

CHAPTER 2

COMBAT HEALTH SUPPORT OPERATIONS**2-1. General**

a. Combat health support provides the capability to prevent DNBI and to collect, triage, treat, and evacuate or RTD sick, injured, or wounded soldiers. The AMEDD objective of conserving the fighting strength faces one of its greatest challenges in stability and support operations. This chapter discusses many of the aspects of providing traditional CHS and the factors that influence its delivery in stability and support operational scenarios.

b. Each stability and support operational mission is unique to the geographical area, the mix of forces, and the objectives of the operation. Due to this fact, the CHS planner must—

- Be included early in the mission planning process.
- Remain flexible to accommodate last minute requirements.
- Remain receptive to new and innovative methods of providing the required support.
- Ensure that thorough coordination is accomplished on all aspects of the operation.

2-2. Planning and Preparing for Contingency Operations

a. In stability and support operations, many of the missions assigned to US Army forces will be received as short-notice deployments. The advance preparation time will be limited. Further, due to the sensitivity or the OPSEC level of the operation, the number of individuals engaged in the planning process may also be restricted. It is, therefore, necessary for the CHS commander to ensure that his unit is administratively ready for a short-notice deployment (Appendix H). He can accomplish this by ensuring that—

- Unit personnel have all required immunizations; that the dental status of the command is monitored; and that any personnel actions stemming from medical conditions (such as military occupation specialty [MOS] reclassification based on physical profile) are expeditiously processed.

- Based on operation plans (OPLANs) and contingency plans, special clothing, equipment, or supplies required for the AO are on hand and in a serviceable condition. For example, if the potential AO is in mountainous terrain, equipment such as pitons, piton hammers, and extra ropes may be required. Depending upon the climate, additional heavy clothing (winter parkas) may be needed to operate at high altitudes. Other supplies and equipment that might be required include sunscreen and sunglasses to combat the effects of bright sunlight. On the other hand, operations in tropical jungles require items such as lightweight jungle fatigues, arthropod netting, insect repellent, and aerosol insecticides, as well as sunscreen and sunglasses.

- Updated medical intelligence on the medical threat in the proposed AO is maintained. This information is vital to ensure that the appropriate immunizations are provided; that any chemoprophylaxis that may be required (such as for malaria) is on hand or obtainable on short notice; and

that effective PVNTMED measures (PMM) are planned for and implemented to counter the specific medical threat. For example, in Operation Urgent Fury, US forces were not familiar with the vegetation indigenous to the area. Some troops began to present with large blisters on their bodies after conducting sweeps of jungle areas and underbrush. This condition initially led to speculation that a CW agent which burned and blistered the skin and damaged the respiratory system might be in use in the AO. The cause of the blistering was determined to be, however, the sap of the manchineel tree. Had the troops been forewarned of the effect of the sap, they would have been better able to protect themselves against injury.

- Soldier stress related to family issues can be reduced by integrating unit families into an active family support group network and by briefing families on the unit mission if OPSEC permits. To enhance readiness, family care plans should be kept up to date.

- Since operations in stability and support operations will normally be joint or combined in nature, it is important that CHS personnel be familiar with the other Services' equipment and procedures. Early and continuous coordination among command surgeons will facilitate this process. For example, if the USAF is providing all of the medical evacuation support or if the USN is providing Echelon III hospitalization afloat, the US Army personnel participating should know how to load and unload patients on the other Services aircraft and ships. During Operation Urgent Fury, problems were experienced with communications between US Army air ambulances and a USN hospital ship. Also, many medical evacuation pilots did not have the appropriate deck-landing certification required to land on a ship. These situations presented difficulties which could easily have been avoided with the proper coordination and familiarization training.

b. To enhance mission success, planning must be thorough, and the plan must be rehearsed. A rehearsal is the process of practicing a plan before its actual execution. Rehearsing key actions allows participants to become familiar with the operation and to visualize the plan. Rehearsals take on an added importance in stability and support operations to ensure synchronization and interoperability among the various participants.

c. A rapid response capability is often needed to mobilize assets to assess what support is required in the event of a disaster or other serious incident. The USAMEDCOM has developed specialty response teams (SRTs) within their table of distribution and allowances (TDA) organization. Refer to Appendix I for further information.

