Center for Army Lessons Learned

News From the Front

The Multinational Patient Evacuation and Coordination Cell in Exercise SABER STRIKE

Lessons for Large-Scale Combat Operations

LTC James D. Clay, Army Capabilities Management; David Cannon, Analyst, Medical Center of Excellence; Carlos Alvarado, Archivist, Army Medical Department Center of History and Heritage; Craig Hayes, Senior Military Analyst, Center Army Lessons Learned

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Overview

Exercise SABER STRIKE is a U.S.-led multinational exercise involving 19 North Atlantic Treaty Organization (NATO) allies and partners. The exercise is conducted throughout the Baltic region and Poland. (See Figure 1.) During Exercise SABER STRIKE 18, the 30th Medical Brigade liaison officer was assigned to the land component command and multinational patient evacuation and coordination cell (PECC) to ensure synchronization among the medical brigade, corps, and multinational staffs. Conducting medical regulation in this dynamic environment facilitated collaboration with NATO counterparts that resulted in observations to benefit medical operations in a joint or multinational environment.

Figure 1. U.S. Soldiers aboard an M1133 medical evacuation vehicle assigned to the 1st Squadron, 2nd Cavalry Regiment, Battle Group Poland, moving in a defensive position during Exercise SABER STRIKE 18 in Bemowo Piskie Training Area, Poland, 12 June 2018. Exercise SABER STRIKE is a U.S. European Command-sponsored, Joint Chiefs of Staff-directed, regional and multilateral command post and field exercise designed to increase interoperability between the U.S. and partner nations. (U.S. Army National Guard photo by 1LT Erica Mitchell)

Multinational Patient Evacuation and Coordination Cell

The multinational PECC in Szczecin, Poland, coordinated evacuation among hospitals until Service members were repatriated. Repatriation is defined as a Service member returning to home station or higher echelons of care from host-nation hospitalization. The PECC consisted of an Officer (OF)-5 (U.S. Army equivalent of a colonel) German multinational lead physician, OF-4 (U.S. Army equivalent of a lieutenant colonel) shift lead, two OF-3s (U.S. Army equivalent of a major) PECC operations officers, two OF-3 U.K. officers, two OF-3 Polish PECC officers, two senior noncommissioned officers for administrative support, and a U.S. Army combat medic specialist. In order to track repatriated patients, U.S. Army Europe (USAREUR) tasked the 30th Medical Brigade to form a patient movement cell to regulate patient evacuation from the point of injury to host-nation hospital care facilities and to provide a medical common operational picture (MEDCOP) of the patients' status. The multinational PECC focused on regulating U.S. and multinational casualties. It provided Multinational Corps Northeast the MEDCOP of the U.S. and multinational forces admitted as inpatients (patients with a hospital stay greater than 24 hours).

The 30th Medical Brigade conducted medical regulation of patients through a casualty management system designed to coordinate and control the movement of patients to the care of the medical treatment facility's most capable medical staff. This system provided the most appropriate care from the point of injury to successive roles of medical care. In conjunction with providing medical regulation through the patient administration section, the 30th Medical Brigade provided the MEDCOP through the clinical operations section to USAREUR, the Multinational Corps Northeast PECC, and Regional Health Command Europe.

Table 1. Reporting for Multinational and USAREUR Patient Movement

	Mission Command Element (MEDSITREP)	30th Medical Brigade (MEDSITREP Patient Movement Tracker)	184th Expeditionary Sustainment Command/21st Theater Sustainment Command (MEDSITREP and Patient Movement Tracker)	Multinational Corps Northeast (Patient Tracking Report)
Hospitalization and Beyond			The 30th Medical Brigade reports to the 184th Expeditionary Sustainment Command and copies the multinational PECC. Tracks: Patient tracking and movement, medical evacuation, MEDCOP, and medical trends.	Exercise SABER STRIKE multinational forces report to the multinational PECC. Tracks: Patient tracking, STRATEVAC, and MEDCOP.
Point of Injury to Hospitalization	U.S. forces RAF, RFF, and enhanced forward presence reports to the mission command element and copies the 30th Medical Brigade.	USAREUR U.S. forces Exercise SABER STRIKE report to the 30th Medical Brigade.		

MEDCOP medical common operational picture
MEDSITREP medical situation report
PECC patient evacuation coordination cell
RAF regionally aligned force
RFF request for force
STRATEVAC strategic evacuation

Table 1 depicts the organizations involved in medical regulation. Evacuation from the point of injury to hospitalization is considered tactical evacuation (TACEVAC), and hospitalization and beyond is considered strategic evacuation (STRATEVAC).

