces may be used to resolve the crisis or conflict, and how might they best be supported medically?
 - (c) If it is disaster relief, FHA, or peace operation, what other resources are available (civil affairs, interagency community, ICRC, etc.) to collect additional medical information about the threat, crisis, conflict, or region?
 - (d) Will the supported population for the operation be comprised of federal agency employees, government contractors, nongovernmental and international organization personnel (American Red Cross workers/volunteers, USAID workers), allied forces, and/or civilian personnel (foreign nationals, victims and rescuers)?
 - (e) Will JTF HSS units provide medical care only to personnel deployed in support of the operation or will care be provided to the civilian population?
 - (f) Has a determination regarding eligibility for care and PM for nonmilitary or allied forces personnel been established?
 - (g) How is the operation being funded? Are there restrictions on the use of certain funds? What record keeping is required to ensure reimbursement?
 - (h) What agencies are involved in the operation? And, what is the HSS capability?
 - (i) What agency has the primary responsibility for the operation?
 - (j) Will the military chain of command be organized as a JTF?
 - (k) Will SOF operate in the JOA during the operation?
 - (l) Will civilian or interagency HSS facilities be utilized (clinics, health centers, or hospitals)?
 1. What capabilities do they possess?
 2. Will they require augmentation by military medical personnel?
 3. Can HSS resources be shared?
 - (m) Are there specific cultural, religious, or social considerations, which may impact HSS during stability operations?

- (2) Are major operations being considered as part of an MNF?
 - (a) Will combat operations be conducted under the sponsorship of the UN?
 - (b) Will the US serve as the lead nation of the MNF?
 - (c) What is the size and composition of the US force?
 - (d) How many other nations will participate? And, what is the size of each nation's contingent?
 - (e) What is the C2 structure of the MNF? Will there be a multinational medical staff to plan for multinational-based HSS operations?
 - (f) What are the HSS capabilities of the MNF? What medical personnel, units, and equipment will other nations of the MNF possess?
 - (g) Who has been designated to provide HSS to the MNF? Will each nation provide all aspect of HSS for their forces? What support will each nation require from the JTF?
 - (h) Will a multinational medical unit or a single nation be designated to provide HSS for all nations in the MNF?
 - (i) Will HSS tasks/responsibilities be distributed to individual multinational nations (e.g., MEDEVAC given to nation A, blood given to nation B, ground transportation to nation C)?
 - (j) Will each nation provide HSS LNOs to participating nations' surgeon's offices?
 - (k) Will US forces be treated by multinational HSS? What are the education, training and experience level of multinational health care professionals? How will providers be credentialed? Who has credentialing authority?
 - (l) Will members of the MNF be eligible for care at US MTFs within the multinational operations area?
 - 1. If members of the MNF are treated at US facilities, will there be a mechanism in place to return them to their parent nation for continued medical care? How will medical information be exchanged? How will it be safeguarded? How will copies of radiographs, ultrasounds, etc., be managed and exchanged?
 - 2. Will there be a costs associated with MNF personnel that are treated at US facilities? Or US personnel treated at MNF facilities? How will reimbursements be managed?

(m) If there are only US facilities within the MNF AOR, who will evacuate MNF patients to their homeland? What coordination will be required to return a MNF patient to his nation's facilities?

(n) Who will ensure communications equipment compatibility, standardization of radio frequencies, reports formats, treatment protocols, and requirements for equipment with allied multinational HSS units?

(o) Has a standardized operational and medical terminology reference guide been established to facilitate the synchronization of HSS efforts, and minimize misinterpretation with allied multinational HSS units?

(p) Will participating nations of the MNF comply with the provision of the Geneva Conventions?

(q) Are there specific cultural, religious, or social considerations, which may impact HSS during major operations?

b. How will EPWs, detained personnel, and HN civilian care be managed?

(1) How will local nationals be transferred from JTF MTFs to HN facilities?

(2) What will be the disposition of EPWs that require more care than the MNF can provide?

(3) How will EPWs who are ready to be released from medical care be dispositioned?

(4) How will deceased HN civilians and EPWs be managed?

c. What is the terrorist threat in the JOA?

17. Preventive Medicine Considerations

a. What is the medical threat within the JOA?

(1) What are the endemic or epidemic disease threats?

(2) Are disease outbreaks seasonally related?

(3) Are there hazardous flora and fauna in the JOA?

(4) What are the environmental and occupational health threats?

(5) What are the arthropod borne, food borne, and water borne disease threat?

(6) Is there a threat from the potential use of CBRN warfare agents?

(7) Do all allied or MNF member's health screening process meet the multinational task force requirements?

(8) Have any of the participating nations conducted previous operations in the proposed AOR and documented the medical threat?

(9) Are immunizations or chemoprophylaxis available to counter the disease threat? And, have participating nations of the MNF been immunized and/or provided chemoprophylaxis? Also, do members of the MNF plan to immunize their personnel to US standards?

(10) How will information regarding health and environmental threats be shared among multinational partners, US and multinational agencies, NGOs and IGOs?

b. Where will troops be billeted?

(1) Will US and multinational troops be billeted in military facilities, housed in makeshift facilities or in a field environment?

(2) Will US troops be housed with members of the MNF?

(3) Have site surveys been conducted for areas to be occupied by MNFs?

(4) If a site survey was conducted, were any areas determined to be hazardous due to sewage overflow, vector borne or other arthropod infestation, or soil contaminated by toxic industrial material? And, can adverse environmental conditions at the site be corrected?

(5) Will there be requirements for pest management operations where troops will be billeted?

(a) Will aerial spray missions be required?

(b) Will rodent control operations be required?

(6) What sources of water are available to multinational JTF personnel?

(a) What water sources are to be used during the operation?

(b) What established water systems are within the JOA?

(c) Are streams, lakes, ponds, reservoirs, or other natural sources available?

(d) If water is available, will the water require treatment prior to consumption?

(7) What personal protective equipment and supplies are required for the operation?

(8) Have multinational JTF personnel received personal protective measures training?

(9) Will multinational JTF personnel require acclimation to the environment within the JOA?
And, will work/rest cycles be required to assist with acclimation to the JOA?

(10) What preventive medicine support will US forces provide to other members of the MNF?

(11) What are the deployment health surveillance requirements in the MNF AOR?

(12) Have the required deployment health surveillance programs been established for pre-, during-, and post-operations?

c. Will there be laboratory support for the diagnosis of diseases?

(1) What laboratory capabilities will medical units deployed during the operation possess?

(2) If laboratory capability is not sufficient in the JOA, where will this support be obtained?

(3) Are civilian laboratories available in the JOA to process laboratory specimens required to diagnosis disease?

d. Will laboratory support provide for the ID and confirmation of biological and chemical warfare agents and support selected biomonitoring requirements?

(1) Will there be a laboratory in the JOA with the capability to test and provide field confirmation of suspected biological and chemical agents?

(2) Will laboratory support be available in the JOA to support any in-theater biomonitoring requirements for the documentation of selected exposures to chemical warfare agents or environmental agents?

(3) If this capability is not available in the JOA, how will this support be obtained?

(4) How will the chain of custody be maintained for these biological and chemical specimens?

(5) Will the US and multinational JTF accept laboratory results from a non-US laboratory?

e. How will medical waste be collected and disposed?

f. How will wastewater disposal be managed?

g. Are refugees and displaced civilians anticipated during stability operations or major combat operations?

(1) Are sufficient sanitation facilities planned and available to support displaced civilians and refugees?

(2) Are sufficient preventive medicine resources planned and available to support refugees and displaced civilians?

(3) How will coordination with international organizations be handled (e.g., UN High Commissioner for Refugees, International Organization for Migration)?

(4) Has coordination with CA personnel been established?

(5) How will unaccompanied minors be managed?

(6) If a child requires evacuation, will the child's parent and/or other family members be allowed to travel with the child?

18. Health Service Support Facilities and Hospitalization Considerations

a. What medical treatment facilities and HSS resources are planned for the theater/JOA?

(1) What is the total number of medical and surgical beds and ancillary support services required for the mission?

(2) Are interpreters available to translate patient complaints to attending medical personnel?

b. What HSS resources are already in the JOA? And what is their capability?

(1) What is the total number of medical and surgical beds and ancillary support services?

(2) Will additional HSS facilities be phased into the JOA as the operation progresses and the theater matures?

(3) Will patients require further evacuation for definitive treatment?

(4) What are the capabilities of HN and friendly neighboring countries HSS facilities? And can they be utilized as a shared resource?

(5) Are organic dental resources deployed with the HSS resource?

c. What units will provide dental service for the MNF?

- (1) Will organic dental resources be deployed?
- (2) Where will dental resources be located?
- (3) Will each nation have field dental services deployed in the MNF AOR?
- (4) Will one nation provide dental support to the MNF?
- (5) Will a preventive dentistry program be implemented for US forces and/or MNFs in the theater?
- (6) What dental conditions will necessitate the evacuation of patients from the theater?
- (7) How will dental patients be evacuated for emergency and essential comprehensive treatment?

d. What mental health support will be available for MNF operations?

- (1) Will US forces be required to provide mental health support to members of the MNF, other agencies and individuals supporting the operation?
- (2) During stability operations (HA, disaster relief), will civilian and/or NGO mental health be available to provide support to victims, caregivers, and rescuers?
- (3) What mental health intervention support will be available should a terrorist incident occur?

e. What multinational JTF HSS facilities will be designated for the care of detainees?

f. What notification procedures are required when a MNF member is admitted to a US medical treatment facility?

- (1) Who notifies the member's national contingent?
- (2) How and when will the patient be transferred to their national contingent?

g. Will non-US physicians and nonmilitary physicians be permitted to treat patients in a US medical treatment facility?

h. If non-US physicians and nonmilitary physicians are permitted to treat patients in a US medical treatment facility, how will they provide credentialing?

i. Has a formulary been established for prescription drugs?

- (1) Does it include medications for diseases endemic to the MNF and the operations area?
- (2) Does the formulary include medications that may be required for HA and disaster relief operations?
- (3) Does the formulary include medications in forms usable for infants and children?
- (4) Have off-the-shelf options for medications for HA been considered (e.g., WHO emergency health kits)?

19. Medical Regulating and Evacuation Considerations

- a. **What is the theater PM policy? And, is it the same for all multinational HSS?**
- b. **What infrastructure is available for patient evacuation?**
- c. **Do all participating nations have organic evacuation assets?**
- d. **What airfields are available for intratheater and intertheater AE?**
- e. **How will patients be regulated?**

- (1) Will casualties go to the same treatment facility or will they be dispersed among various facilities in the JOA?

- (2) What nation will perform the medical regulating function?

- (3) Will the US perform this function for the MNF?

- f. **Who will be responsible for MEDEVAC support?**

- g. **How will MEDEVAC support be requested?**

- (1) Will communications interoperability and capability issues exist between the evacuation platforms and the medical regulating authority?

- (2) How will the supporting MEDEVAC unit be contacted?

- (3) What type of MEDEVAC request format will be required?

- h. **Will an AELT and AEC be activated for the operation?**

- i. **Will a JPMRC be activated for the operation?**

- (1) How will PMIs be handled?
- (2) Will a PMI center be established?
- (3) Who will certify PMI from multinational HSS units?
- (4) Will a PMI pool be established to facilitate the immediate exchange and resupply of PMI?
- (5) Will a process be established at strategic PM hubs to recover PMIs and return them to the PMI pool?
- (6) When PMIs are recovered, will a technical inspection and maintenance be performed on all PMIs prior to their return to the PMI pool to ensure they are in issue-ready condition?
- (7) Will a procedure be established that will facilitate the inclusion of PMI exchange requests with the MEDEVAC requests so that the correct PMI can be replaced when the patient is transferred through the MEDEVAC system?

j. Will a MASF be established for staging patients awaiting MEDEVAC aircraft?

- (1) What nation will provide this function for the MNF?
- (2) Once patients have arrived at the MASF, how long can they be held?
- (3) If a patient's flight is cancelled, who will pick up the patients and sustain them until the next scheduled flight?
- (4) If a patient is on medical equipment, will there be an exchange of medical equipment or the equipment remain with the patient?
- (5) What HSS capability will be established at the APOD or airfield to receive incoming patients and prepare them for further evacuation to the next echelon of care?
- (6) If patients are to be moved to a CRTS, are AE personnel qualified for deck landing?

k. Are high capacity air ambulance operations anticipated for MEDEVAC?

- (1) What will be the requirements for commencing these operations?
- (2) Will USAF CCATTs be employed?

l. What notification procedures are required when a MNF member is evacuated to CONUS?

20. Health Service Logistics Considerations

a. What is the source of CL VIII materiel?

- (1) Will CL VIII be obtained through conventional military channels? Or from the MNF or HN?
- (2) Will CL VIII resupply be obtained through military channels?
- (3) What is the funding source for use of military CL VIII materiel?
- (4) Will the US be required to provide logistic support to the MNF?
- (5) Will donated medical items be used in disaster relief and HA operations?
- (6) If donated items are to be used, what agency will be responsible for receiving, storing, repackaging, and distributing these items? Will this be accomplished by another federal agency or NGO? Or will the MNF JTF be responsible for this mission?

b. Will blood and blood products be required by the mission?

- (1) Are there any cultural, religious, or social prohibitions on the use of blood and blood products for any of the MNF members?
- (2) Will the US be required to provide blood and blood products support to MNF members?

c. Has the CDRR designated a theater LA for medical materiel for the operation?

d. Will HSS logistics FDTs be considered for SPOD, APOD, forward operating bases, intermediate staging bases, and forward staging bases?

e. How will medical equipment maintenance and repair be accomplished?

- (1) What HSS capability can be organized to provide this support?
- (2) Where will units providing this support be located?
- (3) Is this support available within the JOA?
- (4) Can this support be contracted?

21. Veterinary Service Considerations

a. Will MWDs, other government-owned animals, or civilian work dogs be used during the operation?

- (1) What is the MWD population to be supported?
- (2) Will augmentation of veterinary medicine personnel be required for the operation?
- (3) Will veterinary medicine personnel be required to provide care and treatment of other government-owned animals, and civilian work dogs such as search and rescue dogs?
- (4) Will veterinary medicine personnel be required to provide care and humanitarian treatment for animals owned by the local populace?

b. Will veterinary medicine personnel be required to provide care and humanitarian treatment for animals owned by the local populace?

c. Will animal husbandry programs be established and/or supported during the operation?

d. How will animals requiring evacuation be managed?