2-3. Task Organization of Elements

a. Forces used for providing CHS to contingency operations will often be task-organized to accomplish the mission. In a mature theater, there are four echelons of medical care. Each echelon of care incorporates the capabilities of the lower echelon plus enhancing and expanding on that care. Echelon I care is provided by the combat medic (assisted by the administration of first aid by nonmedical soldiers [self-aid, buddy aid, and combat lifesaver]) and the battalion aid station (BAS). The care provided consists of emergency medical treatment (EMT), advanced trauma management (ATM), and those procedures necessary to stabilize a patient for further evacuation (to include early surgical intervention for nontransportable patients) or to return the soldier to duty. Echelon II care is provided by the forward support medical company (FSMC), the main support medical company (MSMC), the area support medical

company (ASMC), and the medical companies/troops of separate brigades and armored cavalry regiments. This echelon of care has a 72-hour holding capability for those patients who can RTD within that time. Echelon II can be augmented by the forward surgical team (FST) to provide surgical intervention within the division area. The theater hospitalization system (Medical Force 2000) is encompassed by Echelon III (combat support hospital [CSH]) and Echelon IV (field hospital [FH] and general hospital [GH]). Under the medical reengineering initiative (MRI) there will be only one hospital in corps and echelons above corps. (For an in-depth discussion of the echelons of medical care, refer to FM 8-10.)

b. In stability and support operations, this full array of medical units may not be in place to provide the required care and to perform the administrative support needed to coordinate patient evacuation, care, and treatment.

c. There is no specific table of organization and equipment (TOE) medical unit which is designed to solely operate in stability and support operations. Rather, during the planning process, it is determined what CHS assets will be required to support the operation. This support is then task-organized from existing units designated to provide CHS for the operation. This type of tailoring of the CHS package for the support of the mission necessitates the early involvement of the CHS planner. If the CHS planner is not included early in the process, the required support may not be tailored to maximize the effective use of limited CHS resources.

2-4. Medical Evacuation Support

a. Evacuation Policy. With a force projection Army the evacuation policy for the AO may only be a matter of hours or days. Soldiers who are wounded, injured, or ill and who cannot be rapidly returned to duty are evacuated to MTFs in a support base outside of the AO or to CONUS. The CHS planners should determine what the evacuation policy will be, and in cases where it is compressed, build the necessary evacuation platforms into the plan. An adequate treatment capability must also be included in the plan to ensure that patients are sufficiently stabilized to withstand the evacuation. The evacuation policy in stability and support operations may be governed by such factors as the—

- Short duration of the operation.
- Inadvisability of building a large military base structure in the AO where the US presence is intended to display a low profile.
- Troop ceiling established for the operation.
- Anticipated patient work load.
- Anticipated level of hostilities.
- Availability of HN support.

b. Coordination. In the mature theater, medical evacuation support is provided by the echelon of care to which the patient is being evacuated. In stability and support operations, medical evacuation support

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may not follow the traditional patient flow means (FM 8-10-6). It may also require a longer lead time for coordination of issues, such as—

- Using civilian controlled air space.
- Crossing national borders.
- Obtaining route approval.

c. United States Air Force Support. A task-organized Echelon II medical unit may be required to coordinate for medical evacuation and medical regulating support directly with the USAF. (In the mature theater, this is normally accomplished by Echelons III and IV MTFs, and the medical brigade, or command medical regulating offices [MROs], Theater Patient Movement Requirements Center [TPMRC], and USAF liaison elements.) The administrative burden for preparation of the required forms for entering the patient into the USAF patient evacuation system is the responsibility of the originating medical facility (OMF) which, in this case, is the Echelon II MTF. The preparation of Department of Defense (DD) Form 600, Patient Baggage Tag, DD Form 601, Patient Evacuation Manifest, and DD Form 602, Patient Evacuation Tag, is normally not done at this echelon, nor does the unit routinely stock these forms. It is, therefore, important for the CHS commander to anticipate this requirement. The unit should have the necessary forms on hand and should have conducted training on their preparation, if required. (For information on the completion of these forms, refer to FM 8-10-6.)

d. United States Navy Support. The USN may also provide medical evacuation, treatment, and hospitalization support during the operation. The CHS commander must ensure that coordination on communications requirements and capabilities and the availability of services is accomplished. Without affecting the required coordination, it may not be possible for US Army elements to communicate effectively with the USN element providing the support.

e. Evacuation Responsibility. Depending on the scenario and resources available, the doctrinal method of the higher echelon of care evacuating patients from the lower echelon may not be possible. The CHS planner must ensure that the medical evacuation support planned is sufficiently flexible to adapt to the realities of the situation. For example, depending upon the CHS resources deployed, air ambulance assets may have to be attached to an Echelon II MTF. To ensure adequate support can be obtained and to sustain the air ambulances, coordination for fuel, aviation maintenance (both unit and intermediate), and Army airspace command and control (A2C2) must be accomplished. Additionally, the CHS commander will need to familiarize himself with requirements for crew endurance, aircrew training programs, aircraft capabilities, and flight surgeon support. The stated evacuation policy for the operation will influence the task organization for the mission. It will also dictate the number of evacuation platforms required to perform the mission efficiently. A short evacuation policy requires that the number of air and ground ambulances, as well as USAF aeromedical evacuation resources, be increased for the mission.