The multinational PECC scope included patient tracking of Service members, both U.S. and multinational, who were considered inpatients (more than 24 hours). At the point of injury, a TACEVAC discussion occurred among the brigade surgeon, patient movement cell, and theater patient movement and relocation cell to determine the patients' evacuation category, location, transportation means, and destination. The theater patient movement and relocation cell, as the final-decision authority, decided which hospital and evacuation process to use to ensure wounded Service members were evacuated based on injury and capabilities available. In the event the patient was categorized as a NATO Category A (urgent) or Category B (priority), the multinational PECC conducted a mission analysis to validate the categorization and evacuation decision. This analysis validated that NATO guidelines for MEDEVAC were

met (for example, a Category A patient was evacuated within 90 minutes, equating to a driving distance of 200 kilometers [124.274 miles] or less. For Category B, the evacuation must occur within 4 hours). In one case, the multinational PECC received a spot report of an inaccurate assessment and precedence categorization due to a hasty analysis. After a series of questions from the patient-tracking checklist, shown in Figure 2, validating the patient status and disposition, the precedence was downgraded from urgent to priority. Although surgery was required, ground transport could be used to move the casualty.

The daily battle rhythm included two patient-movement reports, one from the morning and one from the evening. (See Figure 3.) that included inpatients and outpatients from the 30th Medical Brigade. The multinational PECC pulled information from the hospitals and provided the evening NATO patient-tracking report. (See Figure 4 on page 4.) containing only inpatient information. The two reports served as checks and balances to ensure correct tracking of information. However, local hospitals were reluctant to release evening information due to limited staffing and the desire

1. Ask name, date of birth, unit, injury type with detail, current location, destination, and evacuation category, including who made the determination.

2. Ask time admitted and location of the current hospital, with the correct spelling.

3. Confirm all information against the reports used by the 30th Medical Brigade patient-movement report (Nonsecure Internet Protocol Router Network [NIPR]), land component command PECC patient-tracking report (NATO Classified), or for trends, disease, and nonbattle injury, the 30th Medical Brigade medical situation report (NIPR).

3. Map the location and consider the origin and destination based on injury and capability.

4. Obtain the mode of transportation and departure time (emergency medical services, ambulance, or local company).

5. Call the PECC director for a Category A or B Service member, key leaders, and civilian casualties; death; for a questionable injury, capability, examination, diagnosis, decision, evacuation means, or destination compared to origin.

6. Call the shift leader once all the above information in the checklist is obtained.

7. Log all information onto Department of the Army (DA) Form 1594, *Daily Staff Journal or Duty Officer's Log*, 01 December 2019.

8. Brief the incoming shift on the information entered on DA Form 1594, along with any actions taken and due outs.

Figure 2. PECC patient-tracking checklist

Units: DTG Admitted	Patient Battle Roster	DOB (MM/DD/YEAR)	Unit (BN/BDE)	U.S. Coalition/ Foreign National	Host-Nation Facility	Medical Code/MTF Destination	Category/Type of Injury/Comments	Evacuation Type	Escort (if applicable)	Wheels Up Time	Wheels Down Time	TRACE2ES Cite Number	Comments

BDE brigade
BN battalion
DOB date of birth
DTG date-time group
MTF military treatment facility
PECC patient evacuation coordination cell
TRAC2ES U.S. Transportation Command Regulating and Command and Control Evacuation System

Figure 3. Example patient-movement report

to maintain patient confidentiality. This reluctance resulted in the inability of the multinational PECC to validate evening patient information. The NATO force integration units (NFIUs)—teams of both NATO and host-nation personnel—were formed at the request of the host nation to ensure NATO standards were met. NFIUs played an important communication role and formed habitual relationships with local hospitals. However, with the hospitals' reluctance to pull evening information, the NFIUs were used only during daytime hours. The inability to access evening hospital information created a delay providing an evening MEDCOP to the command.

Although unintended, the multinational PECC emerged as the central coordination hub for all USAREUR patient-tracking operations. The convergence of medical operations and tactical decision making doctrinally remains with the 30th Medical Brigade as the medical mission command authority. However, the 30th Medical Brigade displaced often, making it difficult to synchronize information and operations received from all USAREUR medical organizations. Although the 30th Medical Brigade was assigned a joint network node for this exercise—a tactical network providing beyond line-of-sight communication—the brigade still struggled to maintain communication with its multinational counterparts. Therefore, the multinational PECC managed operational and patient tracking for multinational and U.S. forces.