- (1) Will transportation assets (ground/air) be designated for animal evacuations?
- (2) Will dog handlers accompany MWDs during evacuations?
- (3) If handlers are unable to accompany animals, can they be sedated before evacuation?

e. What are the zoonotic disease threats to MWDs and government-owned animals in the JOA?

- (1) Will zoonotic disease surveillance be conducted?
- (2) Will epidemiological investigations be conducted when outbreaks of transmissible diseases occur?
- (3) What coordination is required with the host nation and/or national contingents?

f. What are the immunization requirements for MWDs and government-owned animals deploying in the JOA?

g. How will rations operations be conducted?

- (1) Will food be procured from local sources?
- (2) Will personnel subsist on meals ready to eat or will other types of rations be available?
- (3) Is there a requirement to inspect food for wholesomeness and quality and food sources for hygiene and safety?

22. Medical Civil-Military Operations

a. General Planning Considerations

- (1) Will medical personnel conduct or support CMO?
- (2) What is the political-military desired end-state?
- (3) How will MCMO support the commander's intent and the desired political-military end-state?
- (4) Who has the CJTF designated as the lead for MCMO? CA? JTFS?
- (5) What medical resources does CA have?
- (6) Does MCMO interfere with the traditional HSS mission?
- (7) Has the CJTF been advised of the capabilities/limitations and major issues involved in the medical civil-military support operation?
- (8) How will the JTF best support the HN if HN does not have a clear long-term strategy?
- (9) What other USG agencies are involved? Who is "supported" and who is "supporting"?
- (10) What multinational agencies are active in the JOA?
- (11) What NGOs and IGOs are active in the JOA?
- (12) What is the role of other USG and multinational agencies? Are projects better performed by one of these agencies?
- (13) Have all restraints and constraints under Title 10 and related DODDs and DODIs been fulfilled?
- (14) Has the independence/impartiality/neutrality of the NGO/IGO community been acknowledged/respected to allow for the mutual exchange of information?

b. How will medical civil-military support operations/activities be coordinated?

- (1) Have liaisons with CA personnel been established?
- (2) Has a CMOC been established? And, has a medical LNO been appointed?
- (3) What other civil-military coordination mechanisms are present (UN's on-site operations coordination center, humanitarian operations center, etc.)? And, do they have medical working groups?
- (4) Have projects been coordinated with information operations and the media?
- (5) Has coordination with civil engineers been considered for water/sanitation projects?
- (6) Have existing projects of other agencies been taken into account, to avoid duplication of effort?
- (7) Have HA, HCA, HAP-EP, and HA (other) missions been coordinated with DOS and HN?

c. Are CJTF resources adequate to conduct medical civil-military support operations?

- (1) Does the medical force have the right training/resources/personnel/equipment to conduct medical civil-military support operations (e.g., training in CMO, information operations, civil-military/interagency relations, HA, traditional medicine, cultural issues, language skills and appropriate medical subspecialties [public health, pediatrics, tropical medicine, geriatrics])?
- (2) Do medical personnel have training or experience in CMO (language/cultural skills, civil-military/interagency/humanitarian training or experience)? And, does the JTF have the appropriate personnel to conduct MCMO (public health, pediatrics, adequate number of female providers, etc.)?
- (3) Will other multinational nations conduct or support medical civil-military support operations?
- (4) Do projects detract from the MNF mission of providing security for other humanitarian actors to work ("humanitarian space")?
- (5) What equipment will be required for the mission (vehicles, radios, specialized equipment for public health, and equipment for pediatric and geriatric care)?
- (6) Who will provide security?
- (7) Who will provide translation and interpretation support?

(8) If the decision is made to emphasize capacity-building projects for the HN, have off-the-shelf courses for this purpose been considered (Defense Institute for Medical Operations, Defense Medical Training Institute, etc.)?

(9) Have local resources been used to the maximum extent possible?

(10) What funding sources will be used? Title 10 HCA, HA, HAP-EP? Overseas humanitarian disaster and civic aid? CERF? Or other funding source?

(11) What are the restraints/constraints of each funding source?

d. Has a needs assessment preceded medical civil-military support operations/activities?

(1) What other assessment and surveys by other agencies have been accomplished?

(2) Has the HN been involved in the assessment process?

e. Will there be an equal exchange of information with agencies/NGOs and IGOs?

(1) Will the JTF share information that does not compromise force protection, but may be useful to civilian agencies?

(2) Have efforts been made to avoid unnecessarily classifying information that may be useful to partner agencies and nations? And, has this been discussed with the JTF J-2?

f. Have HN issues been adequately considered?

(1) Will the HN be considered the lead? And, the JTF the supporting element?

(2) Will projects enhance the legitimacy of the HN?

(3) Will projects boost the population's confidence in the HN?

g. How will projects be selected?

(1) Will projects emphasize capacity building (developing medical societies, training public health personnel, etc.)?

(2) Have local cultural and religious issues been considered (including traditional medicine, female providers for female patients, etc.)?

(3) How will MCMO projects be tracked?

(4) How will locations of projects be listed and standardized? Map grid references? Street addresses?

h. What standard of care will apply if medical care is delivered to civilians? The HN? International consensus standards? Has the HN been involved in this decision?

i. What measures of effectiveness will be used?

j. Have all potential negative effects of MCMO been considered?

(1) How will parallel medical systems be avoided?

(2) How will dependency be avoided?

(3) How will duplication of effort be avoided?

(4) What long-term impact will the projects have?

(5) What is the potential economic impact of medical civil-military support operations/activities (i.e., direct food aid may cause market prices to drop and discourage agriculture)?

(6) Do projects raise unrealistic expectations in the HN population?

(7) Does the activity distort the distinction between civilian and military agencies?

(8) Will projects be sustainable by the HN, UN, or other agencies?

(9) Who will provide follow-up and continuity of care if direct patient care activities are rendered?

(10) What is the plan to transition responsibility for public health and other medical projects back to the HN or other appropriate authority (UN, multinational JTF, etc.)?

SECTION D. HEALTH SERVICE SUPPORT CHECKLIST FOR CRISIS ACTION PLANNING

23. Crisis Action Planning Phase I: Situation Monitoring

a. Monitor the situation and maintain situational awareness.

(1) What is the nature of the crisis – NEO? Possible FHA operation? Combat? Terrorism?

(2) If NEO is anticipated, has a contact listing phone numbers of embassy health officials been established?

(3) Will action be unilateral or multinational? What are potential countries? What type of HSS will they provide?

(4) What is the current situation (who, what, when, where, and why)?

(5) What forces are available?

(a) Who's ready?

(b) What is their actual readiness status?

(c) Do they meet deployment requirements?

(6) What type of military forces may be used to resolve the crisis or conflict, and how might they best be supported medically?

(7) If combined action is possible, what type of medical support could be required or provided by other nations?

(8) Are there any major constraints on employment of forces? What is the environmental assessment?

(9) What staff actions are being taken?

(10) What COAs are being considered?

(11) What is the expected time for earliest commitment of forces?

(12) Have communications requirements been identified to include non-secure and secure channels, frequencies for medical personnel, and any medically dedicated or unique communications nets, operating procedures, or requirements?

(13) Are there any medical communications systems that are already available in the AOR and JOA? If so, what are their capabilities and how are the systems accessed?

(14) How will the communications system support the passing of medical information, reports, and requests?

b. Evaluate the event and incoming reports.

(1) Review critical intelligence report for HSS significance.

(2) Review operational report for HSS significance.

(3) Conduct review of existing OPLANs and CONPLANs for applicability to the area or situation.

(4) Review and evaluate actions of the combatant command.

(5) Evaluate disposition of assigned and available forces.

(6) Evaluate status of theater transportation assets.

(7) What nations are available to provide support for evacuation?

(8) What infrastructure is available for patient evacuation?

(9) Have deployment health surveillance requirements and preventive medicine procedures and countermeasures been established?

(10) If authority to coordinate with in-place and out-of-JOA medical treatment facilities has been granted, has coordination already begun?

c. Gather medical intelligence information and review available options.

(1) Have intelligence offices been coordinated with to provide appropriate medical information?

(2) How should medical requirements be entered into the consolidated intelligence collection plan?

(3) What other resources are available (CA, interagency community, etc.) to collect additional medical information about the threat, crisis, conflict, or region?

(4) Are any in-place medical treatment facilities available for use including: US military assets, HNS, allied assets, or contracts with civilian organizations (e.g. the International Red Cross)?

(5) Review and assess environmental conditions with HSS implications that could adversely affect operations.

d. Furnish required information to appropriate staff directorates and provide support as needed.

e. Provide input (as required) to the commander's assessment.

(1) Have HSS units and personnel resources been identified?

24. Crisis Action Planning Phase II: Planning

a. Review warning order for specified and implied tasks.

b. Conduct parallel planning.

c. Review and consider environmental conditions with HSS implications that could adversely affect operations.

d. Evaluate available HSS resources.

(1) What medical forces are available?

(2) What type of foreign military or civilian medical infrastructure is established within the JOA? What and where are its key elements?

(3) Has the medical supply and resupply status of each service component been reported?

(4) Have provisions for emergency resupply been established?

(5) Have medical sustainability and resupply requirements been identified?

(6) Have provisions been made within the AOR/JOA to provide support to US national, EPWs, civilian internees, non-entitled civilians, refugees, and other detained persons?

(7) Has AE support been properly requested and coordinated, and does the proposed AE support include sufficient crews, equipment sets, staging facilities, and medical supplies?

e. Review status of strategic lift assets.

(1) Has a supportable PM policy been established?

(2) Has a JPMRC been established?

(3) What airfields are available for intratheater and intertheater AE?

f. Evaluate AE from point of injury to CONUS.

g. Act to improve force readiness and sustainability.

(1) Has FHP procedures and countermeasures been established?

(2) Has MIPOE information been provided to the J-2 for inclusion in the JIPOE?

h. If a NEO is anticipated, the JFS and joint medical planner should consider the following:

- (1) How many of the noncombatants are known to require medical care?
- (2) What is the current condition of the noncombatants to be evacuated? Are there existing medical conditions?
- (3) Where are these noncombatants and is there a published plan addressing their collection prior to evacuation?
- (4) Is a permissive or non-permissive NEO anticipated, and how best can it be medically supported?
- (5) Are there any civilian casualty projections for the NEO?
- (6) What is the MEDEVAC policy for NEO casualties?
- (7) Has DOS authorized pets to accompany NEO evacuees? Does the FDA or other agency prohibit any animals from entry into the US?
- (8) What will be done with pets brought to evacuation control points?

i. Other HSS Considerations.

- (1) If foreign governments have made any humanitarian, civil, or security assistance medical requests, how can they be supported?
- (2) Are there any treaties, or legal, HN, or status-of forces agreements (SOFAs) between the US and involved foreign governments that have medical significance?
- (3) Are there any OPLANs or CONPLANs for the area or situation?
- (4) Has direct liaison with embassy health officials been authorized and established?

j. Develop and evaluate COAs using JOPES automated data processing.

- (1) Are all medical units, to include AELT and air crews, on the time-phased force and deployment list (TPFDL) and scheduled for timely arrival?
- (2) Identify combat, combat service, combat service support forces and generate HSS requirement estimates using the MAT.
- (3) What reception and operations support facilities are required and available? And, who will provide HSS for JRSOI?
- (4) If an intermediate staging base is required, what medical units should be positioned there?

k. Coordinate involvement of subordinates.

- (1) Who are the JTF service component surgeons? (If JTF is established.)
- (2) Have medical tasks, functions, and responsibilities been delineated and assigned to the JTF service component medical units?
- (3) Has required medical coordination with allies and the HN been conducted?
- (4) Has JTF service components identified and requested medical personnel augmentation for the medical units and treatment facilities?

l. Review existing OPLANs for applicability.

- (1) What medical assets are provided for in the OPLAN?
- (2) What medical assets are provided for in the draft OPORD?

m. Provide input (as necessary) to commander's estimate to CJCS.

- (1) What precisely must be accomplished in the crisis to strengthen the objectives established by the President?
- (2) What precisely must be accomplished in the crisis to support the objectives established by the President?

n. Analyze COAs, as directed.

- (1) Review and determine what specific HSS factors affect the COA under consideration.
- (2) Identify forces.
- (3) What types and amounts of logistic support are available from friendly and allied nations?
- (4) What forces are readily available and when could they arrive on the scene?
- (5) Is the selected COA medically supportable with currently available medical assets?
- (6) If not, will required medical assets be available before mission execution?
- (7) If not, has the GCC/CJTF been made aware of the risks?

o. Assist creating deployment database in JOPES for each COA.

p. Coordinate HSS sustainment calculations and movement requirements.

(1) Are all medical units-to include AELT and air crews-on the TPFDL and scheduled for timely arrival?

(2) What airports and seaports are available to friendly forces? What medical support will be required at these locations?

q. Review GCC's COAs.

(1) Is available HSS adequate to support planned operations? If not, what additional assets are required and how will the JTF request them?

(2) What specific medical factors affect the actions under consideration?

r. Identify limitations and deficiencies in the preferred COA that must be brought to the commander's attention.

s. Assist in refining HSS requirements.

t. Prepare HSS deployment estimate for each COA.

u. Ensure HSS input into deployment estimate to supported commander.

v. Monitor COA development (What is the backup COA?).

w. Plan for HSS sustainment.

(1) Has a theater LA for medical materiel been considered?

(2) Has an AJBPO been established?

(3) Has the handling, storage, and distribution of whole blood been planned and coordinated with the appropriate entities?

(4) How will CL VIII-A and B be sustained? TMLMC/SIMLM? Accounts established?

x. Provide HSS input to OPORD for approved COA.

(1) Is the medical portion of the OPORD ready to be published?

(2) Does OPORD address assistance to US nationals, civilian internees, detained individuals, displaced persons, and EPWs?

- (3) Does OPORD provide FHP guidance?

y. Review force and unit-related support requirements.

(1) What is the status of communications? Have any dedicated or medically unique nets, procedures, or requirements been properly identified and requested?

- (2) Have multiple means of communications been addressed?

