

## APPENDIX E

**MEDICAL FORCE PLANNING****Section I. MEDICAL TROOP LIST****E-1. Medical Force Planning Process**

To accomplish its assigned mission, the command must be provided with troops of an adequate quantity and type. The demands of HSS on the modern battlefield will present significant challenges to medical commanders at all levels. The medical force structure designed to meet these challenges results from the medical force planning process. The HSS planner must be able to develop medical personnel and unit requirements needed to fulfill the mission of the AMEDD in a TO.

**E-2. Formulation of Medical Requirements Troop Lists**

Planning for medical troop requirements is normally done in three phases: estimation, calculation, and modification. These phases are not mutually exclusive in any sense. Portions may well be nearer final form than are others during the planning sequence.

*a. Phase I—Estimation.*

(1) Normally, there is little tangible, definitive information available to the planner early in a planning sequence. The planner may only know of major combatant elements, a general operational area, and perhaps the mission of the force and its expected duration. Accordingly, the experience of the planner and his systematic use of planning references and tools must be used to formulate a tentative medical troop basis required for support of the force to be deployed. There are, in addition to specifics which may be unique to the background of the planner, two tools which will assist in developing this tentative troop basis:

- Hospital bed computation.
- Basis of allocation.

(2) Knowing the number of major combatant forces (divisions) to be supported, the planner can readily estimate the total number of medical personnel spaces required for the CZ, the COMMZ, or the TO.

(3) Hospital bed computations are also included in the estimate phase as the hospitalization components of the force constitute the major elements of the medical support base, and their types and numbers dictate many of the other smaller units required in that base. The methodology for developing these bed requirements is discussed in Chapter 5.

(4) The overall structure of the tentative medical troop basis is then derived by a detailed review of the basis of allocation for all possible types of field medical units using the appropriate 8-series TOE. Knowing the level of HSS to be provided (employment zone), number of major combatant forces, and proposed distribution of forces, the planner prepares a listing of AMEDD units by number and type that, together with the data provided by bed computations, constitutes a viable tentative troop basis.

*b. Phase II—Calculation.* During the calculation phase of medical force planning, the tentative troop basis is refined based upon additional information and guidance received by the planner. For instance, specific command policies relevant to the HSS of the force, of allied forces, and of the indigenous populace may well cause significant changes in the troop composition. Specific bed requirement computations must be balanced with basis of allocation for

hospitalization units. A detailed, comprehensive, multidisciplinary staff review of the entire plan and the medical troop basis must be completed so that the support provided will be balanced, flexible, doctrinally-sound, and economical in terms of manpower and equipment resources used. Intramedical staff coordination must include an examination of HSS functional requirements. The product of this staffing or calculation phase should be a tailored medical troop basis adequate for support of the force.

*c. Phase III—Modification/Refinement of Troop Basis.*

(1) The final phase in medical force planning then involves final revisions dictated by additional command policy, guidance, or information received by the planner. Typically, such policy might include information on levels of support to be provided in specific specialties, logistics priorities, or support to allies. The more normal situation may include imposition of a personnel ceiling of forces to be deployed. Such a condition requires the assignment of judgmental priorities to the units in the troop basis, possibly only for the purpose of determining deployment phasing or sequencing.

(2) Options available to the planner for reducing medical spaces or units include—

- Recommending reduction in the evacuation policy.
- Substitution of similar units with like capabilities but fewer personnel.
- Use of Type B manning in units where appropriate.
- Elimination of units.

(3) In any reduction, the commander must be kept informed so as to be able to assess the risk involved. The final stage of force planning involves creating a troop list from the troop basis. The planner will—

- Assign specific units to fill the requirements.
- Task organize the medical support organization.
- Define command, control, and functional relationships.

## Section II. TIME-PHASED FORCE AND DEPLOYMENT DATA

### E-3. Planning for Employment

During the planning portion of the JOPES development phase (third phase of a five-phase process), the component/subordinate commanders time phase their force lists to sequence the arrival of forces according to a visualized concept of operations. Planning for employment is the product of mission analysis and intelligence assessment as it is keyed to the supported commander's

concept of operations. It is based on Service doctrine, guidance, review, and the availability of forces. While this planning is ultimately the responsibility of the supported joint commander of the CINC, the component commanders develop detailed lists of combat and support forces to accomplish the assigned tasks. This includes the required closure time of forces (as specified in the supported commander's concept of deployment) to be deployed to the AO. This phase concludes

with the production of the supported commander's Time-Phased Force and Deployment Data (TPFDD).

*a.* The TPFDD includes assigned forces, augmentation forces, and supporting forces which are to be deployed to the AO and forces stationed within the AO.

*b.* The TPFDD is built by each CINC and refined in a conference in detail by various participants to ensure the feasibility and adequacy of the data. The TPFDD is then loaded on a WWMCCS computer so that it may be accessible to planners throughout the joint military community on the WWMCCS.

#### **E-4. Time-Phased Force Deployment List**

The TPFDL is the major tool used by the unified commanders to request forces to support their OPLAN. In determining the adequacy of the logistics support for the TPFDL, the major factors considered are strategic lift, sustainability, pre-positioned war reserve stocks, force shortfalls, and warning time.

#### **E-5. Fielding the Organization**

Actual fielding of the organization is the most

difficult aspect of troop planning. An advanced party should be formed to prepare facilities and pre-position equipment. The advanced party should also coordinate the arrival of the remaining personnel. Then the professional staff and other personnel can join the unit at its destination assured of a place and equipment with which to work.

#### **E-6. Tailoring Health Service Support to the Battlefield Situation**

Health service support is tailored to the constantly changing battlefield situation. In this adjustment process, the methods of employment of medical TOE units must not be confused with their basis of allocation. The staff planners of HSS develop the medical troop list for a theater, using primarily the basis of allocation for the various medical units selected; whereas HSS operators in the various medical command and control headquarters deploy these units on the basis of need which results from shifting patient densities and/or the METT-T. An erroneous belief that the basis of allocation controls the methods of employment for a unit could cause misunderstandings between medical unit commanders and supported commanders and could result in non-effective use of a valuable battlefield health care delivery tool.