Several challenges were noted by the multinational PECC team resulting from a lack of planning and coordination. One challenge was the reluctance of units to follow the contingency plans they submitted. This reluctance stemmed from key leaders who deviated from the contingency plan without higher echelon coordination. The execution of mission command was critical in achieving cross-domain synergy, while providing the commander situational awareness of medical operations and patient status. One brigade deviated from the contingency plan, detailing evacuation to a closer, local Baltic hospital rather than the assessed and planned Polish military hospital. Assessments did show the Polish military hospital

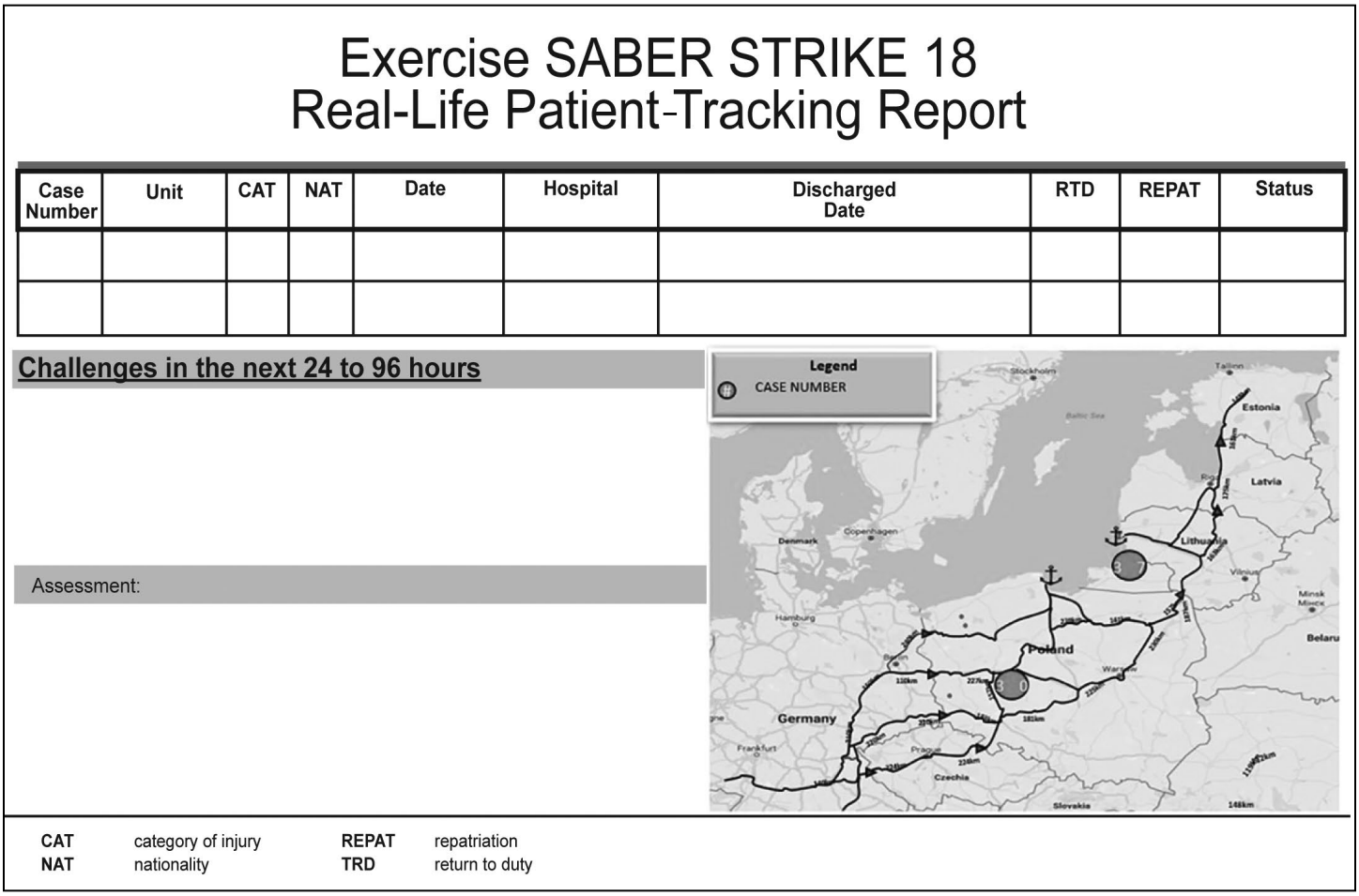

Figure 4. Example patient-tracking report

had more capability; however, the commander on the ground opted for a closer hospital, allowing Soldiers to return to the fight quicker, also resulting in the use of less fuel. This decision made sense, but it needed to be coordinated at the higher command and should have been accounted for in the contingency plan.

Considering the intensity and hyperactivity of large-scale combat operations (LSCO), the joint force expects to experience much larger casualty numbers than operations from the past 20 years. Casualty evacuation, which is a leader function, will need to be trained and carefully synchronized during competition with the joint force and partners. During daily synchronization huddles, the PECC observed key leaders were not present to provide accurate updates or to ensure contingencies were covered to prevent culmination from a medical reason. Based on these challenges, medical regulation cells should be located at the highest levels of command to facilitate communication and adherence to contingency plans. The commander needs to ensure synchronization of contingency plans prior to plan execution and ensure they are updated and coordinated with higher headquarters.