(3) What country clearances are required for overflight, landing, or staging for evacuation aircraft? What are the existing (or needed) agreements for overflight; staging; transit and refueling for evacuation aircraft; and basing rights?

z. Confirm first increment of movement requirements and fully functional AJBPO.

aa. Identify and resolve HSS shortfalls and limitations.

- (1) Have CL VIII responsibilities be established?

- (2) Have CL VIII channels be established?

bb. Review the TPFDD.

cc. Identify early-deploying forces and assign tasks.

- (1) Who will provide HSS for JRSOI?

- (2) Has FHP procedures and countermeasures been established?

- (3) Has MIPOE information been provided to components and early deploying forces?

dd. Identify and plan for PM requirements.

- (1) Is the JPMRC fully functional?

- (2) Is the TAES planning complete?

- (3) Is sufficient TAES assets in-place or programmed for early arrival?

- (4) Have primary and secondary aeromedical airfields been identified?

(5) Are AELTs ready to locate at key locations within each JTF service component medical system?

(6) Do service components understand that they are required to move patients to supporting aeromedical staging facilities, and will they be able to do so?

ee. **Ensure that adequate transportation for HSS is available to support approved COA.**

ff. **Coordinate changes caused by conflicts and shortfalls.**

gg. **Provide HSS and FHP input to GCC's draft execute order (EXORD).**

25. Crisis Action Planning Phase III: Execution

a. **Review GCC's/CJTF's EXORD to ensure HSS and FHP guidance to components.**

b. **Monitor HSS force deployment.**

c. **Validate HSS movement requirements as required.**

d. **Coordinate with appropriate staff directorates and resolve reported shortfalls.**

e. **Coordinate employment of HSS units as required.**

f. **Consider issuance of FRAGORDs to reiterate key FHP themes and countermeasures, and publish medical CONOPS to JTF forces.**

g. **Report movement requirements as required.**

h. **Coordinate HSS sustainment for components.**

SECTION E. HEALTH SERVICE SUPPORT CHECKLIST FOR HUMANITARIAN ASSISTANCE SURVEY TEAM AND ADVANCED ECHELON TEAM

26. Humanitarian Assistance Survey Team and Advanced Echelon Team Planning Considerations

a. **Team — Personnel planning considerations.**

(1) Research and gather applicable country medical intelligence and establish FHP guidance.

(2) Ensure all personal protective equipment is obtained.

(3) Ensure all recommended chemoprophylaxis and immunizations are obtained.

(4) Ensure orders correctly reflect personal data and authorized appropriate mission-related travel variations.

(5) Pack appropriately for climate and duration of deployment.

(6) Pack necessary professional gear and reference materials.

(7) Research and gather pre-deployment country intelligence data (joint intelligence preparation of the battlespace).

(8) Establish local POCs to deployment country (e.g., listing phone numbers of US embassy health officials).

(9) Establish listing of infrastructure sites/locations to survey.

(10) Establish reachback POCs.

(11) Obtain a force protection threat analysis of the local area (source J-2).

(12) Establish charter for mission accomplishments and deliverables.

(13) Ensure that a security and emergency evacuation plan is in place for the HAST.

b. Pre-advanced echelon and employment reception.

(1) Is medical site survey is being performed?

(2) During the site survey, ensure the following issues are coordinated for deploying medical personnel prior to their arrival at the deployment country:

(a) Billeting/Accommodations: _____

(b) Phone Number at Accommodations: _____

(c) Phone Number at AOR or work phone: _____

(d) Cell Phone: _____

(e) Radios: _____ Frequencies: _____ Call Sign: _____

(f) Dedicated transportation: _____

(g) Translator (with a medical background preferred): _____

c. General survey information.

(1) Surveyor: _____

(2) Unit of assignment: _____

(3) Date of Survey: _____

(4) Name of Site and location: _____

(5) Country: _____

(6) Map Grid Location: _____

(7) Global positioning system (GPS) latitude/longitude: _____

(8) Nature of contingency: _____

(9) Summary of population affected (e.g., demographics, size, origin):

d. Mission.

(1) Objective 1:

(2) Objective 2:

(3) Objective 3:

(4) Anticipated duration of potential mission:_____

(5) Desired end state:

e. US embassy information.

(1) US embassy on Site? YES NO

(2) POC numbers for US embassy:

(3) Does the US embassy have a clinic and medical staff? YES NO

(4) If Yes, describe personnel and capabilities:

(5) If No, where does staff obtain medical care? Describe:

(6) Does the US embassy have access to a periodic regional medical officer?

(7) If Yes, list location and POC numbers:

f. Troop Strength to be Supported.

(1) US Military Forces.

- (a) US Army _____
- (b) US Navy _____
- (c) US Air Force _____
- (d) US Marines _____
- (2) Allied Forces (if authorized).
 - (a) NATO _____
 - (b) United Nations _____
 - (c) Other/Origin _____
- (3) Number of American Citizens _____
- (4) US Agency for International Development on Site? YES NO
- (5) IGOs, NGOs, etc. on-site? YES NO
- (6) Third-country nationals of interest to DOS? YES NO
- (7) If Yes, list:

- (8) What is the general feeling towards working with American military?

- (9) Any other US and NATO civilians? NO YES, approx # _____
- (10) Any potential EPWs? NO YES, approx # _____
- (11) If mission is a HA, list number of:
 - (a) Refugees _____

(b) Internally Displaced Persons_____

(c) Other_____

(12) Identify Key Indigenous Officers and Population Leaders:

g. Demographics.

(1) Attach force protection threat analysis of the local area (source J-2).

(2) General description of local civilian population:

(3) Are there any medically significant treaties or legal HNs or SOFAs?

(4) If Yes, list potential impacts:

(5) List any religious/social/political factors of medical significance:

(6) List any public health laws of significance:

(7) Endemic diseases of the local population:

(8) Problematic seasonal diseases in the local population:

(9) What is the occurrence of illnesses and deaths caused by cold?

(10) Are there occurrences of the following diseases (check):

- (a) Malaria.
 - (b) Diarrhea.
 - (c) Cholera.
 - (d) Measles.
 - (e) Polio.
 - (f) Hemorrhagic Fever.
 - (g) Plague.
 - (h) Dengue Fever.
 - (i) Encephalitis.
 - (j) Meningitis.
 - (k) Tuberculosis.
 - (l) Hepatitis.
 - (m) Leptospirosis.
 - (n) Yellow Fever.
 - (o) Influenza.
 - (p) Human immuno-deficiency virus (HIV).
 - (q) Acquired immune deficiency syndrome (AIDS).
 - (r) Other _____
-

(11) Prevalence of sexually transmitted diseases (STDs).

High Average Low

(12) What are the most common STDs? _____

(13) Are there any STD education/prevention programs? Yes No

(14) If Yes, describe:

(15) Are there any unexplained or undiagnosed illnesses/deaths among:

(a) A significant population concentration.

(b) Refugees.

(c) Internally displaced persons.

(16) If deaths are unexplained, include report on location, condition of area, number of ill/dead, demographics on affected population, and symptoms. Also, include occurrences of simultaneous deaths on livestock if applicable.

(17) Gender ratio/ethnicity composition: _____

(18) Description of overall nutritional status: _____

(19) Is there a significant population w/o proper amounts of food/water?

YES NO

(20) Description of population hygiene: _____

(21) Is prostitution legal? Yes No

(22) If Yes, describe requirements for legal status (health cards, regular checkups, etc.):

(23) Illegal drug type and availability: _____

(24) Is there a significant population experiencing an unusually high number of maternal or infant deaths? NO If YES, which population? _____

(25) What is the vaccination program available to the general public? _____

(26) List measures to control outbreaks of diseases: _____

(27) Number of medical personnel trained/treating people to control outbreaks:

(28) List number and capabilities of medical facilities used to control outbreaks:

(29) Common drug (antibiotics) used to control disease outbreaks of:

(a) Malaria.

(b) Diarrhea.

(c) Cholera.

(d) Measles.

(e) Polio.

(f) Hemorrhagic Fevers.

(g) Plague.

(h) Dengue Fever.

(i) Encephalitis.

(j) Meningitis.

(k) Tuberculosis.

(l) Hepatitis.

(m) Leptospirosis.

(n) Yellow Fever.

(o) Influenza.

(p) HIV/AIDS.

(q) Other _____

(30) Does common treatments seem to control outbreaks? Yes No

(31) Number and capabilities of mobile medical teams qualified to deal with disease outbreaks:

(32) Provide list of IGO/NGOs operating in AOR (include capabilities and contact numbers):

h. Environmental Health.

(1) Topography: Mountains Rainforest Desert

(2) Climate: Tropical Humid Arctic Temperate

(3) Temperature Ranges (degrees in Fahrenheit):

(a) Summer _____ to _____

(b) Winter _____ to _____

(4) Significant seasonal variants (monsoon season, rainy season, winter, etc.): ____

(5) Expected climate during operation: _____

(6) Include brief description and number of each:

(a) Military airfields _____

(b) Civilian airfields _____

(c) Helo-pads _____

(d) Rail heads _____

(e) Seaports/beach sites _____

(7) Standard of living of the local population:

Excellent Average Poor Destitute

(8) Typical housing of local population: _____

(9) List local utility companies: _____

(10) What is the primary source of power? _____

(11) Is power available for:

(a) Heat.

(b) Light (electricity).

(c) Hot water.

(12) Status of power distribution grids: _____

(13) Are environmental standards stated and enforced in the AOR? Yes No

(a) If yes, include copies of environmental monitoring reports if available.

(14) Acceptable levels of contaminants set by operational area (if available):

(a) Water _____

(b) Soil _____

(c) Air _____

(15) List water sources (tanks, spring, groundwater, etc.): _____

(16) What is the water quality?: _____

(17) List systems, if any, used to treat local water (include status of each system):

(18) Is there an adequate system to distribute water? Yes No

(19) Is there adequate water pressure? Yes No

(20) List foods most commonly eaten within the AOR: _____

(21) What local food products should be avoided? _____

(22) How is food commonly stored? _____

(23) Do food storage areas provide protection against climate, rodents, insects, other animals, and ultimately disease? YES NO

(24) How is food commonly prepared? _____

(25) Would food handlers/suppliers meet US standards? YES NO

(26) Are there any natural foods (berries, nuts) that are poisonous? YES NO

(a) If YES, what actions/supplies are needed if ingested? _____

(27) What types of zoonoses are prevalent and potentially transmissible from local insects, rodents, and other animals (i.e., malaria/mosquitoes, leishmaniasis/flys, rabies/feral dog)?

(28) What type of insect, rodent, or animal control is practiced? _____

(29) What venomous insects, spiders, and reptiles are natural to the area? _____

(30) Is adequate anti-venom readily available? YES NO

(a) If YES, list closest source: _____

(31) List all discovered and suspected common contaminants in local food and water:

(32) Describe hand-washing facilities, showers, and latrine facilities:

(33) Are septic systems used? YES NO

(34) If YES, what is the condition of the septic tanks and drain fields? _____

(35) What type of liquid waste disposal system is available?

(36) What is the condition of liquid waste drains from buildings?

(37) How is solid waste disposed of (burial, burning, etc.)?

(38) Will the deployed unit have to collect and dispose of solid waste or does the host provide garbage and refuse disposal?

(39) How is regulated medical waste disposed?

(40) Is there history of accidental or intentional chemical/biological/nuclear releases in the operational area? YES NO

(41) If YES, describe (include copies of historical records if possible): _____

(42) Potential Hazards: Chemical Biological Environmental Occupational

(a) List potential hazards:

1. Type: _____

2. Location: _____

3. Description: _____

4. Source cause (if known): _____

(b) List potential hazards:

1. Type: _____

2. Location: _____

3. Description: _____

4. Source cause (if known): _____

(43) Provide name/rank/contact information for (titles may be different; identify closest equivalent):

(a) Director, Environmental Protection Agency _____

(b) Director, Food and Drug Administration _____

(c) Director, Housing Authority _____

(d) Director of Utilities _____

(e) Chief, Waste Disposal and Management _____

i. Host Nation Health Care System.

(1) Is there a national health care system? Yes No

(a) If YES, describe (include organizational chart if possible): _____

(2) How does the general public access health care?

(3) What percentage of the HN gross national product goes towards health care?

(4) What is the policy for providing care to:

(a) Military members _____

(b) General public _____

(c) NGOs _____

(d) Non-state actors _____

(e) Internally displaced persons _____

(f) Refugees _____

(5) Provide name/rank/contact information for (titles may be different; identify closest equivalent):

(a) Chief, Department of Health (Ministry of Health) _____

(b) Chief, Medical Personnel Division _____

(c) Chief, Medical Education Division _____

(d) Chief, Medical Certification Division _____

(e) Chief, Medical Mobilization Division _____

(f) Chief, Medical Response Division _____

j. Host Nation Military Medicine/Health Care.

(1) Is there a medical department within the military system? YES No

(a) If YES, number of medical personnel assigned to the military: _____

(2) Average level of medical education/training? HIGH MEDIUM LOW

(3) Include a wire diagram/organizational chart of the military medical system.

(4) What services are provided by military medicine?

(5) What is the policy for providing care to:

(a) Military members _____

(b) Dependents _____

(c) NGOs _____

(d) Non-state actors _____

(e) Internally displaced persons _____

(f) Refugees _____

(6) List any provisions made for medical care during civil unrest:

(7) What is the medical capability of the military during deployment/“in the field”?
Include design of field hospital layout, medical services, supplies, and bed capacity:

(8) Describe the chain of battlefield evacuation:

k. Physical condition of troops from host/contributing nations.

(1) Origin of troops: _____

(2) Overall health condition: Excellent Good Average Poor

(3) Overall morale: Excellent Good Average Poor

(4) Overall status of immunizations: Current Not Current/No Record

(5) Possess personal protective equipment: YES NO

(6) Adequacy of clothing/equipment: Excellent Good Average Poor

(7) Adequacy of food/water: Excellent Good Average Poor

(8) What is the available medical care for contributing nation's military? _____

(9) What HIV/AIDS prevention programs does the contributing nation's military practice?

(10) Is HIV/AIDS screened for during recruitment and throughout military service? YES NO

(a) If YES, is HIV/AIDS a reason for discharge from the contributing nation's military (circle)? YES NO

1. Management of disaster/humanitarian crises.

(1) Attach a list of organizations involved in disaster response and their capabilities.

