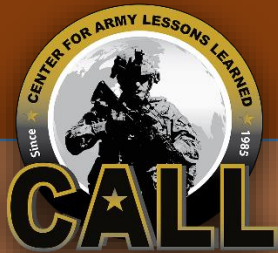


NEWS FROM THE CTC

8 August 2017



Brigade Combat Team Army Health System Operations

MAJ Sean M. Donohue

CPT Heather L. Holub

Approved for public release: Distribution Unlimited

Introduction

For more than a decade, the Army and the Army Medical Department (AMEDD) have been dedicated to mastering Army Health System (AHS) operations during counterinsurgency operations (COIN). The Army has championed point of injury care (POI), changing the landscape of battlefield and trauma medicine throughout the world with staggering success. Preventable battlefield deaths are historically low due to the remarkable impact of tactical combat casualty care (TC3) and the rapidity of clinical practice guideline (CPG) updates that affect every role of care. As the focus of the Army shifts from COIN operations towards the hybrid threat inherent in the decisive action (DA) environment, our combat training centers (CTCs) prepare units for this austere and dynamic threat that places AHS operations on the forefront of the operation. This emphasis once again highlights the need for AHS integration into planning, training, and execution at all levels. At the National Training Center (NTC), we continue to observe areas for greater understanding and application of the complexities of AHS operations in the DA environment at the company (Co), battalion (BN), and brigade (BDE) level. Failure to grasp the integrated hybrid threat effects on AHS operations across the formation results in marked increases in died of wounds (DOW) rates, primarily resultant of poor mission command and shared understanding across the formations. Failure to fully integrate AHS operations into home station training negatively impacts the already steep learning curve inherent to the CTC environment. In the following, we will discuss common AHS challenges experienced by brigade combat teams (BCTs) and what courses of action (COAs) and best practices have proven most effective in mitigating or eliminating them.

Brigade Surgeon Section (BSS) executing effective Mission Command (Communication Platforms):

An essential part of exercising effective mission command (MC) is continuous communications. The current table of organization and equipment (TOE) for medical roles within a BCT does not account for a common communications platform between medical elements, a situation that creates friction when trying to maintain a common operational picture. While the current TOE has proven effective in COIN environments, where stable operations and continuous access to upper tactical internet (UTI) such as the command post of the future (CPOF) is possible, it has proven insufficient for the DA environment. In DA rotations, it is essential to mission success that the Role 1s and Role 2 are able to operate geographically dispersed from large MC nodes in order to maintain proximity to the front line of troops (FLOT), flexibility, and mobility. Challenges arise when the roles of care operate almost exclusively on lower tactical internet (LTI) systems such as joint capabilities release (JCR) or frequency modulation (FM) radio communications while the BSS only has access to UTI.

In the high OPTEMPO environment of DA operations, the BSS is often reliant on other staff sections for access to critical communication platforms and subsequently rendered ineffective or is an all-out failure due in part to lack of dedicated LTI systems within the tactical operations center (TOC). The BSS has limited success in the utilization of other sections' LTI systems due to the competing mission requirements by the system owner. The high operation tempo (OPTEMPO) and constant competition for access to these limited platforms strain AHS operations by preventing effective shared understating of the environment for operational purposes, which effectively prolongs evacuation of casualties. The battalion logistics (S-4) section's TOE has a JCR platform maintained in the administrative logistics operations center (ALOC) but cannot be relied on by the BSS, as it is often reallocated to other MC nodes that have been viewed as a tactical priority to the TOC. In addition, sustainment assets have access to FM capabilities. However, retransmission (RETRANS) is limited and sustainment is often not a priority of

Approved for public release:

Distribution Unlimited

support. Without direct means of communication with the Role 1s and Role 2, the BSS is forced to utilize multiple communication platforms and an elaborate primary, alternate, contingency, emergency (PACE) plan to relay information to the roles of care. This results in de-synchronized operations, as nodes begin to play “telephone” in an attempt to execute the mission plan. This creates confusion for lower echelons who are engaged in enemy contact and need to relate timely patient information and evacuation requests to/through the BSS; lives are literally lost in the PACE plan execution. This also adds additional strain to MC nodes used to execute maneuver operations but now burdened with the additional responsibility of medical coordination. In approximately 15% of the units, after initial failures, leaders would prioritize the BSS for a dedicated JCR platform (often in a vehicle and not in the TOC). This practice resulted in a more effective execution of the AHS and the ability to create seamless coverage across the BCT. It also assisted in the refinement of the planning process, identified friction points, and enabled rapid/quality reporting. This dedicated JCR reduced the conflict of priorities with other staff sections and led to better overall effectiveness of BDE operations.