2-5. Patient Treatment, Stabilization, and Holding

During the initial phase of the operation, medical evacuation support may not be available. The CHS commander must include in his planning the possibility that he may be required to hold seriously injured or

wounded patients for a number of hours or perhaps even days. Faced with this requirement, the CHS commander may have to include a task-organized surgical capability to stabilize these patients sufficiently to withstand the delay in evacuation or he may be required to increase his capability to hold, treat, and care for patients. During this period, the only evacuation means may be by vehicles/aircraft of opportunity. If this situation is planned for, the CHS commander may be able to provide en route medical care for the most seriously injured on these backhaul missions.

2-6. Preventive Medicine

Disease and nonbattle injuries have in past wars exceeded the number of soldiers who were wounded in action (WIA). This is especially true in stability and support operations. The combined effects of endemic and epidemic diseases, soldiers not acclimatized to the environmental conditions, poor sanitation, increased exposure to disease vectors and environmental contamination, and foodborne and waterborne diseases may have a catastrophic effect on mission accomplishment. All commanders must be prepared to counter the medical threat through command emphasis on water discipline programs, physical training, immunization/chemoprophylaxis, personal hygiene, and field sanitation. Field sanitation teams are the eyes of the commander; therefore, they must maintain close coordination and must accurately report on any potential medical threats. The CHS commander must not only be concerned with these activities for his own unit but also for the command as a whole. He must ensure that he has an aggressive pest management program and that dining facilities are inspected. He must also ensure that all supported company-sized or larger units have on hand all authorized unit-level PVNTMED equipment and supplies. For additional information on PVNTMED issues, refer to Chapter 4 of this manual, Army Regulation (AR) 40-5, FM 21-10, and FM 21-10-1.

2-7. Combat Health Logistics

a. In stability and support operations, a medical logistics battalion (forward or rear) may not be available within the AO. Coordination for Class VIII supply/resupply, medical equipment maintenance, eyewear fabrication, and blood management takes on an added importance in stability and support operations. Prior to the operation, the number of days of supply which the in-country CHS organizations will require is determined. A critical items list of supplies which will be in high demand is also prepared. Pre-configured push packages must be developed to maintain appropriate stockage levels in-country until CHL elements enter the theater, become operational, and line order requisitioning procedures can be instituted.

b. When deployed in joint operations, the medical logistics battalion may be designated as the single integrated medical logistics manager (SIMLM) for the mission.

c. For additional information on CHL, refer to Chapter 4 of this manual and FM 8-10-9.

2-8. Veterinary Support

a. Department of Defense Veterinary Support. Department of Defense (DOD) veterinary support in stability and support operations entails the equitable distribution of veterinary support in the areas of food safety surveillance and animal health care to all military services.

b. Planning Factors. The CHS planner must determine the feeding policy, extent of local food procurement, type of available food storage facilities, zoonotic disease threat to US forces, and required health care support for deployed military working dogs (MWD), other government-owned animals, and military mascots.

c. Veterinary Support Packages. Veterinary support packages can be tailored to respond to either food safety surveillance or animal health care missions in the planning process. For additional information, refer to Chapter 4 of this manual and FM 8-55.

2-9. Combat Stress Control

Predeployment training on stress identification and control and command emphasis on stress-related issues will assist in maintaining positive mission focus and in reducing the number of stress casualties and stress-induced misconduct during an operation. The environments in which many stability and support operations occur can induce stress through feelings of loneliness, boredom, and alienation due to cultural and language differences. Some stability and support operations expose soldiers to personal danger, to the injury of other unit personnel, or to injustices, suffering, or death of innocent people. Changing mission objectives and ambiguous ROE can add greatly to the stress of the situation. Command emphasis should be placed on ensuring control measures are implemented by unit commanders and their troop leaders. Where feasible and within the limits of the troop ceiling, the CHS plan should provide a 1- to 3-day medical holding capability for acute stress casualties. This facility can be austere. For additional information, refer to Chapter 4, and to FM 8-51 and FM 22-51.