(2) Attach a diagram national level command and control.

(3) Who does the HN most frequently call upon in times of crises? _____

(4) How do military and civilian agencies interface during crisis management?

(5) Is there a national disaster preparedness and management plan? Yes No

(6) Is there a national disaster management-training program? Yes No

(7) Check the steps taken by the HN to prepare for natural or man-made disasters:

(a) Increased production/stockpiling of food/water/supplies.

(b) Disaster management training for responding personnel.

(c) Creation of specialized response teams.

(d) Crisis management exercises.

(8) Number of personnel “on call” to respond to disasters:

(a) Civilian: _____

(b) Military: _____

(9) Describe procedure to mobilize “on call” personnel:

(10) Number and type of MEDEVAC vehicles “on-call” for disaster:

(11) List all AE capabilities. Include procedures for requesting AE:

(12) Describe casualty handling doctrine for:

(a) Emergency trauma.

(b) Burns.

(c) Chemical/biological warfare.

(13) Provide name/rank/contact information for (titles may be different; identify closest equivalent):

(a) Director, FEMA _____

(b) Director, Disaster Preparedness and Management _____

(c) Chief, Medical _____

(d) Chief, Search and Rescue _____

(e) Chief, Fire Protection _____

(f) Chief, Air Evacuation _____

(g) Chief of Police _____

(h) UN Resident Coordinator _____

(i) UN-OCHA Field Representative _____

(j) Defense Attaché/US Ambassador _____

(14) Has a CMOC been established? YES NO

(15) If YES, list participating organizations and contact information: _____

m. Local Hospital Data.

(1) Hospital name: _____

(2) Military or civilian: _____

(3) Hospital location (street address, GPS coordinates):

(4) Primary POC Name: _____

(5) Title: _____

(6) Hospital phone/facsimile (FAX) numbers (include country code):

(7) Hospital radio frequencies: _____

(8) Overall square footage: _____

(9) Number of hospital beds: _____

(10) Types of hospital beds:

(11) Expansion capability:

(12) Wartime capability:

(13) Burns management capability:

(14) Orthopedic capability:

(15) Neurosurgery capability:

(16) Obstetrics capability:

(17) Intensive care capability:

(18) Trauma capability:

(19) Surgical specialties.

(a) Thoracic: _____

(b) Plastic: _____

(c) Cardiovascular: _____

(20) Nuclear medicine capability.

(a) X-Ray: _____

(b) Computed tomography (better known as CT) imaging: _____

(c) Magnetic resonance imaging (MRI): _____

(d) Ultrasound: _____

(21) Laboratory capabilities.

(a) Biochemical: _____

(b) Microbiological: _____

(c) Hematological: _____

(d) Other: _____

(22) Public health facilities:

(23) Veterinary services:

(24) Other:

(25) Does the facility have disaster preparedness/management plans? Yes No

(26) Disaster preparedness and disaster management capabilities? Yes No

(27) National disaster preparedness/management responsibilities? Yes No

(28) Describe the facility's role during a disaster:

n. Facility.

(1) Describe overall condition of the facility: _____

(a) Cleanliness: _____

(b) Sanitation: _____

(c) Aseptic techniques: _____

(2) Is there adequate patient privacy? YES NO

(3) Is there access to upper floors? YES NO

(a) If YES, what is used (stairs, elevators, etc.): _____

(b) Are there other routes of access if primary fails? YES NO

Describe: _____

(4) Are the floors safe and solid? YES NO

(5) Is the facility climate controlled? YES NO

(6) State of repair and evidence of toxic materials present (e.g. asbestos in ceiling tiles or in boiler/pipe insulation, stored or spilled toxic chemicals):

(7) Evidence of rodents/rodent droppings, or other animals including birds:

(8) Describe the ventilation system (include specialized isolation rooms):

(9) List available buildings, nomenclatures and room numbers:

(10) Are there hand-washing facilities available? Yes No

(11) Are there functional toilets close by? Yes No

(12) Describe the bio-waste, infectious waste and sharps disposal system:

(13) Describe the waste disposal system:

(14) Are there laundry facilities? Yes No

(15) What types of fuel sources are used?

(16) List available facility support infrastructure: adequate fixtures, connected utilities, heat, lighting, electricity, electrical distribution and adaptable sockets, medical gases, etc.):

(17) List voltage, cycle, and phased frequency of electricity:

(18) List type of electrical plug type used and diagram template of prongs:

(19) List alternative (back up) electrical power available and kilowatt capability:

(20) Are there other sources of emergency power? YES NO

(21) Are telephone services available? YES NO

(22) Will the telephone service support:

DSN FAX DATA SECURE COMM

(23) Is there a medical/fire/crash radio network available? YES NO

(a) If YES, list the crisis response radio frequency: _____

(24) Are radios/cell phones available for medical use? YES NO

(25) Alternative communication used? If YES, What?

(26) Does the facility have an Emergency Medical System? YES NO

(a) If YES, how is it activated? _____

(27) Overall security in facility:

(28) Number of personnel dedicated to security: _____

(a) Are they armed? YES NO

(29) Number and type of equipment dedicated to security:

o. Personnel.

(1) Medical personnel (include #, education/training, special qualifications, and accreditation):

(a) Physicians:

(b) Nurses:

(c) Dentist:

(d) Technicians:

(e) Other:

(2) Are personnel English-speaking? YES NO

(a) If NO, what is their primary language? _____

(3) Physician-Nurse ratio: _____

(4) What personnel are available to treat deployed US personnel:

p. Supplies/Materiel.

(1) Are “western” medical supplies available? Yes No

(2) Obtain the most comprehensive/up-to-date supply inventory (include product names, manufacturer, expiration dates).

(3) Are the medical supplies available for US deployed personnel use? YES NO

(a) If YES, is reimbursement required and to who?

(4) Describe all available supply storage facilities:

(a) Flammable storage: _____

(b) Refrigerator storage: _____

(c) Blood storage: _____

(5) Will “cold chain custody” be required (blood/medicines)? YES NO

(a) If YES, how will it be established?

(6) Describe the pharmacy capability:

(7) Obtain the most current and up to date pharmacy formulary listing.

(8) Describe the blood capability.

(a) Inventory:

(b) Capacity:

(c) Storage:

(d) Screening:

<u>1.</u> HIV/AIDS	YES	NO
<u>2.</u> Hepatitis B	YES	NO
<u>3.</u> Hepatitis C	YES	NO
<u>4.</u> Syphilis	YES	NO
<u>5.</u> Malaria	YES	NO
<u>6.</u> Anemia	YES	NO
<u>7.</u> Other		

(9) Methods of sterilization:

(10) List medical manufacturing facilities:

(11) Availability of disposable needles, syringes, IV transfusion bags, catheters, and tubing:

(12) Life Support and Diagnostic Equipment: (number/condition/make and model).

(a) Respirators:

(b) IV equipment:

(c) Defibrillators:

(d) Dialysis equipment:

(e) X-Ray capabilities:

(f) Ultrasound:

(g) Computerized axial tomography (better known as CAT scan):

(h) MRI:

(i) Laboratory equipment:

(j) Other:

(13) Medical materiel storage and distribution nodes:

q. Transportation.

(1) Describe road access:

(2) Describe air access:

(3) Describe rail access:

(4) Are there helo-landing zones? YES NO

(a) If YES, has it been surveyed by US airfield specialist in past year?

YES NO

(b) If YES, obtain a copy of survey to include GPS coordinates, transit time, and capabilities.

(c) Distance to beachhead: _____

(d) Distance to port: _____

(5) Are ambulances available for use? YES NO

(a) List vehicle types/litter capacity:

(b) Number of medical transport personnel: _____

(c) List equipment/supplies aboard: _____

(d) Radio communication aboard? YES NO

(e) List communications capability and frequencies:

(f) What are the clearances/training required for drivers?

(6) Overview of major transportation nodes/staging facilities:

(7) Does the host base operate rotary wing AE? YES NO

(a) If YES, How can the US activate and enter the system?

(8) List all flight support/crash rescue services available:

(9) Provide name/rank/contact information for (titles may be different; identify closest equivalent).

(a) Chief, Medical Transportation Branch: _____

(b) Chief, Ambulance Services: _____

(c) Chief, Air Transportation: _____

r. Summary Evaluation.

(1) Assumptions:

(2) What additional medical services would be needed if American military personnel were deployed?

(3) Critical open issues:

(4) Recommended medical COAs.

(a) COA 1:

(b) COA 2:

(c) COA 3:

(5) Conclusions:

s. **Notes.**

Include in your medical survey report recommendations of all medical requirements necessary to support the mission and population. Each problem identified on the checklist should be addressed. Where several alternatives are viable, identify the recommended best solution. Problems should be worked to the extent possible during the survey while other functional representatives are present on the scene (such as food service, billeting, logistics, communications, security police, procurement, etc.). Discuss problems with other team members including the site survey mission commander or ADVON team chief. Your report should emphasize telephone or written correspondence to answer questions and avoid misunderstandings.

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APPENDIX L

SYSTEMS AND PLANNING TOOLS

1. Introduction

There are numerous joint and Service systems and tools that assist the medical planner. Some of the more common “tools” are listed below with a short description of each. The list is provided to acquaint readers with some of the more common planning systems and tools used by medical planners.

2. Tools and Systems

a. **Medical Analysis Tool.** MAT is a medical planner’s tool that provides a requirements generator and a COA analysis module for CCDR, Service, and component medical planners. Using MAT, medical planners determine the level and scope of medical support needed for a military operation. MAT allows medical planners to estimate and plan theater medical requirements. Planners may also develop and evaluate COAs for probable scenarios.

(1) MAT has two main analytical functions. One function is to estimate medical supportability and sustainability requirements; this is performed by the requirements estimator. The other function is to assess medical supportability and sustainability capability; this is performed by the course-of-action analysis (COAA) tool.

(2) MAT may be used for contingency planning by quantifying the impact of a proposed OPLAN on the medical system. MAT has also been designed for use during contingency/crisis action planning, programming and budget development, exercises, and current operations/execution.

(3) Medical planning may be considered a sequential process. The process is much the same for any of the five major planning situations, from deliberate planning to execution; however, inputs and outputs may be quite different. MAT provides the medical planner with analytical assistance and decision support required for each step in the process.

(4) MAT allows the planner to display the operational scenario graphically. Icons that represent casualty sources, medical facilities, and bed down locations can be overlaid on a map. Lines between MTF locations represent evacuation route connectivity within the system. This graphical display facilitates collaborative planning and enhances situational awareness for the medical planner.

(5) The medical network structure can include any combination of levels or facilities desired by the user. For example, a scenario could be constructed within a single operational zone or a complete theater. Furthermore, the connectivity between treatment nodes can be as sparse or complex as desired by the planner. This level of flexibility has been included to ensure that any MTF relationship, current or future, can be represented.

(6) MAT combines user-generated patient workloads with clinical treatment estimates and relevant policies set by the user to calculate medical requirements. It calculates medical supportability and sustainability requirements in terms of beds needed, numbers of admissions and evacuations, staff, operating rooms and gross medical supply needs.

(7) After estimating medical requirements to support an operation, the planner can use the same data and scenario to perform COAA, also known as capabilities assessments, or to perform a risk assessment. MAT simulates the medical processes that would occur within a theater of operations. Results of the simulation show where potential bottlenecks may occur and/or where resources may be underutilized.

b. **Theater Medical Information Program.** TMIP is a tri-Service system that is designed to provide information to deployed medical forces to support all medical functional areas, including C2, medical logistics, blood management, patient regulation and evacuation, medical threat/intelligence, health care delivery, manpower and training, and medical capability assessment and sustainment analysis. TMIP will perform this service by integrating information from other medical systems, including the Composite Health Care System (CHCS), CHCS II, Defense Blood Standard System, and DMLSS. TMIP will also integrate other medical applications that have been developed for use during deployment such as TRAC2ES. TMIP integrates medical systems at the theater level to support deployed forces, to enhance the Services' capability to collect, process, and disseminate an uninterrupted flow of information, and to allow more efficient protection of lives and resources.

c. **USTRANSCOM Regulating and Command and Control Evacuation System.** TRAC2ES is an automated decision support tool that functions as a single C2 system that can be used in peacetime and contingencies. It provides visibility of in-theater patients requiring evacuation, available transportation assets, available hospital beds (by medical specialty), and patient ITV. TRAC2ES accommodates three modes of operation: deliberate planning, forecasting, and reactive replanning at both the intertheater and intratheater level.

(1) TRAC2ES provides a responsive communications system essential to the conduct of PM. TRAC2ES is a web-based system, which maximizes the internet while maintaining and protecting patient privacy and troop strength information. It replaced aspects of the DMRIS, APES and TAMMIS MEDREG module.

(2) TRAC2ES provides global support throughout the full operational medical continuum: fixed and deployable medical treatment and staging facilities; ground, sea, and air PM systems; and global and TPMRCs. TRAC2ES links GPMRCs and TPMRCs through global communications. It is a seamless, integrated system that is used the same way in peace and war.

(a) TRAC2ES provides real time-phased decision support to plan, replan, and forecast global and theater movement requirements.

(b) One call for PM will result in provision for a conveyance mode and a hospital bed, the "lift-bed plan."

(c) Lift-bed planning provides the one-stop solution for matching conveyance and global medical specialty bed assignment. TRAC2ES can plan, replan, and forecast at least 400 patients in 30 minutes. As TRAC2ES matures, it should be able to plan, replan, and forecast at least 1,750 patients in 30 minutes.

(3) TRAC2ES provides ITV by allowing authorized users to determine a patient's last known location and scheduled and actual itineraries.

(a) The minimum requirement or threshold for TRAC2ES provides ITV within 10 minutes, 95% of the time at theater hospitalization capability, to include last known location and scheduled and actual itineraries.