We recommend that the TOE be updated so that the BSS is allocated its own JCR platform and further recommend that it be kept on the current operations (CUOPs) “floor” to facilitate coordination among warfighting functions. Until this delta has been addressed, we recommend a relook at prioritization of JCR platform needs within the BCT. Success is derived by ensuring that the BSS has priority continuous access to a dedicated platform.

Military Decisionmaking Process (MDMP):

At the BN level, medical operations officers (MEDOs) are grossly underutilized and their function is misunderstood to the point where they are often relegated only to tracking and reporting casualty information rather than being recognized as part of the BN special staff. While the BN MEDO is trained and has the ability to plan and execute the BN concept of the AHS, they are often viewed only as the medical platoon leader (not doctrinal) and as such, generally do not participate in the MDMP process with the rest of the BN staff nor have the opportunity to shape the AHS plan. Because the MEDO is not integrated into the MDMP process, the development of an AHS plan (if it occurs) is often accomplished by the BN S-4 resulting in an AHS plan that mirrors the logistical plan (Role 1s with MC nodes, casualty collection points (CCP)/ logistic resupply points (LRPs), etc.) rather than the operational plan. Not utilizing the MEDO, trained in doctrinal application of AHS operations, results in a poor, fractured, and ineffective concept of AHS¹. It is important to recognize that with logistics “hours” may mean lives, but with medical, minutes “do” mean lives.

Successful units not only include the BN MEDOs in all stages of the MDMP process but also integrate them into the BN TOC. This staffing model allows the MEDOs to be available for last minute MDMP sessions as well as enabling them to act as medical mission command (MC) for the BN. This facilitates more fluid and effective coordination with higher headquarters for support and allows them to maneuver their BN medical assets forward to better support the BN operational plan. A well-developed BN AHS plan has the added benefit of being able to refine the BDE AHS plan to ensure more effective coverage. To ensure that the BN MEDO is prepared for this responsibility, efforts to send them to the Medical Operations (70H) course should be made and an intensive mentorship program coordinated by the BDE MEDO.

¹ ATP 4-02.55 Army Health System Support Planning (Headquarters, Department of the Army, p. September 2015)

Approved for public release:

Distribution Unlimited

At the BDE level, we see better integration of the BSS into MDMP, although maneuver leaders struggle to understand the roles and responsibilities of the individuals within the BSS. They often look to the senior officer (BDE Surgeon) to be involved in MDMP and develop the BDE AHS plan. This responsibility is inherent in the role of BDE medical planner who is trained to array and employ the BDE's medical assets, while the BDE Surgeon may not have the same institutional and operation experiences. It is critical that the BDE staff understand the roles and responsibilities of the individuals within the BSS and employ them to their advantage. By the TOE, the BSS has three organic positions (surgeon, planner, and noncommissioned officer in charge [NCOIC]) and must provide continuous CUOPs coverage, future operations (FUOPs), and manage transitions with multiple command nodes. It is imperative that all three individuals understand both CUOPs and FUOPs in order to ensure seamless coverage throughout all phases of operations.