Exercise SABER STRIKE 18 had limited casualty play and did not reflect the complexities of LSCO. The exercise provided enough casualties to test the medical regulating system but not enough to overwhelm it. Commanders in Europe must consider the scale of fighting, multiple corps, and the scope of multi-domain operations. Additionally, a lack of air superiority, extended distances, distributed operations, rapid aggregation, joint and partner integration, and lower-echelon migration (such as with the Joint Concept for Health Services) further enhanced the complexity. Functions drive structures, and medical regulation will need to occur at the highest echelons of leadership to enable patient tracking and synchronization of medical operations. The patient-movement cell should serve at the corps level to enable command emphasis from division and higher echelons to ensure unit participation and accurate reporting of medical operations.

For operational processes, operations teams should always use operations boxes for distribution lists. Using operations boxes can ensure all those who are involved will receive the required information. For example, if a patient's information is sent by email to one or even several persons, there is a possibility it will get overlooked. An operations box is a more systematic way of providing patient information. This step is often missed and results in compartmentalized information. However, one issue with operations boxes is that they cannot receive encrypted emails. Therefore, the decision should be made up front about what information will be distributed and whether it has personally identifiable information (PII). If the email requires encryption, then an operations box cannot be used.

Initially, the multinational PECC used a daily medical situation report that captured all the information required for hospital admissions and STRATEVAC. This report was a one-stop shop for all patient information, until concern was raised about violation of the Health Insurance Portal and Accountability Act because the report contained PII. Therefore, the use of the report was discontinued. There was also a loss of a database containing patient information that could have been used to address queries or document injuries. In the future, the daily medical situation reports should be maintained on a secure drive. Also, to maintain patient confidentiality, only required information should be sent to those on a need-to-know basis, and in a format that cannot be manipulated.

Knowledge management facilitated continuity between shifts and observation of lessons learned and best practices. The All Partners Access Network (APAN) database, accessible to U.S. and NATO forces, ensured continuity and collaboration across U.S. and NATO organizations. However, data loaded into APAN did not include PII because the system was subject to hacking. Each shift filed products that included a patient-tracking report, a NATO record of patients validated by the NATO force integration unit, the patient-movement report documenting the disposition of U.S. forces, a chronological record of events, and a list of patients using Department of the Army (DA) Form 1594. (See Figure 5, on page 6.)

DAILY STAFF JOURNAL OR DUTY OFFICER'S LOG
For use of this form, see TC 3-22.8; the proponent agency is TRADOC.

PAGE NO. | NO. OF PAGES

ORGANIZATION OR INSTALLATION | LOCATION | PERIOD COVERED: FROM (HOUR, DATE) TO (HOUR, DATE)

ITEM NO.	TIME IN	TIME OUT	INCIDENTS, MESSAGES, ORDERS, ETC.	ACTION TAKEN	INIT.

TYPE NAME AND GRADE OF OFFICER OR OFFICIAL ON DUTY | SIGNATURE

DA FORM 1594, DEC 2019 PREVIOUS EDITION OF THIS FORM IS OBSOLETE. APD AEM v1.00ES

Figure 5. DA Form 1594

DA Form 1594 is a form used to check for patient information that can be missed in the patient -tracking report or patient-movement report. A patient-tracking checklist ensured the PECC personnel knew the correct questions to ask during phone calls, which reduced the need for redundant phone calls.

Patient tracking ensures patients are moved to the appropriate medical treatment based on patient care categories. Exercises such as Exercise SABER STRIKE train units to perform patient tracking to include movement of patients from point of injury to aid stations by means other than air or ground MEDEVAC. (See Figure 6.)

Figure 6. A combined forces squad with U.S. Soldiers assigned to the 1st Armored Brigade Combat Team, 34th Infantry Division, Minnesota Army National Guard; British Royal Marines; and Polish soldiers, transport wounded soldiers to an HH-60M MEDEVAC Black Hawk helicopter during Exercise SABER STRIKE 17, near Sventezeris, Lithuania, 18 June 2017. (U.S. Army photo by SGT Shiloh Capers)

Casualty evacuation, use of opportunity lift, ring routes, short takeoff and landing flights, and ground convoy movement of Soldiers for medical care require prior coordination and planning to facilitate patient care. Tracking patient movements requires collaborative work within the sustainment and protection warfighting functions and with NATO partners to identify, track, and report casualties in a timely manner. Patient tracking allows units to maintain connectivity for successful medical and casualty evacuation coordination, which produces successful patient care outcomes.

The main takeaway from these observations is that medical regulation of the European theater is complex and involves synchronization of national assets, an emphasis on ground transportation across multiple borders, and interoperability among NATO and U.S. forces. The medical regulation function must be located at the highest headquarters structure to ensure command emphasis and the appropriate enablers are in place to provide the best medical care to Service members.