(b) Ultimately, TRAC2ES will locate patients, medical crew, medical and nonmedical attendants, and PMI within 5 minutes, 95% of the time at FRC capability.

d. **Joint Medical Semi-Automated Forces (JMeDSAF).** JMeDSAF is an object-based distributed tactical simulation that provides a synthetic battle staff for medical joint command staff training and medical rehearsal. It can be run in real time or faster than real time. JMeDSAF provides entity-level (single combatant/unit) simulation with automated and semi-automated interactions with a synthetic environment, other entities, and weapons systems. It also provides input to standard C2 systems by various gateways. When JMeDSAF is used as a medical mission rehearsal tool, planned operations are modeled and force-on-force interactions are simulated. Resulting WIA and DNBI casualties are transported, treated, and evacuated IAW doctrine.

e. **Medical Surveillance System (MSS)** provides the CCCR with medical situational awareness information. MSS is fed information from across the theater. This information includes patient visibility (where a patient is and their condition at that point in time), bed status, trending information concerning symptoms, international classifications of diseases (ICD) codes, common procedural terminology (CPT) codes, and DNBI information. When this information is analyzed, the combatant command surgeon will be able to take preventative actions to further protect individual soldiers. In the future, this information will be able to be shown as part of the COP, giving an integrated picture of what is occurring across the theater, and allowing commanders to analyze massive amounts of information quickly in order to make time sensitive decisions.

f. **Lower Echelon Reporting and Surveillance Module (LERSM).** The LERSM component provides a query capability to the local military treatment facility commander from information collected at his location. It provides local situational awareness information and medical treatment facility patient visibility along with support for predefined status reporting and epidemiology monitoring of ICD codes, CPT codes, and DNBI information. When this information is analyzed, the local military treatment facility commander will be able to take preventative actions to further protect individual soldiers.

g. **CBRN Casualty and Resource Estimation Support Tool (CBRN CREST).** CBRN CREST supports deliberate medical planning in an iterative, integrated process for the US Army

at the corps, division, and medical brigade levels. CREST is considered a developmental product and has not been validated and verified. Using scenarios as a driver for the tool, it allows medical personnel to estimate casualty streams and resource usage, and develop appropriate medical courses of action. The user-defined deployment and defensive posture of combat and rear area personnel is coupled with one or more CBRN attack scenarios on the map in accordance with the current threat assessment and planning guidance. The capability of individual deployed medical resources to meet demand is analyzed and the results are displayed. Key functions of the tool include:

- (1) Map-based representation of operational units, support units, medical treatment facilities, medical evacuation flow, and coverage of CBRN threats.
- (2) Estimation of required medical treatment resources.
- (3) Analysis of required medical resources and available resources at each level of care.
- (4) Comparison of alternative medical COAs.

h. **TAMMIS Customer Assistance Module (TCAM)/DCAM.** TCAM is a module of the TAMMIS logistics application that provides a capability to perform basic customer level medical supply functions such as ordering, receiving, managing dues-in and inventory control. TCAM allows customers to perform these functions off-line and to exchange files with the supporting supply support activity (SSA) when NIPRNET communications are available. This exchange includes the downloading of selected catalog files from the SSA's TAMMIS system allowing customers to research the catalog for prime and substitute items. When NIPRNET is not available, customer files can be exported to floppy disk, CD, or printed copy for physical delivery to the supporting supply activity. TCAM is the primary means for Echelon I and II customers to submit CL VIII orders to supporting MEDLOG elements or units. DCAM is a nearly identical product that will operate as the remote customer module for the medical communications for combat casualty care/TMIP MEDLOG support system. It will differ from TCAM in that it will be certified using the DOD Information Technology Security Certification & Accreditation Process and will have the capability to exchange files back and forth between two separate DCAM devices. This will allow automated information transfer between levels I and II.

i. **TAMMIS.** TAMMIS is the primary Army legacy system for MEDLOG. It operates on the Combat Automated Support System-Medical server and provides Intermediate-level supply management capabilities for operation of CL VIII SSAs as well internal supply operations for combat support hospitals. Intermediate-level supply capabilities include the ability to process orders from external retail-level customers and to manage the materiel release process facilitate shipping operations to reach distant customers using military or commercial transportation networks. It requires the ability to print DOD standard shipping documents, aggregate materiel shipments by customer, and pass data to external DOD systems for movement planning and ITV. These capabilities are not in the current DMLSS application, and are not programmed for development for several years; therefore TAMMIS will remain the only medical logistics

management system capable of supporting theater medical supply operation until it can be replaced. At this time the proposed replacement of TAMMIS is TEWLS.

j. **DMLSS 3.0** (Defense Medical Logistics Standard Support, version 3.0). DMLSS 3.0 is a fully integrated, application that supports the management of medical supply, medical equipment maintenance, medical assembly management, property accounting, and facility management at the unit or MTF.

k. **Defense Blood Standard System (DBSS)**. DBSS is an automated information system used to ensure a safe blood supply and is designed to manage collection, processing and tracking procedures for blood, and automate standards and safeguards for the Medical Health System blood supply. DBSS is regulated by the FDA. Theater DBSS (TDBSS) is the configuration of DBSS employed for theater operations. TDBSS is currently used in combat support hospitals and in BSUs.

l. **Joint Medical Asset Repository**. JMAR is a single source for acquiring and providing timely and accurate joint medical logistics and blood asset information for DOD.

m. **Medical Materiel Mobilization Planning Tool** is a web-based program that provides users with the ability to forecast CL VIII requirements based upon components of MES and troop population. It provides the capability for user units to maintain balances of their MES components, providing centralized asset visibility of MES. It can be used in garrison for unit-level medical assembly management and during mobilization and deployment operations by medical units, MEDLOG units and supporting installations to identify materiel requirements necessary to provide units with MES shortages.

n. **Unit Level Logistics System (ULLS)**. ULLS automates organizational-level supply, maintenance, property accountability, readiness and unit status reporting functions in tactical units for the Army, the Army National Guard, and the Army Reserve. ULLS provides visibility of equipment status and the overall unit readiness in the same format as ground equipment. Information in ULLS is transmitted by NIPRNET or removable media to the MEDLOG companies/battalions and higher HQs for quantifiable data analysis to determine parts stockage, equipment reliability, and to determine future equipment acquisitions. Medical repair parts are not ordered through ULLS and maintenance histories with detailed repair information is not maintained on the system.

o. **Global Transportation Network (GTN)**. The GTN supports ITV. ITV provides information needed to answer status-of-movement questions for customers around the world, including US forces deployed to remote locations. The GTN also supports USTRANSCOM's mission as the C2 HQ for the DTS. The GTN creates ITV information by consolidating and integrating data from many other computer system sources called "GTN data feeds." They each provide data to the GTN as an ancillary mission, because they exist for some other specific purpose. The information collected by the GTN is housed and managed within a database. ITV information in the GTN database lends itself to a question-and-answer format. In the terminology of automated information systems, this is called query-response.

The GTN's current configuration is predominantly a query-response format that specifically facilitates the retrieval of ITV information.

APPENDIX M

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The development of JP 4-02 is based upon the following primary references:

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Title 10, USC – Armed Forces.

2. Multinational Documents

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b. *Geneva Convention for the Amelioration of the Condition of the Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea*, 12 August 1949.

c. *Geneva Convention Relative to the Treatment of Prisoners of War*, 12 August 1949.

d. *Geneva Convention Relative to the Protection of Civilian Persons in Time of War*, 12 August 1949.

e. *The American, British, Canadian, and Australian (ABCA) Armies Coalition Health Interoperability Handbook*.

f. *American, British, Canadian, and Australian (ABCA) Coalition Operations Handbook*.

3. Department of Defense Directives

a. DOD 4515.13R, *Air Transportation Eligibility*.

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g. DODD 6200.4, *Force Health Protection*.

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- i. DODD 6490.2, *Comprehensive Health Surveillance*.
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- k. DODI 3020-41, *Contractor Personnel Authorized to Accompany the US Armed Forces*.
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- c. JP 3-0, *Joint Operations*.
- d. JP 3-05, *Doctrine for Joint Special Forces*.
- e. JP 3-11, *Joint Doctrine for Operations in Nuclear, Biological, Chemical (NBC) Environment*.
- f. JP 3-16, *Multinational Operations*.
- g. JP 3-33, *Joint Task Force Headquarters*.
- h. JP 3-50, *Personnel Recovery*.
- i. JP 4-0, *Doctrine for Logistic Support of Joint Operations*.
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k. AR 40-56, *Introduction, Requirements Determination, & Publication of New Standardized Medical Items Into the Department of Defense*.

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m. AR 40-61, *Medical Logistics Policies*.

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- s. AR 40-400, *Patient Administration*.
- t. AR 40-538, *Property Management During Patient Evacuation*.
- u. AR 40-562, *Immunizations and Chemoprophylaxis*.
- v. AR 40-656, *Veterinary Surveillance Inspection of Subsistence*.
- w. AR 40-657, *Veterinary/Medical Food Inspection and Laboratory Service*.
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- y. FM 4-02.1, *Combat Health Logistics*.
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- bb. FM 4-02.19, *Dental Service Support in a Theater of Operations*.
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jj. USACHPPM Technical Guide 244, *The Medical CBRN Battlebook*.

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mm. Army Medical Research Institute of Infectious Diseases, *Medical Management of Biological Casualties Handbook*.

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d. AFI 41-201, *Managing Clinical Engineering Programs*.

e. AFI 41-209, *Medical Logistics Support*.

f. AFI 41-214, *Air Force Medical Logistics List Server*.

g. AFI 41-301, *Worldwide Aeromedical Evacuation System*.

h. AFI 41-305, *Administering Aeromedical Staging Facilities*.

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12. Other References

The Unofficial Joint Medical Officer's Handbook.

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APPENDIX N

ADMINISTRATIVE INSTRUCTIONS

1. User Comments

Users in the field are highly encouraged to submit comments on this publication to: Commander, United States Joint Forces Command, Joint Warfighting Center, ATTN: Joint Doctrine Group, 116 Lake View Parkway, Suffolk, VA 23435-2697. These comments should address content (accuracy, usefulness, consistency, and organization), writing, and appearance.

2. Authorship

The lead agent for this publication is the United States Army. The Joint Staff doctrine sponsor for this publication is the Director for Logistics (J-4).

3. Supersession

This publication supersedes JP 4-02, 30 July 2001, *Doctrine for Health Service Support in Joint Operations*; JP 4-02.1, 6 October 1997, *Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations*; and JP 4-02.2, 30 December 1996, *Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations*.

4. Change Recommendations

- a. Recommendations for urgent changes to this publication should be submitted:

TO: HQDA WASHINGTON DC/CASG-SCD-D//
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CDRUSJFCOM SUFFOLK VA//JT10//

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- b. When a Joint Staff directorate submits a proposal to the Chairman of the Joint Chiefs of Staff that would change source document information reflected in this publication, that directorate will include a proposed change to this publication as an enclosure to its proposal. The Military Services and other organizations are requested to notify the Joint Staff/J-7 when changes to source documents reflected in this publication are initiated.

c. Record of Changes:

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GLOSSARY

PART I — ABBREVIATIONS AND ACRONYMS

2E	Role 2 enhanced
2LM	Role 2 light maneuver
AABB	American Association of Blood Banks
AAC	activity address code
AAST	aeromedical evacuation administrative support team
ABO	blood typing system
ACAT	aeromedical evacuation command augmentation team
ADVON	advanced echelon
AE	aeromedical evacuation
AEC	aeromedical evacuation crew
AECM	aeromedical evacuation crew member
AECS	aeromedical evacuation command squadron
AECT	aeromedical evacuation control team
AEG	air expeditionary group
ELT	aeromedical evacuation liaison team
AEOT	aeromedical evacuation operations team
AEPST	aeromedical evacuation plans and strategy team
AES	aeromedical evacuation squadron
AESC	aeromedical evacuation support cell
AEW	air and space expeditionary wing
AFDD	Air Force doctrine document
AFI	Air Force instruction
AFMAN	Air Force manual
AFMIC	Armed Forces Medical Intelligence Center
AFPD	Air Force policy directive
AFTTP(I)	Air Force tactics, techniques, and procedures (instruction)
AIS	automated information system
AJBPO	area joint blood program office
AIDS	acquired immune deficiency syndrome
ALCT	airlift control team
AMBUS	ambulance bus
AMC	Air Mobility Command
AMD	air mobility division
AMOCC	air mobility operations control center
AO	area of operations
AOC	air operations center
AOR	area of responsibility
APES	Automated Patient Evacuation System
APOD	aerial port of debarkation
APOE	aerial port of embarkation
APS	Army pre-positioned stocks

AR	Army regulation
ASBP	Armed Services Blood Program
ASBPO	Armed Services Blood Program Office
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASF	aeromedical staging facility
ASWBPL	Armed Services Whole Blood Processing Laboratories
ATO	air tasking order
BDC	blood donor center
BEE	bioenvironmental engineering officer
BI	battle injury
BLDREP	blood report
BLDSHIPREP	blood shipment report
BMET	biomedical equipment technician
BPD	blood products depot
BSCT	behavioral science consultation team
BSD	blood supply detachment
BSU	blood supply unit
BTC	blood transshipment center
C	centigrade
C2	command and control
CA	civil affairs
CASEVAC	casualty evacuation
CASF	contingency aeromedical staging facility
CBRN	chemical, biological, radiological, and nuclear
CBRNE	chemical, biological, radiological, nuclear, or high-yield explosives
CCATT	critical care air transport team
CCDR	combatant commander
CD	compact disc
CDC	Centers for Disease Control and Prevention
CDF	contractors deploying with the force
CERF	Central Emergency Revolving Fund (UN)
CHCS	composite health care system
CJCS	Chairman of the Joint Chiefs of Staff
CJCSI	Chairman of the Joint Chiefs of Staff instruction
CJCSM	Chairman of the Joint Chiefs of Staff manual
CJTF	commander, joint task force
CL	class
CM	consequence management
CMC	crew management cell
CMO	civil-military operations
CMOC	civil-military operations center
COA	course of action