While BSSs are more often able to develop comprehensive AHS plans because they are included into the MDMP process, they are challenged to influence brigade support battalion (BSB) operations. Often roles and responsibilities are not clearly defined between the BSS, support operations officer (SPO) MED, Role 2, and BSB commander (CDR). When this occurs, the BSB plan invariably overrides the BSS plan and, again, often mirrors the logistical plan which violates the principles of AHS operations. Without the insight and situational awareness facilitated from being integrated with the BDE TOC (and taking part in MDMP), the BSB plan may be convenient for the BSB/Role 2, but is ineffective for the BDE. It is not uncommon for BSB leadership to plan ambulance exchange points (AXPs) in anticipated enemy locations or refuse to jump the Role 2 forward of the brigade support area (BSA). The BSS needs to provide top-down planning, but also refine its plan based on bottom-up refinement from the BNs. This planning model prevents "stove pipe" AHS plans for the BSB and maneuver BNs and allows for seamless medical coverage. Regularly we see logistical leaders trump the BDE AHS plan. When this occurs it is imperative that the BSS articulate to the BDE leaders the cause and effect of both COAs and garner their support for the BDE AHS plan.

BDE AHS plans that are effective start with BSS integration into staff planning and effective MDMP, utilizing bottom-up refinement from the BN MEDOs to ensure the BSS staff recognizes its constraints/limitations and plan for the necessary support required by the BDE operation. The BSS then works with the SPO MED and Role 2 CDR to develop a plan that meets the six principles of AHS². Throughout this process the BSS should work closely with the BDE CSM and BN CSMs who, through the 1SGs, execute the plan. AHS success cannot be accomplished without senior NCO involvement.

Developing a Comprehensive AHS Plan:

Some factors that units need to consider when developing the AHS plan.

- Casualty Estimates:** Should influence priorities of support and movement of Role 2 and many other things such as augmentation requirements for non-standard evacuation platforms; security requirements for AXPs; predicting Class VIII demands, etc.
- PACE (BN and BDE):** The lowest elements should dictate the PACE plan and it needs to be feasible.
- Capabilities/Limitations:** Seeing your unit clearly and allowing it to influence support plan.
- CLVIII status/requesting:** Know how to resupply and should be part of commander's critical information requirements (CCIRs).

² ATP 4-02.55 Army Health System Medical Functions (Headquarters, Department of the Army, p. September 2015)

Approved for public release:

Distribution Unlimited

- Primary and Alternate Routes:** Do the necessary terrain analysis and have a contingency plan(s) for evacuation and placement of assets.
- Decontamination Locations:** Should show both BDE and BN decontamination (DECON) sites.
- Clean and/or Dirty Routes:** Can be your primary and alternate routes but have different contingencies based on the threat.
- Time Distance Analysis:** Should start with backwards planning, influencing the emplacement of roles of care and ground MEDEVAC support. This analysis can also influence the priority of support for the limited MEDEVAC assets. Should be done for both primary and alternate routes.
- BDE AXPs:** Identify if manned or unmanned. If manned what does the package consist of?
- Triggers:** Movements or activation of sites should be trigger based. Creating a trigger-based plan allows for conformity to maneuver plan. If time (H-1) is utilized it can lead to confusion, a more effective method is utilization of maneuver triggers such as departure from a particular phase line (PL).
- Priorities of Support:** Through mission analysis (movement and maneuver plan) and casualty estimates, priority of support for medical assets should be identified.
- CASEVAC:** Number of vehicles (on call vs. dedicated) and type.
- Security:** What, if any, security?
- Location of all Medical Assets with in the Operational Environment (Civilian and Military)**
- Graphic overlays:** CPOF and JCR.

Creating Shared Understanding:

It is critical that the BSS facilitate shared understanding across the BDE. To improve the dissemination of AHS plans to BN maneuver leaders, the essence should be captured in paragraph 4 of the operation order (OPORD); maneuver leadership should not have to read through all of Annex F to piece together the plan. Additionally, medical concept of the operation (MEDCOP) can be maintained as a living document to provide units with the critical information needed to execute the plan and create shared understanding. This document can include casualty estimates, triggers, priority of air/ground support, AXP grids, primary/alternate routes, CPOF graphics, time/distance analysis, MEDEVAC/casualty evacuation (CASEVAC) platforms, PACE plan, clean and dirty routes, DECON locations, location of all medical assets (civilian/military) within the area of operations, etc.