COAA	course-of-action analysis
COMAFFOR	commander, Air Force forces
CONOPS	concept of operations
CONPLAN	concept plan
CONUS	continental United States
COP	common operational picture
COS	chief of staff
CPO	chief petty officer
CPT	common procedural terminology
CRAF	civil reserve air fleet
CREST	casualty and resource estimation support tool
CRTS	casualty receiving and treatment ship
CS	civil support
CWT	customer wait time
D&R	debrief and reintegrate
DBSS	Defense Blood Standard System
DCAM	Defense Medical Logistics Standard Support (DMLSS) customer assistance module
DDC	defense distribution center
DDOC	deployment distribution operations center
DHS	Department of Homeland Security
DIRMOBFOR	director of mobility forces
DJTFS	deputy joint task force surgeon
DLA	Defense Logistics Agency
DLIS	Defense Logistics Information Service
DMLSS	Defense Medical Logistics Standard Support
DMRIS	defense medical regulating information system
DMSB	Defense Medical Standardization Board
DNBI	disease and nonbattle injury
DOD	Department of Defense
DODD	Department of Defense directive
DODI	Department of Defense instruction
DOS	Department of State
DS	direct support
DSCA	defense support to civil authorities
DSCP	Defense Supply Center Philadelphia
DTS	Defense Transportation System
EA	executive agent
EACS	expeditionary aeromedical evacuation crew member support
EACT	expeditionary aeromedical evacuation coordination team
EAES	expeditionary aeromedical evacuation squadron
EASF	expeditionary aeromedical staging facility
EAST	expeditionary aeromedical evacuation staging team

EHO	environmental health officer
EMF	expeditionary medical facility
EMS	emergency medical services
EPW	enemy prisoner of war
ESO	environmental science officer
EXORD	execute order
FAX	facsimile
FCC	Federal coordinating center
FDA	Food and Drug Administration
FDT	forward distribution team
FEMA	Federal Emergency Management Agency
FFP	fresh frozen plasma
FHA	foreign humanitarian assistance
FHP	force health protection
FM	field manual
FRAGORD	fragmentary order
FRC	forward resuscitative care
GC	Geneva Convention Relative to the Protection of Civilian Persons in Time of War
GCC	geographic combatant commander
GPMRC	Global Patient Movement Requirements Center
GPS	global positioning system
GPW	Geneva Convention Relative to the Treatment of Prisoners of War
GS	general support
GTN	Global Transportation Network
GWS	Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field
GWS Sea	Geneva Convention for the Amelioration of the Condition of the Wounded, Sick, and Shipwrecked Members of the Armed Forces at Sea
HA	humanitarian assistance
HAST	humanitarian assistance survey team
HAP-EP	humanitarian assistance program-excess property
HCA	humanitarian and civic assistance
HIV	human immuno-deficiency virus
HMMWV	high mobility multipurpose wheeled vehicle
HN	host nation
HNS	host-nation support
HQ	headquarters
HSLs	health service logistic support
HSS	health service support

IAW	in accordance with
ICD	international classifications of diseases
ICRC	International Committee of the Red Cross
ID	identification
IDP	internally displaced person
IGO	intergovernmental organization
IHO	industrial hygiene officer
IHS	international health specialist
ISS	in-system select
ITV	in-transit visibility
IV	intravenous
J-1	manpower and personnel directorate of a joint staff
J-2	intelligence directorate of a joint staff
J-3	operations directorate of a joint staff
J-4	logistics directorate of a joint staff
J-6	communications system directorate of a joint staff
JAOC	joint air operations center
JBPO	joint blood program office
JDOMS	Joint Director of Military Support
JFACC	joint force air component commander
JFC	joint force commander
JFS	joint force surgeon
JIPOE	joint intelligence preparation of the operational environment
JMAR	joint medical asset repository
JMC	joint movement center
JMeDSAF	joint medical semi-automated forces
JMLO	joint medical logistics officer
JMOC	joint medical operations center
JMWG	joint medical working group
JOA	joint operations area
JOPES	Joint Operation Planning and Execution System
JP	joint publication
JPG	joint planning group
JPMRC	joint patient movement requirements center
JPMT	joint patient movement team
JPRC	joint personnel recovery center
JRSOI	joint reception, staging, onward movement, and integration
JTF	joint task force
JTFS	joint task force surgeon
LA	lead agent
LERSM	lower echelon reporting and surveillance module
LNO	liaison officer
LOAC	law of armed conflict

LOC	line of communications
LOX	liquid oxygen
MA	medical attendant
MAJCOM	major command (USAF)
MASCAL	mass casualty
MASF	mobile aeromedical staging facility
MAT	medical analysis tool
MBCDM	medical biological chemical defense materiel
MCMO	medical civil-military operations
MCRP	Marine Corps reference publication
MCWP	Marine Corps warfighting publication
MEDEVAC	medical evacuation
MEDLOG	medical logistics
MEDREG	medical regulating
MES	medical equipment set
MIPOE	medical intelligence preparation of the operational environment
MLMC	medical logistics management center
MLPS	Medical Logistics Proponent Subcommittee
MNF	multinational force
MNFC	multinational force commander
MRI	magnetic resonance imaging
MRO	medical regulating officer
MSS	medical surveillance system
MTF	medical treatment facility
MWD	military working dog
NAPMIS	Navy Preventive Medicine Information System
NATO	North Atlantic Treaty Organization
NAVMED	Navy medicine
NAVSO	naval special operations forces
NBI	nonbattle injury
NCO	noncommissioned officer
NDMS	National Disaster Medical System
NEO	noncombatant evacuation operation
NGO	nongovernmental organization
NIPRNET	Non-Secure Internet Protocol Router Network
NRP	National Response Plan
NTTP	Navy tactics, techniques, and procedures
OCHA	Office for the Coordination of Humanitarian Affairs
OCONUS	outside the continental United States
OEH	occupational and environmental health
OEM	original equipment manufacturer

OPCON	operational control
OPLAN	operation plan
OPORD	operation order
ORM	operational risk management
PA	physician assistant
PAD	patient administration director
PAR	population at risk
PBA	performance-based agreement
PM	patient movement
PMI	patient movement item
PMR	patient movement request
PMRC	patient movement requirements center
POC	point of contact
POW	prisoner of war
PR	personnel recovery
PRA	patient reception area
PRT	patient reception team
R&R	rest and recuperation
RBC	red blood cell
Rh	Rhesus factor
RSOI	reception, staging, onward movement, and integration
RTD	returned to duty
SEAL	sea-air-land team
SecDef	Secretary of Defense
SERE	survival, evasion, resistance, and escape
SIMLM	single integrated medical logistics manager
SIPRNET	SECRET Internet Protocol Router Network
SJA	staff judge advocate
SME	subject matter expert
SOC	special operations command
SOCCT	special operations critical care evacuation team
SOF	special operations forces
SOFA	status-of-forces agreement
SOP	standard operating procedure
SPOD	seaport of debarkation
SSA	supply support activity
STD	sexually transmitted disease
T-AH	hospital ship
TACC	tanker airlift control center
TAES	theater aeromedical evacuation system
TAMMIS	theater Army medical management information system

TBTC	transportable blood transshipment center
TCAM	theater Army medical management information system (TAMMIS) customer assistance module
TCN	third country national
TDBSS	Theater Defense Blood Standard System
TEWLS	Theater Enterprise Wide Logistics System
TLAMM	theater lead agent for medical materiel
TMIP	theater medical information program
TMLMC	theater medical logistic management center
TPFDD	time-phased force and deployment data
TPFDL	time-phased force and deployment list
TPMRC	theater patient movement requirements center
TRAC2ES	transportation command regulating and command and control evacuation system
ULLS	unit level logistics system
UN	United Nations
USA	United States Army
USACHPPM	US Army Center for Health Promotion and Preventive Medicine
USAF	United States Air Force
USAID	United States Agency for International Development
USARIEM	United States Army Research Institute of Environmental Medicine
USC	United States Code
USEUCOM	United States European Command
USD(P&R)	Under Secretary of Defense (Personnel & Readiness)
USG	United States Government
USJFCOM	United States Joint Forces Command
USMC	United States Marine Corps
USN	United States Navy
USNORTHCOM	United States Northern Command
USNS	United States naval ship
USPACOM	United States Pacific Command
USTRANSCOM	United States Transportation Command
UTC	unit type code
VA	Veterans Administration
VFS	validating flight surgeon
VMI	vendor managed inventory
VTC	video teleconferencing
WHO	World Health Organization
WIA	wounded in action
WMD	weapons of mass destruction
WOC	wing operations center (USAF)

WRAIR
WRM

Walter Reed Army Institute of Research
war reserve materiel

PART II — TERMS AND DEFINITIONS

acute care services. Medical services provided for patients with conditions that generally have a rapid onset and follow a short course or require immediate attention. Most battlefield care rendered after wounding, illness, or injury onset is acute care service. Acute care service is delivered after the onset of symptoms, which differentiates it from preventive care that is delivered before symptoms appear. (Approved for inclusion in the next edition of JP 1-02.)

aeromedical evacuation. The movement of patients under medical supervision to and between medical treatment facilities by air transportation. Also called AE. (JP 1-02)

aeromedical evacuation system. A system that provides: a. control of patient movement by air transport; b. specialized medical aircrew, medical crew augmentees, and specialty medical attendants and equipment for inflight medical care; c. facilities on or in the vicinity of air strips and air bases for the limited medical care of intransit patients entering, en route via, or leaving the system; and d. communication with originating, destination, and en route medical facilities concerning patient transportation. Also called AES. (JP 1-02)

ambulance exchange point. A location where a patient is transferred from one ambulance to another en route to a medical treatment facility. This may be an established point in an ambulance shuttle or it may be designated independently. Also called AXP. (JP 1-02)

battle injury. Damage or harm sustained by personnel during or as a result of battle conditions. Also called BI. (Approved for inclusion in the next edition of JP 1-02.)

battlespace. The environment, factors, and conditions that must be understood to successfully apply combat power, protect the force, or complete the mission. This includes the air, land, sea, space, and the included enemy and friendly forces; facilities; weather; terrain; the electromagnetic spectrum; and the information environment within the operational areas and areas of interest. (JP 1-02)

buddy-aid. Acute medical care (first aid) provided by a non-medical Service member to another person. (Approved for inclusion in the next edition of JP 1-02.)

casualty. Any person who is lost to the organization by having been declared dead, duty status—whereabouts unknown, missing, ill, or injured. (JP 1-02)

casualty category. A term used to specifically classify a casualty for reporting purposes based upon the casualty type and the casualty status. Casualty categories include killed in action, died of wounds received in action, and wounded in action. (JP 1-02)

casualty evacuation. The unregulated movement of casualties that can include movement both to and between medical treatment facilities. Also called CASEVAC. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

casualty receiving and treatment ship. In amphibious operations, a ship designated to receive, provide treatment for, and transfer casualties. (JP 1-02)

casualty status. A term used to classify a casualty for reporting purposes. There are seven casualty statuses: (1) deceased; (2) duty status - whereabouts unknown; (3) missing; (4) very seriously ill or injured; (5) seriously ill or injured; (6) incapacitating illness or injury; and (7) not seriously injured. (JP 1-02)

casualty type. A term used to identify a casualty for reporting purposes as either a hostile casualty or a nonhostile casualty. (JP 1-02)

civil-military medicine. A discipline within operational medicine comprising public health and medical issues that involve a civil-military interface (foreign or domestic), including military medical support to civil authorities (domestic), medical engagement cooperation activities, and medical civil-military operations. (Approved for inclusion in the next edition of JP 1-02.)

combat and operational stress. The expected and predictable emotional, intellectual, physical, and/or behavioral reactions of Service members who have been exposed to stressful events in war or military operations other than war. Combat stress reactions vary in quality and severity as a function of operational conditions, such as intensity, duration, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission. (JP 1-02)

combat and operational stress control. Programs developed and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units; optimize mission performance; conserve fighting strength; prevent or minimize adverse effects of combat and operational stress on members' physical, psychological, intellectual and social health; and to return the unit or Service member to duty expeditiously. (Approved for inclusion in the next edition of JP 1-02.)

combatant command. A unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the Secretary of Defense and with the advice and assistance of the Chairman of the Joint Chiefs of Staff. Combatant commands typically have geographic or functional responsibilities. (JP 1-02)

combatant commander. A commander of one of the unified or specified combatant commands established by the President. Also called CCDR. (JP 1-02)

combat service support. The essential capabilities, functions, activities, and tasks necessary to sustain all elements of operating forces in theater at all levels of war. Within the national and theater logistic systems, it includes but is not limited to that support rendered by service forces in ensuring the aspects of supply, maintenance, transportation, health services, and other services required by aviation and ground combat troops to permit those units to accomplish their missions in combat.

Combat service support encompasses those activities at all levels of war that produce sustainment to all operating forces on the battlefield. Also called CSS. (JP 1-02)

combat zone. 1. That area required by combat forces for the conduct of operations. (JP 1-02)

command and control. The exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. Command and control functions are performed through an arrangement of personnel, equipment, communications, facilities, and procedures employed by a commander in planning, directing, coordinating, and controlling forces and operations in the accomplishment of the mission. Also called C2. (JP 1-02)

commonality. A quality that applies to materiel or systems: a. possessing like and interchangeable characteristics enabling each to be utilized, or operated and maintained, by personnel trained on the others without additional specialized training; b. having interchangeable repair parts and/or components; and c. applying to consumable items interchangeably equivalent without adjustment. (JP 1-02)

common operational picture. A single identical display of relevant information shared by more than one command. A common operational picture facilitates collaborative planning and assists all echelons to achieve situational awareness. Also called COP. (JP 1-02)

communications zone. Rear part of theater of war or theater of operations (behind but contiguous to the combat zone) which contains the lines of communications, establishments for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces. Also called COMMZ. (JP 1-02)

contingency contractor personnel. Defense contractors and employees of defense contractors and associated subcontractors, including US citizens, US legal aliens, third country national personnel, and citizens of host nations, who are authorized to accompany US military forces in contingency operations, other military operations, or exercises designated by the geographic combatant commander. This includes employees of external support, systems support, and theater support contractors. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

contractors deploying with the force. A sub-category of “contingency contractor personnel.” Contractors deploying with the force are employees of system support and external support contractors and associated subcontractor, at all tiers, who are specifically authorized in their contract to deploy through a deployment center or process and provide support to US military forces in contingency operations or in other military operations, or exercises designated by a geographic combatant commander. Also called CDF. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

definitive care. Care rendered to conclusively manage a patient's condition. It includes the full range of preventive, curative acute, convalescent, restorative, and rehabilitative medical care. This normally leads to rehabilitation, return to duty, or discharge from the Service. (Approved for inclusion in the next edition of JP 1-02.)

deployment health surveillance. The regular or repeated collection, analysis, archiving, interpretation, and distribution of health-related data used for monitoring the health of a population or of individuals, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury. It includes occupational and environmental health surveillance and medical surveillance subcomponents. (Approved for inclusion in the next edition of JP 1-02.)

detainee. A term used to refer to any person captured or otherwise detained by an armed force. (JP 1-02)

directed energy. An umbrella term covering technologies that relate to the production of a beam of concentrated electromagnetic energy or atomic or subatomic particles. Also called DE. (JP 1-02)

disease and nonbattle injury. All illnesses and injuries not resulting from enemy or terrorist action or caused by conflict. Indigenous disease pathogens, biological warfare agents, heat and cold, hazardous noise, altitude, environmental, occupational, and industrial exposures, and other naturally occurring disease agents may cause disease and nonbattle injury. Disease and nonbattle injuries include injuries and illnesses resulting from training or from occupational, environmental, or recreational activities, and may result in short- or long-term, acute, or delayed illness, injury, disability, or death. Also called DNBI. (Approved for inclusion in the next edition of JP 1-02.)

disease and nonbattle injury casualty. A person who is not a battle casualty but who is lost to the organization by reason of disease or injury, including persons dying of disease or injury, by reason of being missing where the absence does not appear to be voluntary, or due to enemy action or being interned. Also called DNBI casualty. (JP 1-02)

duty status - whereabouts unknown. A transitory casualty status, applicable only to military personnel, that is used when the responsible commander suspects the member may be a casualty whose absence is involuntary, but does not feel sufficient evidence currently exists to make a definite determination of missing or deceased. Also called DUSTWUN. (JP 1-02)

en route care. Continuation of the provision of care during movement (evacuation) between the health service support capabilities in the continuum of care, without clinically compromising the patient's condition. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

essential care. Medical treatment provided to manage the casualty throughout the range of care. This includes all care and treatment to either return the patient to duty (within the theater evacuation policy), or begin initial treatment required for optimization of outcome, and/or stabilization to ensure the patient can tolerate evacuation. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

evacuation. 1. Removal of a patient by any of a variety of transport means (air, ground, rail, or sea) from a theater of military operation, or between health service support capabilities, for the purpose of preventing further illness or injury, providing additional care, or providing disposition of patients from the military health care system. 2. The clearance of personnel, animals, or materiel from a given locality. 3. The controlled process of collecting, classifying, and shipping unserviceable or abandoned materiel, US or foreign, to appropriate reclamation, maintenance, technical intelligence, or disposal facilities. 4. The ordered or authorized departure of noncombatants from a specific area by Department of State, Department of Defense, or appropriate military commander. This refers to the movement from one area to another in the same or different countries. The evacuation is caused by unusual or emergency circumstances and applies equally to command or non-command sponsored family members. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

executive agent. A term used to indicate a delegation of authority by the Secretary of Defense to a subordinate to act on the Secretary's behalf. Designation as executive agent, in and of itself, confers no authority. The exact nature and scope of the authority delegated must be stated in the document designating the executive agent. An executive agent may be limited to providing only administration and support or coordinating common functions, or it may be delegated authority, direction, and control over specified resources for specified purposes. Also called EA. (JP 1-02)

external support contractors. US national or third party contract personnel hired from outside the operational area. (JP 1-02)

first responder care. The health care capability that provides immediate clinical care and stabilization to the patient in preparation for evacuation to the next health service support capability in the continuum of care. (Approved for inclusion in the next edition of JP 1-02.)

first responders. The primary health care providers whose responsibility is the provision of immediate clinical care and stabilization in preparation for evacuation to the next health service support capability in the continuum of care. In addition to treating injuries, they treat Service members for common acute minor illnesses. (This term and its definition modify the existing term "first responder phase" and its definition and are approved for inclusion in the next edition of JP 1-02.)

force health protection. Measures to promote, improve, or conserve the mental and physical well-being of Service members. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. Also called FHP. (This term and its definition

modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

forward aeromedical evacuation. That phase of evacuation that provides airlift for patients between points within the battlefield, from the battlefield to the initial point of treatment, and to subsequent points of treatment within the combat zone. (JP 1-02)

forward resuscitative care. Care provided as close to the point of injury as possible based on current operational requirements to attain stabilization and achieve the most efficient use of life-and-limb saving medical treatment. Forward resuscitative care typically provides essential care for stabilization to ensure the patient can tolerate evacuation. Also called FRC. (This term and its definition modify the existing term “forward resuscitative surgery” and its definition and are approved for inclusion in the next edition of JP 1-02.)

Global Patient Movement Requirements Center. A joint activity reporting directly to the Commander, US Transportation Command, the Department of Defense single manager for the strategic and continental United States regulation and movement of uniformed services and other authorized patients. The Global Patient Movement Requirements Center provides medical regulating and aeromedical evacuation scheduling for the continental United States and intertheater operations and provides support to the theater patient movement requirements centers. The Global Patient Movement Requirements Center coordinates with supporting resource providers to identify available assets and communicates transport to bed plans to the appropriate transportation agency for execution. Also called GPMRC. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

health care provider. Any member of the Armed Forces, civilian employee of the Department of Defense, or personal services contract employee under Title 10 United States Code Section 1091 authorized by the Department of Defense to perform health care functions. The term does not include any contract provider who is not a personal services contract employee. Also called DOD health care provider. (Approved for inclusion in the next edition of JP 1-02.)

health hazard assessment. An assessment that characterizes the possible health risks of occupational exposures of Service members during the course of their normal duties. (Approved for inclusion in the next edition of JP 1-02.)

health service logistic support. A functional area of logistic support that supports the joint force surgeon’s health service support mission. It includes supplying Class VIII medical supplies (medical material to include medical peculiar repair parts used to sustain the health service support system), optical fabrication, medical equipment maintenance, blood storage and distribution, and medical gases. Also called HSLS. (JP 1-02)

health service support. All services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not

limited to, the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat stress control; and medical, dental, veterinary, laboratory, optometric, nutrition therapy, and medical intelligence services. Also called HSS. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

health surveillance. The regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential health risks, thereby enabling timely interventions to prevent, treat, reduce, or control disease and injury. It includes occupational and environmental health surveillance and medical surveillance subcomponents. (Approved for inclusion in the next edition of JP 1-02.)

health threat. A composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of nuclear, biological, and chemical weapons (to include weapons of mass destruction) that have the potential to affect the short- or long-term health (including psychological impact) of personnel. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

hospital. A medical treatment facility capable of providing inpatient care. It is appropriately staffed and equipped to provide diagnostic and therapeutic services, as well as the necessary supporting services required to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic. (JP 1-02)

hostile casualty. A person who is the victim of a terrorist activity or who becomes a casualty “in action.” “In action” characterizes the casualty as having been the direct result of hostile action, sustained in combat or relating thereto, or sustained going to or returning from a combat mission provided that the occurrence was directly related to hostile action. Included are persons killed or wounded mistakenly or accidentally by friendly fire directed at a hostile force or what is thought to be a hostile force. However, not to be considered as sustained in action and not to be interpreted as hostile casualties are injuries or death due to the elements, self-inflicted wounds, combat fatigue, and except in unusual cases, wounds or death inflicted by a friendly force while the individual is in an absent-without-leave, deserter, or dropped-from-rolls status, or is voluntarily absent from a place of duty. (JP 1-02)

host-nation support. Civil and/or military assistance rendered by a nation to foreign forces within its territory during peacetime, crises or emergencies, or war based on agreements mutually concluded between nations. Also called HNS. (JP 1-02)

interoperability. 1. The ability to operate in synergy in the execution of assigned tasks. 2. The condition achieved among communications-electronics systems or items of communications-

electronics equipment when information or services can be exchanged directly and satisfactorily between them and/or their users. The degree of interoperability should be defined when referring to specific cases. (JP 1-02)

intertheater evacuation. None. (Approved for removal from the next edition of JP 1-02.)

intertheater patient movement. Moving patients between, into, and out of the different theaters of the geographic combatant commands and into the continental United States or another supporting theater. (This term and its definition modify the existing term “intertheater evacuation” and its definition and are approved for inclusion in the next edition of JP 1-02.)

intransit aeromedical evacuation facility. A medical facility, on or in the vicinity of an air base, that provides limited medical care for intransit patients awaiting air transportation. This type of medical facility is provided to obtain effective utilization of transport airlift within operating schedules. It includes “remain overnight” facilities, intransit facilities at aerial ports of embarkation and debarkation, and casualty staging facilities in an overseas combat area. (JP 1-02)

in-transit visibility. The ability to track the identity, status, and location of Department of Defense units, and non-unit cargo (excluding bulk petroleum, oils, and lubricants) and passengers; patients; and personal property from origin to consignee or destination across the range of military operations. Also called ITV. (JP 1-02)

intratheater evacuation. None. (Approved for removal from the next edition of JP 1-02.)

intratheater patient movement. Moving patients within the theater of a combatant command or in the continental United States. (This term and its definition modify the existing term “intratheater evacuation” and its definition and are approved for inclusion in the next edition of JP 1-02.)

joint force. A general term applied to a force composed of significant elements, assigned or attached, of two or more Military Departments operating under a single joint force commander. (JP 1-02)

joint force commander. A general term applied to a combatant commander, subunified commander, or joint task force commander authorized to exercise combatant command (command authority) or operational control over a joint force. Also called JFC. (JP 1-02)

joint force surgeon. A general term applied to a Department of Defense medical department officer appointed by the joint force commander to serve as the joint force special staff officer responsible for establishing, monitoring, or evaluating joint force health service support. Also called JFS. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

joint movement center. The center established to coordinate the employment of all means of transportation (including that provided by allies or host nations) to support the concept of operations. This coordination is accomplished through establishment of transportation policies within the assigned operational area, consistent with relative urgency of need, port and terminal capabilities, transportation asset availability, and priorities set by a joint force commander. Also called JMC. (JP 1-02)

joint patient movement requirements center. A joint activity established to coordinate the joint patient movement requirements function for a joint task force operating within a unified command area of responsibility. It coordinates with the theater patient movement requirements center for intratheater patient movement and the Global Patient Movement Requirements Center for intertheater patient movement. Also called JPMRC. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

joint patient movement team. Teams comprised of personnel trained in medical regulating and movement procedures. These teams can supplement a global, theater, or joint patient movement requirements center staff. Joint patient movement teams are under the operational control of the Global Patient Movement Requirements Center until attached to a theater/joint patient movement requirements center or forward element supporting the respective joint operation or Federal Emergency Management Agency contingency. Also called JPMT. (Approved for inclusion in the next edition of JP 1-02.)

killed in action. A casualty category applicable to a hostile casualty, other than the victim of a terrorist activity, who is killed outright or who dies as a result of wounds or other injuries before reaching a medical treatment facility. Also called KIA. (JP 1-02)

lead agent. 1. An individual Service, combatant command, or Joint Staff directorate assigned to develop and maintain a joint publication. 2. In medical materiel management, the designated unit or organization to coordinate or execute day-to-day conduct of an ongoing operation or function. Also called LA. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

logistic support (medical). Medical care, treatment, hospitalization, and evacuation, as well as the furnishing of medical services, supplies, materiel, and adjuncts thereto. (JP 1-02)

mass casualty. Any large number of casualties produced in a relatively short period of time, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, or armed attack that exceeds local logistic support capabilities. Also called MASCAL. (JP 1-02)

medical civil-military operations. All military health-related activities in support of a joint force commander that establish, enhance, maintain or influence relations between the joint or multinational force and host nation, multinational governmental and nongovernmental civilian organizations and authorities, and the civilian populace in order to facilitate military operations, achieve US operational objectives, and positively impact the health sector. Also called MCMO. (Approved for inclusion in the next edition of JP 1-02.)

medical contingency file. A web-based database within the Defense Supply Center Philadelphia's Readiness Management Application that identifies and manages Department of Defense medical contingency materiel requirements. (Approved for inclusion in the next edition of JP 1-02.)

medical evacuees. Personnel who are wounded, injured, or ill and must be moved to or between medical facilities. (JP 1-02)

medical intelligence. That category of intelligence resulting from the collection, evaluation, and analysis, and interpretation of foreign medical, bio-scientific, and environmental information that is of interest to strategic planning and to military medical planning and operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors. Also called MEDINT. (JP 1-02)

medical intelligence preparation of the operational environment. A systematic continuing process that analyzes information on medical and disease threats, enemy capabilities, terrain, weather, local medical infrastructure, potential humanitarian and refugee situations, transportation issues, and political, religious and social issues for all types of operations. Medical intelligence preparation of the operational environment is a component of the health service support mission analysis process, and the resulting statistics serves as a basis for developing health service support estimates and plans. It includes: defining the operational environment, describing the operational environment effects on health service support operations, evaluating the operational environmental threats, and determining courses of action to meet actual and potential threats. Also called MIPOE. (Approved for inclusion in the next edition of JP 1-02.)

medical protocols. Directives issued by competent military authority that delineate the circumstances and limitations under which United States medical forces will initiate medical care and support to those individuals that are not Department of Defense health care beneficiaries or designated eligible for care in a military medical treatment facility by the Secretary of Defense. (Approved for inclusion in the next edition of JP 1-02.)

medical regulating. The actions and coordination necessary to arrange for the movement of patients through the levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities and available bed space. (JP 1-02)

medical surveillance. The ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population's health, well-being and performance. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

medical treatment facility. A facility established for the purpose of furnishing medical and/or dental care to eligible individuals. Also called MTF. (JP 1-02)

military health system. A health system that supports the military mission by fostering, protecting, sustaining, and restoring health. It also provides the direction, resources, health care providers, and other means necessary for promoting the health of the beneficiary population. These include developing and promoting health awareness issues to educate customers, discovering and resolving environmentally based health threats, providing health services, including preventive care and problem intervention, and improving the means and methods for maintaining the health of the beneficiary population, by constantly evaluating the performance of the health care services system. (Approved for inclusion in the next edition of JP 1-02.)