These efforts are important, but ineffective if the BN MEDOs, Role 1s, and companies do not have ready access. Even though the MEDCOP is produced and published, do not rely on units to actually read it. Notify them that the MEDCOP has been published and where to find it, but also provide the most pertinent details in a JCR or other type of chat window to ensure that the message is received. The BSS should not rely on the BNs to disseminate its plans; this creates a single point of failure and leads to a lack of situational awareness (SA) and understanding with those who will have to execute the plan. By breaking down the plan and messaging it out on a shared communication platform, the BSS ensures timely dissemination of the information. This also allows subordinate units to address and de-conflict any issues that might arise. In addition, graphic overlays on JCR can be pushed down to every platform allowing for a common operational picture. Additional products such as a synchronization matrix, MEDCOP, concept of support should be developed for distribution in order to create greater situational understanding among key medical executors (1SGs, PSGs, SPO, BN S-4s, etc.)

Shared understanding is also essential to the execution of area support. When subordinate units execute plans on their own without effective guidance from higher, their plans are not nested with the

Approved for public release:

Distribution Unlimited

BDE. While units may be doing their best to exercise disciplined initiative, this often results in Role 1 treatment capabilities being located within one kilometer of each other (or the Role 2) which results in duplication of treatment efforts. Medical should be thought of as sectors of fire; how do we position our assets to provide the best coverage for the BDE? With the development of comprehensive BN AHS plans, bottom up/top down refinement, and the ability to effectively communicate, the result is a well dispersed medical array aligned appropriately with the operation and the Soldier.

Rehearsals are also a critical way of creating shared understanding. Medical should be integrated into the combined arms rehearsal (CAR) in order to create shared understanding and more accurately portray the impact of casualties on the mission. Sustainment rehearsals provide a more comprehensive understanding of sustainment operations, de-confliction, and coordination. Sustainment rehearsals are also a critical way of creating shared understanding. Unfortunately, they are often the first rehearsals to be eliminated or are conducted over CPOF, which is a less than ideal platform. If done over CPOF, it is unlikely the necessary audience is on the other end and it is difficult to see and appreciate the AHS operations in time and space with any clarity. A more effective method is a terrain model rehearsal for AHS, though care should be taken to prevent the rehearsal from becoming a back brief to the CDR.

Most successful units use the terrain model to its fullest extent, moving from location to location, as they walk through each phase of the operation. In addition, these units brief the audience so all can hear, clarify, and understand the operation. There should be a designated individual to inject friction points to prompt a response and generate critical assessments of the plan and identify alternative actions. These friction points should not be known in advance to the briefer and should test the limits of the unit's capabilities (responding to two casualties is not a friction point for a medical asset, but may be a salient point for a rifle squad rehearsal). The participants in the rehearsal are important as well; ensure that key participants (BN MEDOs/CSMs) in the execution are present. Sustainment rehearsals are important opportunities to conduct last minute coordination, as well as to identify and remedy/mitigate issues. It is important that the BSS follow up any changes made during the sustainment rehearsal with fragmentary order and direct messaging to the medical echelons.

Transitions:

At NTC, we see BSSs that fail to grasp the importance of acting as MC for medical assets. They see their role solely as FUOPs at the detriment of CUOPs; this is particularly true when the BSS has fractured communications with medical elements. It is critical for the BSS to plan for continuous MC in the event that the BDE TOC is degraded by enemy action, or when the TOC is jumping to a new location. These two eventualities are not often planned for in requisite detail and AHS operations routinely cease until they are reestablished in a new location, leaving all medical assets arrayed across the battlefield without support for up to or more than 48 hours. Most units will state, when pressed for an answer, that the SPO MED or Role 2 are the alternate MC nodes, however these assets are not equipped or located in a position to have adequate situational understanding of the common operational picture to support the mission. When MC is thrust upon them, they routinely fail³.

Units with the most success send medical representation from the BSS with the TAC/mobile command group to allow for seamless coverage between both MC nodes. They are able to maintain

³ ATP 4-02.3, Army Health System Support to Maneuver Forces (Headquarters, Department of the Army, p. June 2014)

**Approved for public release:
Distribution Unlimited**

communications and make necessary coordination with different warfighting functions. As a last resort, the SPO MED and Role 2 should still be looked at as a tertiary MC node should both TAC/TOC be destroyed or lose communication capabilities.

Maintaining SA:

Quality reporting directly impacts the ability of the BSS to execute MC. We have observed that units are accustomed to executing a twice daily reporting system; however, this is inadequate in the high OPTEMPO DA/ hybrid threat environment. Receiving updates from the formation only twice daily does not allow the BSS to see AHS operations in real time and space. It is of paramount necessity that the BSS sit-down and identify CCIRs from all its formations. As an example, the following are some suggested trigger-based reporting events: when Roles 1/2 break down-when moving-when set, when an ambulance or identified CASEVAC platform is destroyed, loss of key personnel, or Role 1/2 capabilities degradation, identification of possible community health issues both inside and outside formations. The combination of time and trigger-based reporting metrics that are standardized across the formation, and over multiple communication platforms, enable the BSS to make necessary coordination with BDE staff and maneuver commanders, and facilitates better support to the operation.

Standard reporting measures for casualty reporting must be created, staffed, and utilized within the formation. We often observe the use of 9-line MEDEVAC requests as a method of communicating casualty information when there is no actual requirement for immediate evacuation support from higher. This particular situation is most problematic when it occurs at POI in instances where leaders submit up 9-lines as a means to report these casualties rather than utilizing operational injury reports. Confusion occurs as the 9-line reaches the company or battalion CP and results in processing and execution of a MEDEVAC mission, rather than the personnel staff officer (S-1) acknowledging that battle operational multiservice injuries have occurred. Every air MEDEVAC mission in an operational environment comes with inherent risks and those risks are often greatly increased in the DA environment. Unnecessary maneuvering of assets forward to the POI/FLOT in the DA environment puts air assets at risk of being engaged by enemy anti-aircraft weapons, not to mention may result in actual MEDEVAC missions being neglected or deleted. Where large numbers of casualties are concerned and multiple aircraft are required to support, this may divert CASEVAC rotary assets from other operations to support the mission unnecessarily. Lastly, we see multiple 9-lines generated for the same group of casualties when the requesting unit feels they are not getting a response in what they feel to be a timely manner. Generation of multiple requests for the same event (or Soldiers) generates multiple points of confusion across the formations and results in missions being executed repetitively.

In the DA environment, what proves most effective is the utilization of a simpler format at POI for reporting (number by type, number ambulatory, number litter, etc.) casualties to the Role 1s/MEDO/S-1. Once at the Role 1, patients are triaged, treated, and an appropriate 9-line is then generated. This 9-line should be submitted directly from the Role 1 to the BSS. Routing through multiple MC nodes creates confusion, unnecessary delays, and potential for single points of failure. If Role 1s have no direct communications with BDE, we recommend they relay 9-lines through the BNs, being mindful to be specific in their wording of casualty location. It is also critical to identify in writing, who is the launch authority and who is the mission authority for air MEDEVAC.

Approved for public release:

Distribution Unlimited

Role 1 Movement:

To adhere to the principles of AHS support, it is necessary for the Role 1s to act as their own MC node, especially when conducting split operations. Soldiers assigned to Role 1 care need to be well versed and rehearsed in efficient set-up/tear down, the ability to maneuver and utilize terrain effectively, and to maintain communications throughout all phases of the operation. Currently, medical assets are not comfortable with executing their doctrinal mission, commander's plan, and maneuvering across the operational environment as their own MC. These skills have atrophied during COIN. We see the Role 1s remain located with MC nodes such as the combat trains command post (CTCP) for communications, logistical support, and security. While this arrangement is convenient for the co-located parties, it is not where the Role 1s can best serve the BN, resulting in a high number of DOWs that could have otherwise been mitigated. Once the BN observes the ineffectiveness of keeping the Role 1s too far rearward from the FLOT, units may then decide to co-locate them with the company trains. This arrangement has similar benefits to the previous COA, but with the Role 1s located further forward. The drawback to this second COA is the inability of the Role 1 to remain centralized and supportive of multiple companies. While located with one company, the Role 1 may be further away from others and unable to support. In addition, units often do not develop a comprehensive AHS plan when executing this second COA; BNs leave MC up to the company trains and the Role 1 is along for the ride. Issues arise when the Role 1 receives casualties and must stop to treat and evacuate which then provides the following problem: does the company trains remain with the Role 1 or does it continue to support its company? Often the trains leave the Role 1, and now devoid of their MC node, the Role 1 remains in place and powerless to make an educated tactical decision on forward movement and emplacement.

Successful units recognize that the doctrinal Team A and B main aid station (MAS) and forward aid station (FAS) are interchangeable and maneuver both forward and geographically centralized to provide the best coverage. This can be done in a bounding fashion where at any given time there is an established Role 1. When confronted with large terrain features or an extensive FLOT, both Role 1s can be pushed forward using maneuver triggers to maintain forward momentum⁴.

Role 1 Ambulance Movement:

Because of the lack of AHS planning at the BN level, ambulance deployment is often standardized in an inefficient manner. At least one ambulance, if not two, are pushed out to the company level and any remaining ambulances are subsequently split between Team A/B (FAS and MAS). This can be a successful approach as long as the unit is mindful of maintenance issues, personnel, and equipment constraints/limitations. It is common for the TOE allotment of ambulances to not be available for deployment due to these manning and maintenance issues. Based on the unit TOE, there may be as few as four organic MEDEVAC platforms, so any loss of an asset may result in significant changes to operations. Challenges with ambulance placement across the battlefield is further complicated when the Role 2, due to constraints/limitations, is unable to fulfill its operational role and evacuate casualties from Role 1 to Role 2.

One drawback to emplacing evacuation assets forward with maneuver companies is that it can lead to a lack of planning for CASEVAC operations. If vehicles are not prepared to receive casualties and loading/unloading procedures are not rehearsed, CASEVAC operations will often not occur and companies will alternatively delay evacuation in favor of a ground MEDEVAC. This declination of

⁴ ATP 4-02.3, Army Health System Support to Maneuver Forces (Headquarters, Department of the Army, p. June 2014)

Approved for public release:

Distribution Unlimited

CASEVAC in favor of MEDEVAC often causes greater loss of tactical momentum than if units had executed a rehearsed CASEVAC plan and subsequently extends the tactical field care phase unnecessarily.

The use of ambulances forward, attached to the company, often results in ambulance deployment to POI and results in numerous ambulances being destroyed trying to reach casualties in engagement areas. By doctrine and TOE, ambulances are designed and fielded to be roughly equivalent in speed and protection to their supported maneuver elements, however they are consistently prosecuted as soft targets by the non-Geneva Conventions-abiding enemy. The Role 1 has a doctrinal responsibility to support near-FLOT (CCP)/ (AXP) in order to limit the distance companies have to traverse to evacuate casualties, but the ambulance is not necessarily intended to be pushed right to the limits of advance (LOA). With the emplacement of ambulances far forward, the CCP/AXP support by Role 1 is not possible due to a lack of evacuation platforms. This results in ambulances traveling from POI all the way to the Role 1, or alternatively the CASEVAC mission executes the same movement. Utilization of CASEVAC/MEDEVAC to CCP/AXP cuts distances traveled by both parties and increases the patient contact time with medics. Another drawback to this far-forward placement of ambulances is the inability to mass these limited assets to the areas of greatest need. If one company is overwhelmed while the others are not engaged, there is no way to effectively maneuver evacuation assets to support the troops in heavy contact, leading to potentially higher DOW rates and loss of tactical momentum. This is further compounded when Role 1s find themselves evacuating casualties from Role 1 to the higher echelon AXP or even directly to the Role 2. POI medical care is focused on the three core phases of TC3: 1. Care under fire (effective), 2. Tactical field care, and 3. Tactical evacuation, all of which are focused on preventable causes of death on the battlefield. Once evacuated to the Role 1, Soldiers may require yet more invasive/extensive interventions prior to evacuation to Role 2. The Role 1 can evacuate up to four urgent casualties in an ambulance with one medic in the back maintaining standard of care. In situations where all the ambulances assigned to the Role 1 are forward and CASEVAC remains the only option, these urgent casualties will now require an “attendant” each to manage care in route back to Role 2; this requirement can quickly deplete treatment squads⁵.

Units that are successful adhere to the AHS principles and approach each mission as unique. Commanders/MEDOs need to be aware of the constraints/limitations for their units and place the ambulances where they can most effectively support the mission⁶.

Planning for Role 2 Movement:

Maintaining the continuity of roles of care is critical and challenging in the DA environment and requires prior planning and coordination. Because of these challenges, units will often resort to their comfort level, which typically includes the Role 2 remaining within the BSA footprint. While the BSA location may be effective for logistical operations, it is unable to maintain proximity and the rapid deployment capability that is necessary in DA AHS operations. Remaining with the BSA leads to extensive distances that no number of ambulances forward can reduce. Additionally when relocating with the BSA, Role 2 down times can be lengthy, anywhere from 16 to 24 hours.

⁵ ATP 4-02.Casualty Care (Headquarters, Department of the Army, p. May 2013)

⁶ ATP 4-02.3, Army Health System Support to Maneuver Forces (Headquarters, Department of the Army, p. June 2014)

Approved for public release:

Distribution Unlimited

Units who have experienced success at NTC have taken different approaches, highlighting that there is no singular right answer to the problem set. Units first identify key times during the operation where casualty estimates are at their lowest and then may then choose to move the Role 2 with the forward logistical element (FLE) forward. This move addresses maintaining proximity and support, however during this down time, casualties continue to inundate Role 1s, which in turn prevents them from maneuvering forward and perpetuates the problem. To address this issue, some Role 2s will send a treatment squad forward to act as a torch element/quartering party to identify the new location and establish Role 1 capabilities. Once the lead element capability is established, the Role 2 begins breakdown and all new casualties at BN Role 1s are directed to the new location. This allows Role 1s to maintain their maneuverability and not become backlogged with patients and facilitates the casualties to receive Role 2 care more rapidly than if they had to wait at the BN Role 1s⁷.

Role 2 Ambulance Movement:

Doctrinally it is the Role 2's responsibility to evacuate casualties from Role 1 to Role 2, but due to personnel and vehicle constraints/limitations previously mentioned, it is not always possible. These limited assets must be deployed to their greatest advantage, a task that takes detailed planning. Many units fail to do the necessary analysis, alternatively deploying these assets in a set/cookie cutter manner. For example, units may assign one ambulance per BN for the entirety of the DA operation; this is not a preferred method. The BSS needs to first understand the Role 2 capabilities, just because Role 2 may have ten ambulances by TOE does not mean they are all fully mission capable (FMC) or that crews are available to operate them. Once there is an accurate understanding of capabilities and limitations, the BSS should address the type of operation being supported. During a defensive fight, AXP's may not be the preferred method as the time-distance analysis does not support their placement. Alternatively, it is recommended that the unit emplace ambulance(s) in with the decisive operation (DO) or with those who are positioned the furthest away (recon squadron) from the Role 2. In an offensive fight and with limited assets, the supporting of AXP's rather than the emplacement of ambulances at the BN level may provide better support to the BCT as a whole.

AXP's are only "points in the desert" and it is a struggle for units with communication issues to utilize unmanned AXP's. Often extensive periods of time elapse before the Role 2 ambulances are deployed and poor communication results in Role 1s having to bear the burden of evacuating casualties all the way back to Role 2. At NTC, we find that fewer manned AXP's, rather than numerous unmanned AXP's, often meet with greater success because units know that they have an already established/manned location for casualty evacuation. Manned AXP's, in general, also tend to have better communication and are more likely able to coordinate air support due to the distance from the FLOT/engagement area⁸.

⁷ ATP 4-02.3, Army Health System Support to Maneuver Forces (Headquarters, Department of the Army, p. June 2014)

⁸ ATP 4-02.3, Army Health System Support to Maneuver Forces (Headquarters, Department of the Army, p. June 2014)

Approved for public release:

Distribution Unlimited

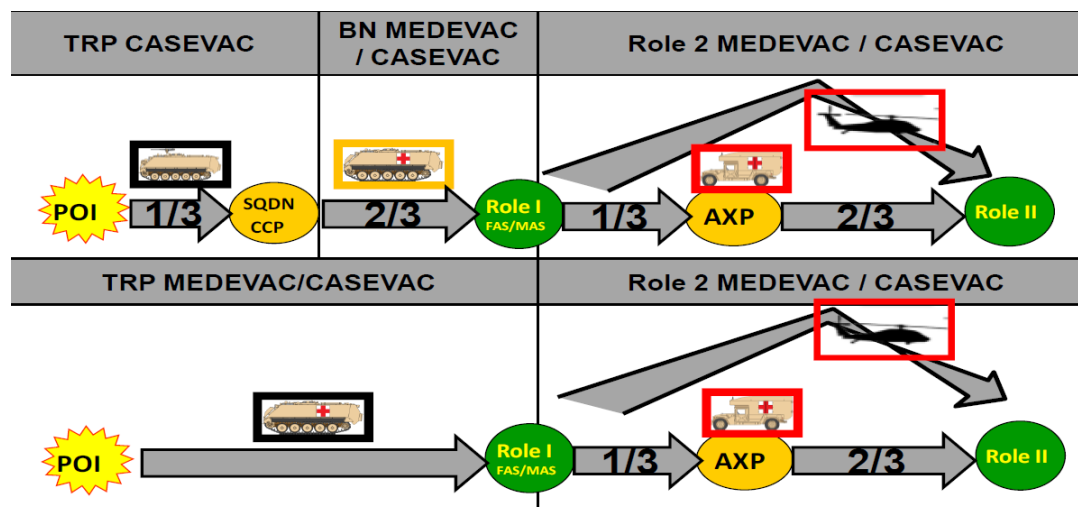


Figure 1. NTC Casualty Evacuation "A Way" slide.

The Army has made great strides in preventing operational deaths and is confident in the application of COIN paradigms of AHS. As we are presented with the dynamic new problem set of executing AHS operations in a DA environment, the emphasis on diligent planning to prevent loss of life and effectively support maneuver operations, Army and AMEDD leaders need to be willing to shake-off years of COIN training and apply formerly bygone but refined tactics, techniques, and procedures (TTP) in order to succeed. This application of AHS, most specifically in the third phase of TC3 (TACEVAC) will be the next greatest challenge to face the AMEDD and the Army in mitigating preventable operational deaths. Effective AHS impacts, and is impacted by, every individual Soldier across the formation. Successful AHS operations require the understanding and support of leaders at all echelons and it is critical that AHS be integrated into all training events. Integration leads to the refining of an effective AHS plan in order to better provide seamless medical care across the BCT to save Soldiers' lives.

"You CANNOT outsource your CASEVAC."- FORSCOM SURGEON MG Providence

About the Authors:

CPT Heather Holub AMEDD Captains Career Course Instructor, Leader Training Center, AMEDDC&S HRCoE JBSA FSH, TX. She previously served for one year as the Brigade Surgeon Section OC/T and two years as the Reconnaissance Medical Trainer OC/T at the NTC in Fort Irwin, CA. Her previous assignments were as the BSMC (Role 2) CDR, BSMC XO, BSMC TMT/EVAC/BMSO PL CDR 701st BSB 4IBCT 1ID, Fort Riley KS. She has deployed to Operation Enduring Freedom and Operation Iraqi Freedom.

MAJ Sean Donohue, PA-C, MPAS is assigned to the Office of the Chief Legislative Liaison, House Liaison Division. He was formerly the Command Surgeon, National Training Center, Fort Irwin, CA. Previous assignments include Senior PA, 11th Armored Cavalry Regiment; Senior PA, U.S. Army Africa; Battalion PA, 4th Brigade 319th Field Artillery (Airborne) 173rd Airborne Brigade Combat Team. He has deployed to Operation Enduring Freedom, Hurricane Katrina/Rita response and had multiple trips to the African continent.

Approved for public release:

Distribution Unlimited

**Approved for public release:
Distribution Unlimited**