multinational. Between two or more forces or agencies of two or more nations or coalition partners. (JP 1-02)

national military strategy. A document approved by the Chairman of the Joint Chiefs of Staff for distributing and applying military power to attain national security strategy and national defense strategy objectives. Also called NMS. (JP 1-02)

nonhostile casualty. A person who becomes a casualty due to circumstances not directly attributable to hostile action or terrorist activity. Casualties due to the elements, self-inflicted wounds, and combat fatigue are nonhostile casualties. Also called NHCS. (JP 1-02)

not seriously injured. The casualty status of a person whose injury may or may not require hospitalization; medical authority does not classify as very seriously injured, seriously injured, or incapacitating illness or injury; and the person can communicate with the next of kin. Also called NSI. See also casualty status. (JP 1-02)

occupational and environmental health surveillance. The regular or repeated collection, analysis, archiving, interpretation, and dissemination of occupational and environmental health-related data for monitoring the health of, or potential health hazard impact on, a population and individual personnel, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury when determined necessary. (Approved for inclusion in the next edition of JP 1-02.)

occupational and environmental health threats. Threats to the health of military personnel and to military readiness created by exposure to hazardous agents, environmental contamination, or toxic industrial materials. (JP 1-02)

operation order. A directive issued by a commander to subordinate commanders for the purpose of effecting the coordinated execution of an operation. Also called OPORD. (JP 1-02)

opportune lift. That portion of lift capability available for use after planned requirements have been met. (JP 1-02)

organic. Assigned to and forming an essential part of a military organization. Organic parts of a unit are those listed in its table of organization for the Army, Air Force, and Marine Corps, and are assigned to the administrative organizations of the operating forces for the Navy. (JP 1-02)

originating medical facility. A medical facility that initially transfers a patient to another medical facility. (JP 1-02)

patient. A sick, injured, wounded, or other person requiring medical and/or dental care or treatment. (JP 1-02)

patient movement. The act or process of moving a sick, injured, wounded, or other person to obtain medical and/or dental care or treatment. Functions include medical regulating, patient evacuation, and en route medical care. (JP 1-02)

patient movement policy. Command decision establishing the maximum number of days that patients may be held within the command for treatment. Patients who, in the opinion of responsible medical officers, cannot be returned to a duty status within the period prescribed are evacuated by the first available means, provided the travel involved will not aggravate their disabilities. (This term and its definition modify the existing term “evacuation policy” and its definition and are approved for inclusion in the next edition of JP 1-02.)

patient movement requirements center. Term used to represent any theater, joint or the Global Patient Movement Requirements Center function. A joint activity that coordinates patient movement. It is the functional merging of joint medical regulating processes, Services’ medical regulating processes, and patient movement evacuation requirements planning (transport to bed plan). Also called PMRC. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

population at risk. The strength in personnel of a given force structure in terms of which casualty rates are stated. Also called PAR. (Approved for inclusion in the next edition of JP 1-02.)

port of debarkation. The geographic point at which cargo or personnel are discharged. This may be a seaport or aerial port of debarkation; for unit requirements; it may or may not coincide with the destination. Also called POD. (JP 1-02)

port of embarkation. The geographic point in a routing scheme from which cargo or personnel depart. This may be a seaport or aerial port from which personnel and equipment flow to port of debarkation; for unit and non-unit requirements; it may or may not coincide with the origin. Also called POE. (JP 1-02)

preventive medicine. The anticipation, communication, prediction, identification, prevention, education, risk assessment, and control of communicable diseases, illnesses and exposure to endemic, occupational, and environmental threats. These threats include nonbattle injuries, combat stress responses, weapons of mass destruction, and other threats to the health and readiness of military

personnel. Communicable diseases include anthropod-, vector-, food-, waste-, and waterborne diseases. Preventative medicine measures include field sanitation, medical surveillance, pest and vector control, disease risk assessment, environmental and occupational health surveillance, waste (human, hazardous, and medical) disposal, food safety inspection, and potable water surveillance. Also called PVNTMED. (JP 1-02)

prisoner of war. A detained person as defined in Articles 4 and 5 of the Geneva Convention Relative to the Treatment of Prisoners of War of August 12, 1949. In particular, one who, while engaged in combat under orders of his or her government, is captured by the armed forces of the enemy. As such, he or she is entitled to the combatant's privilege of immunity from the municipal law of the capturing state for warlike acts which do not amount to breaches of the law of armed conflict. For example, a prisoner of war may be, but is not limited to, any person belonging to one of the following categories who has fallen into the power of the enemy: a member of the armed forces, organized militia or volunteer corps; a person who accompanies the armed forces without actually being a member thereof; a member of a merchant marine or civilian aircraft crew not qualifying for more favorable treatment; or individuals who, on the approach of the enemy, spontaneously take up arms to resist the invading forces. Also called POW or PW. (JP 1-02)

reachback. The process of obtaining products, services, and applications, or forces, or equipment, or material from organizations that are not forward deployed. (JP 1-02)

rehabilitative care. Therapy that provides evaluations and treatment programs using exercises, massage, or electrical therapeutic treatment to restore, reinforce, or enhance motor performance and restores patients to functional health allowing for their return to duty or discharge from the Service. Also called restorative care. (This term and its definition modify the existing term "restorative and rehabilitative care" and its definition and are approved for inclusion in the next edition of JP 1-02.)

repatriate. A person who returns to his or her country or citizenship, having left said native country either against his or her will, or as one of a group who left for reason of politics, religion, or other pertinent reasons. (JP 1-02)

resuscitative care. Advanced emergency medical treatment required to prevent immediate loss of life or limb and to attain stabilization to ensure the patient could tolerate evacuation. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

retrograde personnel. Personnel evacuated from a theater who may include medical patients, noncombatants, and civilians. (JP 1-02)

risk management. The process of identifying, assessing, and controlling risks arising from operational factors and making decisions that balance risk cost with mission benefits. Also called RM. (JP 1-02)

rules of engagement. Directives issued by competent military authority that delineate the circumstances and limitations under which United States forces will initiate and/or continue combat engagement with other forces encountered. Also called ROE. (JP 1-02)

safe haven. 1. Designated area(s) to which noncombatants of the United States Government's responsibility and commercial vehicles and materiel may be evacuated during a domestic or other valid emergency. (JP 1-02)

seriously ill or injured. The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that there is cause for immediate concern, but there is not imminent danger to life. Also called SII. See also casualty status. (JP 1-02)

seriously wounded. A casualty whose injuries or illness are of such severity that the patient is rendered unable to walk or sit, thereby requiring a litter for movement and evacuation. (JP 1-02)

slightly wounded. A casualty whose injuries or illness are relatively minor, permitting the patient to walk and/or sit. (JP 1-02)

stabilized patient. A patient whose airway is secured, hemorrhage is controlled, shock treated, and fractures are immobilized. (JP 1-02)

stable patient. A patient for whom no inflight medical intervention is expected but the potential for medical intervention exists. (JP 1-02)

standardization. The process by which the Department of Defense achieves the closest practicable cooperation among the Services and Department of Defense agencies for the most efficient use of research, development, and production resources, and agrees to adopt on the broadest possible basis the use of: a. common or compatible operational, administrative, and logistic procedures; b. common or compatible technical procedures and criteria; c. common, compatible, or interchangeable supplies, components, weapons, or equipment; and d. common or compatible tactical doctrine with corresponding organizational compatibility. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

strategic estimate. The estimate of the broad strategic factors that influence the determination of missions, objectives, and courses of action. The estimate is continuous and includes the strategic direction received from the President, Secretary of Defense, or the authoritative body of an alliance or coalition. (JP 1-02)

subordinate unified command. A command established by commanders of unified commands, when so authorized through the Chairman of the Joint Chiefs of Staff, to conduct operations on a continuing basis in accordance with the criteria set forth for unified commands. A subordinate unified command may be established on an area or functional basis. Commanders of subordinate unified commands have functions and responsibilities similar to those of the commanders of unified commands and

exercise operational control of assigned commands and forces within the assigned operational area. Also called subunified command. (JP 1-02)

supported commander. 1. The commander having primary responsibility for all aspects of a task assigned by the Joint Strategic Capabilities Plan or other joint operation planning authority. In the context of joint operation planning, this term refers to the commander who prepares operation plans or operation orders in response to requirements of the Chairman of the Joint Chiefs of Staff. 2. In the context of a support command relationship, the commander who receives assistance from another commander's force or capabilities, and who is responsible for ensuring that the supporting commander understands the assistance required. (JP 1-02)

supporting commander. 1. A commander who provides augmentation forces or other support to a supported commander or who develops a supporting plan. This includes the designated combatant commands and Department of Defense agencies as appropriate. 2. In the context of a support command relationship, the commander who aids, protects, complements, or sustains another commander's force, and who is responsible for providing the assistance required by the supported commander. (JP 1-02)

supporting plan. An operation plan prepared by a supporting commander or a subordinate commander to satisfy the requests or requirements of the supported commander's plan. (JP 1-02)

sustainment. The provision of logistics and personnel services required to maintain and prolong operations until successful mission accomplishment. (JP 1-02)

systems support contractors. Contract personnel, normally with high levels of technical expertise, hired to support specific military systems. See also external support contractors; theater support contractors. (JP 1-02)

tactical aeromedical evacuation. That phase of evacuation which provides airlift for patients from the combat zone to points outside the combat zone, and between points within the communications zone. (JP 1-02)

tactical air transport operations. The carriage of passengers and cargo within a theater by means of: a. airborne operations: (1) parachute assault, (2) helicopterborne assault, (3) air landing; b. air logistic support; c. special missions; d. aeromedical evacuation missions. (JP 1-02)

telemedicine. Rapid access to shared and remote medical expertise by means of telecommunications and information technologies to deliver health services and exchange health information for the purpose of improving patient care. (Approved for inclusion in the next edition of JP 1-02.)

theater hospitalization capability. Essential care and health service support capabilities to either return the patient to duty and/or stabilization to ensure the patient can tolerate evacuation to a definitive care facility outside the theater. It includes modular hospital configurations

required to support the theater (emergency medical services, surgical services, primary care, veterinary services, dental services, preventive medicine, and combat and operational stress control, blood banking services, hospitalization, laboratory and pharmacy services, radiology, medical logistics and other medical specialty capabilities as required). (Approved for inclusion in the next edition of JP 1-02.)

theater patient movement requirements center. The activity responsible for intratheater patient movement management (medical regulating and aeromedical evacuation scheduling), the development of theater-level patient movement plans and schedules, the monitoring and execution in concert with the Global Patient Movement Requirements Center. Also called TPMRC. (Approved for inclusion in the next edition of JP 1-02.)

theater support contractors. Contract personnel hired in, and operating in, a specific operational area. (JP 1-02)

throughput. 1. In transportation, the average quantity of cargo and passengers that can pass through a port on a daily basis from arrival at the port to loading onto a ship or plane, or from the discharge from a ship or plane to the exit (clearance) from the port complex. Throughput is usually expressed in measurement tons, short tons, or passengers. Reception and storage limitation may affect final throughput. 2. In patient movement and care, the maximum number of patients (stable or stabilized) by category, that can be received at the airport, staged, transported, and received at the proper hospital within any 24-hour period. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

unaccounted for. An inclusive term (not a casualty status) applicable to personnel whose person or remains are not recovered or otherwise accounted for following hostile action. Commonly used when referring to personnel who are killed in action and whose bodies are not recovered. See also casualty; casualty category; casualty status; casualty type. (JP 1-02)

unified action. A broad generic term that describes the wide scope of actions (including the synchronization of activities with governmental and nongovernmental agencies) taking place within unified commands, subordinate unified commands, or joint task forces under the overall direction of the commanders of those commands. (JP 1-02)

unstable patient. A patient whose physiological status is in fluctuation. Emergent, treatment and/or surgical intervention are anticipated during the evacuation. An unstable patient's rapidly changing status and requirements are beyond the standard en route care capability and requires medical/surgical augmentation. (Approved for inclusion in the next edition of JP 1-02.)

very seriously ill or injured. The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that life is imminently endangered. Also called VSII. See also casualty status. (JP 1-02)

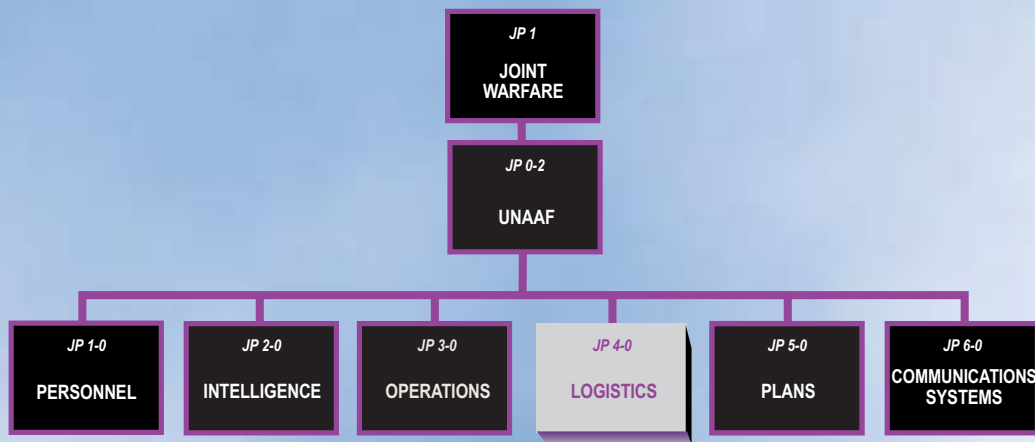
walking patient. A patient whose injuries and/or illness are relatively minor, permitting the patient to walk and not require a litter. (JP 1-02)

wellness. Force health protection program that consolidates and incorporates physical and mental fitness, health promotion, and environmental and occupational health. (JP 1-02)

wounded. See seriously wounded; slightly wounded. (JP 1-02)

wounded in action. A casualty category applicable to a hostile casualty, other than the victim of a terrorist activity, who has incurred an injury due to an external agent or cause. The term encompasses all kinds of wounds and other injuries incurred in action, whether there is a piercing of the body, as in a penetration or perforated wound, or none, as in the contused wound. These include fractures, burns, blast concussions, all effects of biological and chemical warfare agents, and the effects of an exposure to ionizing radiation or any other destructive weapon or agent. The hostile casualty's status may be categorized as "very seriously ill or injured," "seriously ill or injured," "incapacitating illness or injury," or "not seriously injured." Also called WIA. (JP 1-02)

JOINT DOCTRINE PUBLICATIONS HIERARCHY



All joint doctrine and tactics, techniques, and procedures are organized into a comprehensive hierarchy as shown in the chart above. **Joint Publication (JP) 4-02** is in the **Logistics** series of joint doctrine publications. The diagram below illustrates an overview of the development process:

