

Joint Publication 4-02



Health Service Support



26 July 2012



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PREFACE

1. Scope

This publication provides doctrine for the planning, preparation, and execution of health service support across 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 joint operations and provides the doctrinal basis for US military coordination with other US Government agencies during operations 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 education 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 Joint Staff, commanders of combatant commands, subunified commands, joint task forces, subordinate components of these commands, the Services, and combat support agencies.

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:

A handwritten signature in black ink, appearing to read 'W. E. Gortney', written in a cursive style.

WILLIAM E. GORTNEY
VADM, USN
Director, Joint Staff

**SUMMARY OF CHANGES
REVISION OF JOINT PUBLICATION 4-02
DATED 31 OCTOBER 2006**

- **Adds chapter on force health protection with subordinate core functional capabilities.**
- **Includes time sensitive en route care as part of overarching joint medical capability for health service support.**
- **Clarifies United States Transportation Command (USTRANSCOM) policy for patient movement of contaminated, contagious, or potentially exposed casualties.**
- **Acknowledges the United States Air Force Air Mobility Command role as the Department of Defense lead agent for aeromedical evacuation policy, training, and standardization of procedures.**
- **Assigns theater patient movement requirements center processes and responsibilities to USTRANSCOM Surgeon's Office.**
- **Clarifies Special Operations Forces Operational Medicine mission and responsibilities.**
- **Creates four levels of identification for chemical, biological, radiological, and nuclear hazards; presumptive, field confirmatory, theater validation, and definitive.**
- **Eliminates the use of the Joint Medical Analysis Tool as the approved asset for calculating medical requirements.**
- **Updates references and acronyms.**

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EXECUTIVE SUMMARY COMMANDER'S OVERVIEW

- **Provides an Overview of Health Support to Joint Operations**
 - **Explains Roles and Responsibilities in Health Service Support**
 - **Describes Health Service Support Casualty Management, Medical Logistics, and Health Information Management**
 - **Details Force Health Protection Casualty Prevention, Preventive Medicine, and Health Surveillance**
 - **Covers Health Service Support across the Range of Military Operations**
 - **Addresses Joint Health Planning Considerations and Medical Logistics**
-

Health Support to Joint Operations Overview

Military Health System

The Military Health System supports the operational 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.

Principles of Health Service Support

The principles of health service support (HSS) consist of conformity, proximity, flexibility, mobility, continuity, and control.

Conformity

Conformity with the tactical plan is the most basic element for effectively providing health support. Medical planners must be involved early in the planning process, and once the plan is established, it must be rehearsed with the forces it supports.

Proximity

The principle of proximity is to provide health support to sick, injured, and wounded military personnel at the right time and to keep morbidity and mortality to a minimum.

Flexibility

Flexibility is being prepared and empowered to shift medical resources to meet changing requirements. The medical commander must build flexibility into

the operation plan (OPLAN) to support the combatant commander's (CCDR's) scheme of maneuver.

Mobility

The principle of mobility is to ensure that medical assets remain within supporting distance of maneuvering forces.

Continuity

Continuity of care and treatment is achieved by moving the patient through progressive, phased roles of care, extending from the point of injury or wounding to the US-support base. Each type of medical unit contributes a measured, logical increment of care appropriate to its location and capabilities.

Control

Control is required to ensure that scarce medical resources are efficiently employed and support the tactical and strategic plan. It also ensures that the scope and quality of medical treatment meet professional standards, policies, and US and international law.

Joint Medical Capabilities

Health support is provided to military personnel by applying prevention, protection, and treatment capabilities. The five overarching joint medical capabilities for HSS are: first responder care capability, forward resuscitative care capability, theater hospitalization capability, definitive care capability, and en route care capability.

Roles and Responsibilities

Command and Control

Each Service is designated to provide scalable and tailorable medical command and control modules for early entry and expeditionary operations which could augment the theater capability until an operational health care infrastructure is established.

Joint Force Surgeon's Office

The joint force surgeon's (JFS's) office coordinates HSS and force health protection (FHP) capabilities for the joint force, under the leadership and guidance of the JFS. Working with the combatant command (CCMD) surgeon, the JFS assesses joint force HSS and FHP requirements and capabilities (both quantitatively and qualitatively), and provides

Organizing the Joint Force Surgeon's Office

recommendations to the joint force commander (JFC).

The JFS's office must be adequately staffed and task organized to support the mission of the joint force.

The **deputy JFS** facilitates the JFS's staff actions that support the JFC; serves as the JFS in the absence of the incumbent; and provides and reinforces the JFS's guidance and intent.

The **plans and operations section** is the focal point for all medical operational matters within the JFS's office.

The **medical logistics (MEDLOG) section** is the central point for MEDLOG within the JFS's office for planning, developing, and coordinating the MEDLOG infrastructure and support for the joint force.

The **FHP section's** primary function is to assist the JFS and component surgeons with establishing policies and procedures to deliver a healthy and fit force, prevent casualties, and maintain the health of the joint force while deployed.

Liaison officer section's primary functions are to monitor, coordinate, advise, synchronize, and facilitate multinational medical contributions.

Joint Force Surgeon's Office Battle Rhythm

The JFS's office daily operations cycle or "battle rhythm" is developed by the deputy JFS and is normally maintained in the joint medical operations center (JMOC). The purpose of the JFS's office battle rhythm is to provide the JFS's staff with a daily schedule of events necessary to support the joint force mission.

Staff Organizations

The JFS may establish staff organizations or may be asked to provide medical liaison relationships and membership to internal joint force organizations to coordinate medical issues. These staff organizations and internal joint force organizations may include and are not limited to: joint patient

movement requirements center, area joint blood program office, JMOC, joint medical working group, joint planning group, logistics directorate of a joint force (J-4) medical liaison cell, civil-military operations center, advanced echelon team, and humanitarian assistance survey team.

Joint Force Surgeon Reachback

Reachback allows for medical infrastructure support services that sustain forward-deployed medical forces to transfer products and ideas as they are required in the joint operations area (JOA). It also provides a channel to contact subject matter experts (SMEs) when a technical issue exceeds the joint force's medical SMEs' capability.

Health Service Support

Casualty Management

A characteristic of health support is the distribution of medical resources and capabilities to provide roles of medical care. This role of care includes: immediate lifesaving measures and disease and nonbattle injury (DNBI) prevention and care.

Role 1. The first medical care military personnel receive is provided at Role 1 (also referred to as unit-level medical care).

Role2. Role 2 provides advanced trauma management and emergency medical treatment including continuation of resuscitation started in Role 1.

Role 3. In Role 3, the patient is treated in a medical treatment facility or veterinary facility (for working animals) that is staffed and equipped to provide care to all categories of patients, to include resuscitation, initial wound surgery, and post-operative treatment.

Role 4. Role 4 medical care is found in US base hospitals and robust overseas facilities.

Medical Logistics

Medical logistics provides intensive management for planning and executing MEDLOG support operations to include medical distribution (which includes transportation planning and coordination), medical equipment maintenance and repair, blood management, optical fabrication and repair, and the

centralized management of patient movement items.

Health Information Management

The **Secretaries of the Military Departments** implement policy and follow implementing instructions, and report metrics in accordance with requirements established by the Assistant Secretary of Defense (Health Affairs) (ASD[HA])

The **Chairman of the Joint Chiefs of Staff (CJCS)** assesses HSS and FHP as part of the overall force planning function of any force deployment decision and periodically reassess the health support posture of deployed forces. Designates theater lead agents for medical materiel for CCMDs based upon recommendations from Defense Logistics Agency (DLA) and in coordination with the Secretaries of the Military Departments.

The **CCDRs**, through the CJCS have overall responsibility for HSS and FHP for forces assigned or attached to their command.

DLA is designated Department of Defense (DOD) executive agent for medical materiel for DOD.

The **DOD MEDLOG Executive Council**, under the direction, authority, and control of the Secretary of Defense (SecDef), with policy guidance from the Office of the ASD(HA), shall provide oversight of the DOD MEDLOG.

The **Defense Medical Material Program Office** under the direction, authority, and control of the Director of the TRICARE Management Activity, with policy guidance from the Office of the ASD(HA), shall provide coordination and support for collaborative DOD MEDLOG policies and objectives with regard to the acquisition and life cycle management of medical supplies and equipment

United States Transportation Command is the DOD's single manager for policy and standardization of procedures and information support systems for global patient movement.

United States Air Force Air Mobility Command is the DOD's lead agent for aeromedical evacuation policy, training, and standardization of procedures.

Force Health Protection

Casualty Prevention

Casualty prevention supports military personnel by applying prevention and protection capabilities. Casualty prevention includes all measures taken by commanders, leaders, individual military personnel, and the health care system to promote, improve, or conserve the mental and physical well-being of military personnel.

Preventive Medicine

Preventive medicine (PVNTMED) is the anticipation and prevention, control of communicable diseases, illnesses, and exposure to endemic, occupational, and environmental threats. PVNTMED includes FHP measures taken against infectious, endemic, environmental, occupational, industrial, and operational health risks.

Health Surveillance

Health surveillance includes identifying the population at risk; identifying and assessing their potentially hazardous exposures (such as medical, food/water, occupational and environmental, psychological, and chemical, biological, radiological, and nuclear [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/battle injury rates and other measures of health outcomes to higher authority in a timely manner.

Combat and Operational Stress Control

Combat and operational stress control includes programs and actions to be taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units.

Preventive Dentistry

Preventive dentistry incorporates primary, secondary, and tertiary measures to reduce or eliminate conditions that may decrease military personnel fitness in performing their mission and which could result in being removed from their unit for treatment.

Vision Readiness

Vision readiness encompasses the Service member having optimal visual clarity in order to most effectively and efficiently complete their assignments as well as the optical devices needed for vision correction (if required) and for eye protection of all service members during hazardous activities, including deployment.

Laboratory Services

Deployable environmental laboratory services include capabilities in identification and field confirmation of endemic diseases, occupational and environmental health hazards, and CBRN agents. The focus of the laboratory is the total health environment of the JOA, not individual patient care.

Veterinary Services

The United States Army (USA) is the DOD executive agent for veterinary support for the Services. USA veterinary units are task-organized and tailored in order to support government-owned animal health care, veterinary PVNTMED, and food safety and security programs.

Health Service Support Operations

Combat Operations

Due to the necessity to perform lifesaving interventions for personnel suffering combat trauma within minutes of wounding or injury, medical resources must be arrayed in close proximity to the forces supported. This also permits the medical assets to rapidly clear the JOA of casualties and enhances the JFC's ability.

Stability and Civil-Military Operations

Medical stability operations include supporting efforts to establish or restore medical support necessary to sustain the population until local civil services are restored; assessments of the civilian medical and public health systems such as infrastructure, medical staff, training and education, MEDLOG, public health programs, and promoting and enhancing the host nation medical infrastructure. 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 medical civil-military operations.

Limited Contingencies and Crisis Response

Limited contingencies are operations that are inherently joint and require strategic reachback. Medical planning during limited contingencies must remain flexible to unique support arrangements which capitalize on the strengths of all units employed in the JOA.

Defense Support of Civil Authorities

Requests for health support during disasters in the US will normally be initiated by Department of Health and Human Services through submission of a request for assistance or mission assignment. Requests typically flow from Federal Emergency Management Agency to Joint Director of Military Support and are processed forward to SecDef for approval.

Special Operations Forces

The theater special operations command component commander coordinates conventional HSS packages to augment the special operations forces (SOF) organic medical capability using the organic surgeon section. SOF medics are all advanced tactical paramedic certified. In addition, some SOF personnel are state certified or national certified emergency medical technicians or paramedics. SOF advanced tactical paramedics are capable of providing advanced tactical combat casualty care.

Multinational Operations

Multinational support operations are complicated by a number of characteristics that impact fundamentally upon the provision of HSS. Contributing nations bear ultimate responsibility for ensuring the provision of HSS to their forces allocated to multinational operations. Operational HSS to multinational forces must meet standards that are acceptable to all participating nations. Care provided to US forces participating in a multinational operation must meet US standards.

Detainee Operations

During the conduct of joint and multinational operations, the JFS and component medical forces must be prepared to provide health support to a wide array of individuals that may be detained by US forces. 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.

Operations in a Chemical, Biological, Radiological, and Nuclear Environment

The component command surgeons, working with the appointed JFS, are responsible for guiding and integrating all medical capabilities available to the command to support mission accomplishment in a CBRN environment. Medical forces may require coordination and cooperation with agencies, organizations, and individuals outside the military chain of command or direct control.

Contractor Support

Prior to deploying, certain medical readiness requirements must be satisfied for contingency contractors authorized to accompany the force to deploy to an operational area. The CCMD surgeon and subordinate JFSs should ensure that HSS, either as a responsibility of the contractor or the geographic combatant commander/JFC, is fully delineated in OPLANs, operation orders, and operational specific policy to assure appropriate medical staffing in the area of responsibility/JOA. Contingency contractors authorized to accompany the force are not authorized primary and routine medical or dental care unless specifically authorized under the terms of the DOD contract and approved by the supported JFC.

Joint Health Planning

Health Support Planning Considerations

Timely, effective planning and coordination are essential to ensure adequate and sustainable health support in a JOA. Organization of the health support system is determined by the joint force's mission, the threat, intelligence, anticipated number of patients, duration of the operation, the theater patient movement policy, available lift, MEDLOG capabilities, and hospitalization requirements.

Planning Joint Medical Logistics

Medical units as well as maneuver units usually begin requesting MEDLOG 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 MEDLOG planner must coordinate with the

command J-4 and other designated movement control organizations. Medical materiel will typically flow through the same distribution channels and is subject to the same movement controls as all other classes of supply.

Systems and Planning Tools

The Joint Medical Planning Tool will take Service-specific casualty rates, admission rates, and population at risk from time-phased force and deployment data, contingency planning, theater patient movement policy, and merges those figures to generate joint medical requirements.

CONCLUSION

This publication provides doctrine for the planning, preparation, and execution of health service support across the range of military operations.

CHAPTER I

HEALTH SUPPORT TO JOINT OPERATIONS OVERVIEW

“The preservation of a soldier’s health should be [the commander’s] first and greatest care.”

**Excerpt from the first regulations published for an American force,
(Regulation 5, 1778–1779)**

1. Introduction

Joint health care operations are conducted as part of an interrelated military health system that shares medical services, capabilities, and specialists among the Service components and partners with multi-agencies and nations to implement a seamless unified health delivery effort within a joint command and control (C2). Joint medical capabilities (i.e., health support) are grouped under the joint functions of sustainment and protection. Health service support (HSS) falls under sustainment, and force health protection (FHP) falls under protection. Health support capabilities, which encompasses HSS and FHP, are employed during all military operations. These capabilities span the operational environment from point of injury/illness to the appropriate role of care.

2. Military Health System

The Military Health System supports the operational 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, problem intervention services, and pastoral care and religious support), and improving the means and methods for maintaining the health of the beneficiary population by constantly evaluating the performance of the health support. The Military Health System supports all US military personnel (active, and retired military personnel and their families if an enrollee is in TRICARE). However, this publication will only address health support for the military personnel in joint and Service organizations in the preparation and conduct of joint operations.

3. Principles of Health Service Support

The principles of HSS consist of conformity, proximity, flexibility, mobility, continuity, and control.

a. Conformity with the tactical plan is the most basic element for effectively providing health support. In order to develop a comprehensive concept of operations (CONOPS), the medical commander must have direct access to the tactical commander.

Medical planners must be involved early in the planning process, and once the plan is established, it must be rehearsed with the forces it supports.

b. The principle of proximity is to provide health support to sick, injured, and wounded military personnel at the right time and to keep morbidity and mortality to a minimum. Medical assets are placed within supporting distance of the supported maneuver forces, but not close enough to impede ongoing combat operations. As the battle rhythm of the medical commander is similar to the tactical commander's, it is essential that medical assets are positioned to rapidly locate, acquire, stabilize, and evacuate casualties.

c. Flexibility is being prepared and empowered to shift medical resources to meet changing requirements. Changes in tactical plans or operations make flexibility in medical planning and execution essential. The medical commander must build flexibility into the operation plan (OPLAN) to support the combatant commander's (CCDR's) scheme of maneuver. He must also ensure that the flexibility exists to rapidly transition from one level of violence to another if the situation escalates. As the current era is one characterized by persistent conflict, the medical commander may be supporting simultaneous actions along the continuum from stable peace through general war. The medical commander exercises his command authority to effectively manage his scarce medical resources so that they benefit the greatest number of military personnel in the joint operations area (JOA).

d. The principle of mobility is to ensure that medical assets remain within supporting distance of maneuvering forces. The mobility and survivability (such as armor plating and other force protection measures) of medical units organic to maneuver elements must be equal to the forces being supported. Major medical headquarters (HQ) continually assess and forecast unit movement and redeployment. Medical support must be continually responsive to shifting medical requirements in the operational environment. In noncontiguous operations, the use of ground ambulances may be limited depending on the security threat in unassigned areas, and air ambulance use may be limited by environmental conditions and enemy air defense threat. Therefore, to facilitate a continuous evacuation flow, patient movement must be a synchronized effort to ensure timely, responsive, and effective support is provided to the tactical commander. The only means available to increase the mobility of medical units is to evacuate all patients that they are holding. Medical units anticipating an influx of patients must medically evacuate patients on-hand prior to the start of the engagement.

e. Continuity of care and treatment is achieved by moving the patient through progressive, phased roles of care, extending from the point of injury or wounding to the US-support base. Each type of medical unit contributes a measured, logical increment of care appropriate to its location and capabilities. In current operations, lower casualty rates, availability of rotary-wing air ambulances, and other situational variables often times enables a patient to be evacuated from the point of injury directly to the supporting medical treatment facility (MTF). In more traditional combat operations, higher casualty rates, extended distances, and patient condition may necessitate that a patient receive treatment at each role of care to maintain his physiologic status and enhance his chances

of survival. The medical commander's depth of medical knowledge, ability to anticipate follow-on treatment requirements, and assessment of the availability of specialized medical resources enable him to adjust the flow of casualties to ensure that everyone treated receives the care required to optimize patient outcomes. The medical commander may recommend changes in the theater evacuation policy to adjust patient flow within the deployed setting.

f. Control is required to ensure that scarce medical resources are efficiently employed and support the tactical and strategic plan. It also ensures that the scope and quality of medical treatment meet professional standards, policies, and US and international law. Within the JOA, the individual responsible to orchestrate this complex support for the joint force commander (JFC) is the joint force surgeon (JFS). The JFS establishes relationships with theater MTF commanders and others who exercise command authority over medical forces to synchronize activities. In a joint, interagency, intergovernmental, and multinational environment, it is essential that coordination be accomplished across all Services and multinational forces to leverage all of the specialized skills within the theater.

4. Joint Medical Capabilities

Health support is provided to military personnel by applying prevention, protection, and treatment 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. The five overarching joint medical capabilities for HSS are:

a. First Responder Care Capability

(1) The first responder care capability is defined by its time requirements. It is this health care capability that provides first responder care, which is immediate medical care and stabilization to the patient in preparation for evacuation to the next higher role of care. This capability can be divided into three categories of self-aid or buddy aid (nonmedical), emergent care services, and primary care.

(2) Primary care outpatient services often begin with the employment of basic or advanced first aid (via self-aid or buddy aid), followed by nonphysician medical care, and, in some instances, physician primary care. Emergent care services offer basic pre-hospital trauma life support to include paramedic emergency care, initial resuscitative and fluid therapy, and cardiac life support. First responders provide initial treatment for injuries.

(3) Primary care/outpatient activities (such as aid stations, clinics, and organic medical departments) may offer basic ancillary services such as limited pharmacy, laboratory, and radiology. They may also include sub-specialties like basic behavioral (mental) health and dental as well as some preventive medicine (PVNTMED) capabilities.

(4) First responder care capability is also known as tactical combat casualty care. Tactical combat casualty care occurs during a combat mission and is the military counterpart to pre-hospital trauma life support. Pre-hospital trauma care in the military is most commonly provided by enlisted personnel and includes self-aid and buddy aid and combat life savers. Typically, enlisted combat medics in the United States Army (USA), corpsmen in the United States Navy (USN), United States Marine Corps (USMC), and United States Coast Guard (USCG), and both medics and pararescuemen in the United States Air Force (USAF) deliver this capability. Tactical combat casualty care focuses on the most likely threats, injuries, and conditions encountered in combat and on a strictly limited range of interventions directed at the most serious of these threats and conditions. Tactical combat casualty care is divided into three phases.

(a) Care under fire phase—combat life savers, pararescue, and other medical personnel and their units are under effective hostile fire and are very limited in the care they can provide. In essence, only those life-saving interventions that must be performed immediately are undertaken during this phase.

(b) Tactical field care phase—medical personnel and their casualties are no longer under effective hostile fire and can provide more extensive casualty care. In this phase, interventions directed at other life-threatening conditions as well as resuscitation and other measures to increase the comfort of the patient may be performed.

(c) Tactical evacuation phase—casualties are being transported to an MTF by an aircraft or vehicle, and there is an opportunity to provide additional medical personnel and equipment to maintain the interventions already performed, to further increase the role of care rendered to the casualty, and to be prepared to deal with the potential for the patient's condition to change during the evacuation.

b. Forward Resuscitative Care Capability

(1) Forward resuscitative care 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 lifesaving and limb-saving medical treatment. The forward resuscitative care 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.

(2) Advanced emergency services build upon first responder care 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: medical-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.

c. Theater Hospitalization Capability

(1) This capability delivers health support required to medically sustain forces in the JOA. This health support capability involves hospitals purposely positioned to provide support in the JOA. Hospitalization capabilities in the JOA deploy as modules or multiple individual capabilities that provide incrementally increased medical services in a progressively more robust JOA. The hospitalization capability in the JOA offers essential care to either return the patient to duty (within the theater patient movement policy) and/or stabilization to ensure the patient can tolerate evacuation to a definitive care facility outside the JOA. In addition to the availability of substantial medical personnel skills, hospitalization capability in the JOA 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.

(2) Hospitalization capabilities in the JOA can vary according to the regional infrastructure, operational area, and tempo of operation. A robust capability in the JOA would contain the following services not normally resident at the lower roles: advanced burn management; blood bank services; medical logistics (MEDLOG); optometry and ophthalmology; pediatrics; obstetrics; gynecology; internal medicine; cardiology; pathology; infectious disease; intensive/critical care beds and nursing; medical nutrition therapy; behavioral health; occupational health; physical and occupational therapies; dental; PVNTMED; veterinary; and other medical specialties. Additional surgical capabilities exist for eye, maxillofacial, and neurosurgery. There are also expanded capabilities for radiology, pharmacy, and laboratory services.

d. Definitive Care Capability

(1) 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 military personnel, 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. It extends to the families of members of the Armed Forces of the United States and Service retirees.

(2) 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 health support, 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.

e. En Route Care Capability

(1) The purpose of an en route care capability is the continuation of care during movement (evacuation) without clinically compromising the patient's condition. En route care 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 an MTF that can meet the needs of the patient. Each Service component has organic vehicles that can be used for patient movement from point of injury to initial treatment at a medical care capability.

(2) En route care capability can take three forms. Casualty evacuation (CASEVAC) involves the unregulated movement of casualties aboard ships, land vehicles, or aircraft. Medical evacuation (MEDEVAC) traditionally refers to USA, USN, USMC, and USCG patient movement using predesignated tactical or logistic aircraft (both fixed-wing and rotary-wing), boats, ships, and other watercraft temporarily equipped and staffed with medical attendants for en route care. Aeromedical evacuation (AE) refers to the Air Force system providing time-sensitive en route care to regulated patients to and between medical treatment facilities MTF. See Annex A, "Aeromedical Evacuation," to Appendix B, "Patient Movement," for a detailed discussion of AE.

(3) The reduced medical footprint forward and current "evacuate and replace" philosophy place a high demand on the en route care capabilities of all Services. Consequently, Service medical elements should integrate with lift operations as well as with the associated capabilities of multinational partners for patient movement.

CHAPTER II ROLES AND RESPONSIBILITIES

“A soldier’s health must come before economy or any other consideration.”

Napoleon I, 17 June 1813

1. Command and Control

The complexities of the operational environment and the myriad of medical functions and assets necessitate a C2 capability that can plan, control, and assess the limited medical resources available to their full potential and capability. Each Service is designated to provide scalable and tailorable medical C2 modules for early entry and expeditionary operations which could augment the theater capability until an operational health care infrastructure is established.

2. Joint Force Surgeon’s Office

a. The JFS’s office coordinates HSS and FHP capabilities for the joint force, under the leadership and guidance of the JFS. The JFS’s staff should be reasonably balanced in experience and rank among the Services concerned and should be of sufficient size to effectively coordinate support for the following tasks:

(1) Joint coordination of HSS and FHP initiatives.

(2) Deployment health surveillance.

(3) HSS and FHP operations that sustain collaborative joint planning between CCDRs, Services, Department of Defense (DOD) agencies, nongovernmental organizations (NGOs), intergovernmental organizations (IGOs), and host nation (HN) and multinational participants as required.

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

(5) Development of the medical plan and course of action (COA) analysis.

(6) Review of subordinate plans and operations.

(7) Joint coordination of intratheater patient movement.

(8) Reachback support.

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

(a) Hospitalization.

(b) Patient movement.

- (c) Service component transportation assets.
- (d) MEDLOG support.
- (e) Blood management.
- (f) Intelligence support to joint health operations.
- (g) PVNTMED, medical surveillance, and intelligence.
- (h) Patient area reception.
- (i) Medical aspects of reintegration.
- (j) Impacts of the law of war and medical ethics.
- (k) Medical aspects to support personnel recovery.
- (l) Medical repatriation of partner nation patients.

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

b. The discussion of the JFS role and responsibilities applies to surgeons at all levels.

c. Working with the combatant command (CCMD) surgeon, the JFS assesses joint force HSS and FHP requirements and capabilities (both quantitatively and qualitatively), and provides recommendations to the JFC. The responsibilities of the JFS are similar to those of the CCMD surgeon. The JFS should:

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

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

(3) Assist the JFC with establishing specific joint force medical readiness requirements to include predeployment 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, and nuclear (CBRN) and environmental and/or industrial threats. The needs of contractors authorized to accompany the force in the JOA should also be considered when establishing medical readiness requirements.

(4) Advise the JFC concerning the following:

(a) The health of the joint force such as disease and nonbattle injury (DNBI)/battle injury (BI) rates and other health factors that could affect joint task force (JTF) operations to include medical threat identification 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 prophylactic countermeasures (including immunizations); field sanitation measures and hygiene; veterinary services; epidemiology; and prevention programs based on the environment, personnel, and medical intelligence.

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

(f) FHP operations during the joint reception, staging, onward movement, and integration (JRSOI) phase of the joint force deployment/redeployment process.

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

(5) Establish medical request for forces, request for assistance, and request for support. Coordinate and process requirements and support needed for mission execution through functional directorates.

(6) Establish priorities for actions within the JFS's staff and identify medical issues that are significant information reporting requirements.

(7) Determine patient movement requirements.

(8) Establish, as a minimum, an area joint blood program office (AJBPO) and a joint patient movement requirements center (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 patient movement components.

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

(10) Monitor medical regulating and patient movement 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).

(11) Assist the JFC in formulating a recommended patient movement policy within the operational area and monitor evacuation requirements.

(12) During HSS and FHP planning:

(a) Participate in planning and review plans to evaluate if appropriate medical resources and infrastructure are available to support the approved CONOPS. If required, request additional resources or suggest modifications to the plan but at a minimum identify the risks to the commander.

(b) Assist commanders to build and maintain a fit and healthy joint force. Focus on prevention of casualties and effective and efficient care for casualties and the entire process of delivering responsive health support to the deployed joint force.

(c) Monitor, facilitate, and coordinate essential care of the injured and ill in the operational area and their rapid evacuation to definitive medical care.

(d) Identify joint deficiencies and risks and develop joint alternative COAs to address shortfalls.

(e) Consider as medical functions for planning: patient movement, blood program, hospitalization (includes medical nutrition therapy for hospitalized patients), forward resuscitative care capabilities, health support for other than US forces, return to duty, MEDLOG, PVNTMED, dental services, veterinary services, combat and operational stress control, medical communications system and intelligence, and HN support or other United States Government (USG) department and agency support.

(f) Consider support for medical civil-military operations.

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

(14) Coordinate membership and required medical liaison relationships to appropriate joint force staff organizations.

(15) In conjunction with the joint force staff judge advocate, provide the JFC with medical engagement protocol recommendations.

(16) Assist component commands in identifying HSS and FHP requirements and assign cross-Service support where practical; conduct liaison with each component surgeon to establish and maintain HSS and FHP support.

(17) Evaluate and characterize medical and OEH threats in the JOA and make recommendations for countermeasures to control or reduce medical and OEH threats that may impact personnel health or mission objectives.

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

(19) Establish a 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 the environmental and occupational monitoring results and exposure diagnoses and communicating health risks.

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

(21) Communicate risks on health and safety including protective countermeasures and other topics such as use of chemoprophylaxis, immunizations, pretreatments, insect repellants, sanitation, and first aid to joint force personnel in the JOA (to include all military personnel, all DOD civilian and other deployed federal employees; and contractors authorized to accompany the force).

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

(23) Provide support to the intelligence directorate of a joint staff (J-2) especially for conducting joint intelligence preparation of the operational environment and producing and distributing associated products.

(24) Provide PVNTMED/public health support and information on cultural issues relevant to interactions with HN medical systems and participate in the selection of bed-down locations.

(25) Provide guidance for the development of medical annexes to joint plans and medical estimates based on casualty planning factors.

(26) 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 departments and agencies and activities/interest in the public health sector.

(27) Coordinate with special operations forces (SOF) within the JOA and provide HSS and FHP as required.

(28) Ensure appropriate medical care is provided for civilians, contractors authorized to accompany the force, allied military personnel, and detainees, as required by US and international law, mission requirements, established medical engagement protocols, DOD policy, contractual obligations, and applicable national agreements.

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

(30) Develop mass casualty (MASCAL) plans for the JOA.

(31) Plan for medical support to recovery operations. Coordinate with the reintegration team chief.

(32) Coordinate disaster relief/foreign humanitarian assistance (FHA) augmentation and provide medical support to the resultant civil-military operations. In addition, other special operations units may need conventional force medical augmentation in austere environments.

(33) Recommend the task organization of medical units to satisfy all joint force mission requirements and monitor the availability of and recommend the reassignment and utilization of medical assets in the JOA.

(34) Determine, in conjunction with the joint force staff judge advocate and the chain of command, the eligibility for medical care in joint force MTFs.

(35) Maintain situational awareness by coordinating medical information with the CCMD surgeon, component surgeons, joint force medical units, multinational force surgeons, and other agency medical support personnel as required.

(36) Coordinate medical consultation services for the joint force to include telemedicine as required.

(37) Collect and forward medical statistical data pertinent to the JOA as required.

(38) Recommend policies and determine requirements and priorities for MEDLOG to include blood and blood products, medical supply and resupply, and medical equipment maintenance and repair services.

(a) Ensure communications equipment compatibility, standardization of radio frequencies, reports formats, treatment protocols, and requirements for equipment with multinational medical units, and other USG departments and agencies when appropriate.

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

(39) Ensure that medical records are established and maintained on patients that are treated at MTFs in the operational area of the JFS.

(40) Ensure a dental capability is established as required by the mission.

(41) Ensure a pharmacy capability is established as required by the mission.

(42) Ensure a veterinary program is established as required by mission requirements.

(43) Ensure access to clinical and environmental laboratory capabilities for the identification and confirmation of the use of chemical, biological, or radiological hazards against joint forces as required by mission requirements. There are four levels of

identification for CBRN hazards: presumptive, field confirmatory, theater validation, and definitive.

For more information on the definitions and descriptions of the levels of identification, see Army Tactics, Techniques, and Procedures 3-11.37/Marine Corps Warfighting Publication (MCWP) 3-37.4/Navy Tactics, Techniques, and Procedures (NTTP) 3-11.29/Air Force Tactics Techniques, and Procedures (Instruction) (AFTTP[I]) 3-2.44, Multiservice Tactics, Techniques, and Procedures for CBRN Reconnaissance and Surveillance.

(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 on an ongoing basis.

(46) In conjunction with the operations directorate of a joint force (J-3) and logistics directorate of a joint force (J-4), ensure that health support, either as a responsibility of the contractor or the JFC, is fully delineated in OPLANs, operation orders (OPORDs), and contracts to assure appropriate medical staffing for contractors authorized to accompany the force in the JOA.

(47) In conjunction with the joint force staff judge advocate and CCMD JFS, develop joint force policies and procedures for detainee medical care to include:

(a) Ensuring the appointment of a detainee operations medical director to oversee and guide all elements of health care delivery to detainees within the operational area.

(b) Ensuring that the medical annex of OPORDs and contingency plans include procedures for the treatment of all detainees. Medical support should specifically include: emergency and essential medical care that provides for restoration of functional health, prevention of disease and establishing policy for the medical repatriation of detainees. Services include professional medical services and medical supply. Medical support should have oversight of all sanitary aspects of food service including provisions for potable water, field hygiene and sanitation, pest management and entomological support, PVNTMED (to include immunizations as directed and established by applicable policies), and review/coordination of use and assignment of medically trained detainees and medical materials. Ensuring personnel in US custody shall receive health care consistent with the standard of health care that applies for US military personnel in the same geographic area.

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

(d) Coordinating with the detention facility commander and facilities officer for 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, suicide prevention, medical ethics, reporting of suspected abuse, nutrition and cleanliness of detainees, and to detect contagious diseases. Monthly screenings should include documentation of the weight of each detainee.

(g) Ensuring that PVNTMED and veterinary services, food safety, and defense inspections are conducted at the joint force detention facility.

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

(i) Recommending to the JFC an immunization policy for detainees as dictated by the 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) Ensuring the prevention of detainees attempting or committing suicide while in custody.

(m) Developing plans for prisoners on a hunger strike and plans for prisoners who refuse medical treatment.

(n) Ensuring that detainees evacuated to a joint force MTF for treatment are escorted by an armed guard as designated by the JFC. The guard must remain with the patient while in the patient movement and treatment chain.

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

(p) Ensuring that physical security is provided by nonmedical personnel as designated by the JFC.

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

(r) Ensure procedures for identifying, reporting, and resolving of medical ethics and other legal issues are established and disseminated.

(s) Ensure any health care personnel that in the course of treatment relationship or in any way observes or suspects a possible violation of applicable standards, including those prescribed in Department of Defense Instruction (DODI) 2310.08E, *Medical Program Support for Detainee Operations*, and Department of Defense Directive (DODD) 2310.01E, *The Department of Defense Detainee Program*, will report those circumstances to the chain of command.

(t) Identify any behavioral health science requirements.

(u) Ensure that a restraint procedure is deemed necessary based purely on medical criteria for the protection of the physical or behavioral safety of the detainee, other patients, or the MTF staff. Health care personnel will not participate in the process of restraining the detainee. Rather, military police or other security personnel will be responsible for restraint of the detainees.

(v) Ensure the caloric content and dietary suitability of detainee rations. Ensure consideration of habitual diet and religious/cultural requirements of the detainees.

(48) Ensure that greater emphasis be placed on PVNTMED training and equipping SOF personnel due to limited support availability.

(49) Plan for medical support to the media and the media pool.

3. Organizing the Joint Force Surgeon's Office

a. The JFS's office must be adequately staffed and task organized to support the mission of the joint force. Some considerations for determining the duties and responsibilities by the staff include:

- (1) The mission of the joint force.
- (2) Medical 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 JFS may be required to staff are provided below. Some of the functions of these positions can be combined or eliminated, as necessary and appropriate. Typical staff positions include:

(1) Deputy surgeon.

(2) Medical operations officer.

(3) Senior medical operations noncommissioned officer/chief petty officer.

(4) Medical plans officer.

(5) Environmental science officer/environmental health officer.

(6) Industrial hygiene officer/bioenvironmental engineer/sanitary engineer.

(7) Medical intelligence officer.

(8) Area joint blood program officer.

(9) Patient movement (evacuation) officer.

(10) MEDLOG officer.

(11) PVNTMED officer/public health officer/public health nurse.

(12) Veterinary services officer.

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

(14) International health specialist officer.

(15) Administrative staff.

(16) Medical maintenance officer.

(17) Medical information systems officer.

c. The JFS's office may be organized in many different ways. One example is shown in Figure II-1 and is used for illustrative purposes only. The mission of the functional areas and duties of the staff include:

(1) **Deputy Joint Force Surgeon.** It is recommended that the individual completes the joint medical planner's course and the joint force senior medical leader seminar. The deputy JFS facilitates the JFS's staff actions that support the JFC; serves as

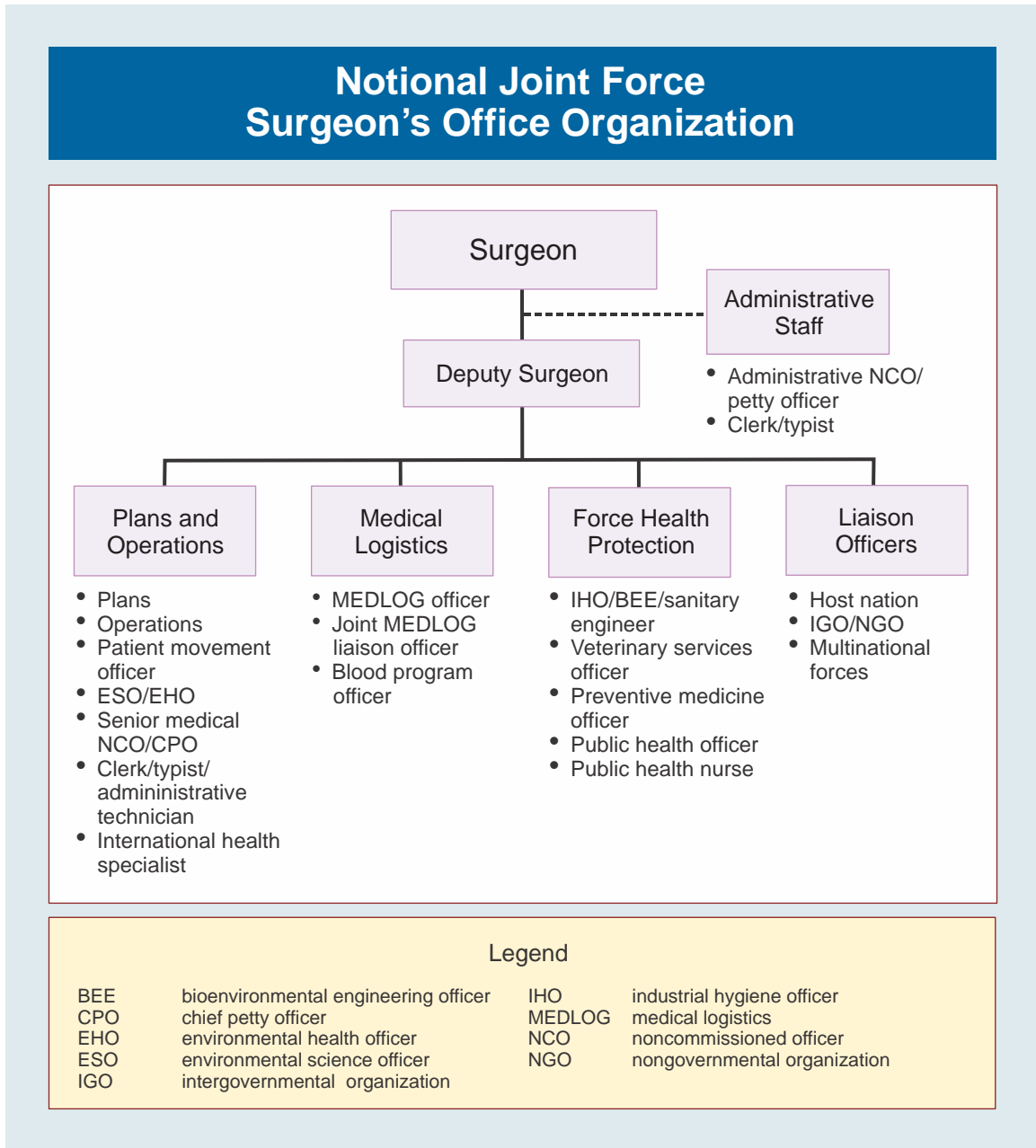


Figure II-1. Notional Joint Force Surgeon's Office Organization

the JFS in the absence of the incumbent; and provides and reinforces the JFS's guidance and intent. Specific responsibilities of the deputy JFS may include:

(a) Assisting the JFS 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 joint force J-4, civil-military operations center, joint civil-military coordination board, humanitarian assistance survey team (HAST); joint interagency coordination group and membership duties to the joint planning group and other joint force organizations.

4. Maintaining oversight on the implementation of JFS's policies/procedures.

5. Supervising augmentation medical teams, as required.

6. Ensuring that the appropriate training is conducted for JFS's staff.

7. Maintaining a master policy file and monitoring the JFS's office standard operating procedures (SOPs).

8. Monitoring JFS's staff actions and functions to ensure compliance of assigned taskings (to include common administrative tasks).

9. Ensuring that command strategic message themes and information operation objectives are planned into all command surgeon actions and activities.

(b) Supervising the plans and operations section of the JFS's office and the development of HSS and FHP plans.

(c) Keeping the JFS informed on the status of HSS and FHP throughout the joint force by monitoring the status of patient beds, evacuation requirements, joint blood program, MEDLOG, laboratory capability, combat and operational stress control, veterinary support and food safety/defense and food service programs, dental services, deployment health surveillance and PVNTMED programs, and health engagement activities that promote health and welfare of human populations such as global health security, humanitarian action, foreign disaster assistance, and humanitarian civic assistance.

(d) Forming, organizing, and supervising appropriate JFS medical boards, offices, and cells as required.

(e) Supervising the development of annex Q (Medical Services) of the OPORD/OPLAN.

(f) Compiling reports reflecting the overall medical readiness of the joint force.

(g) Establishing the JFS's staff daily operations cycle or battle rhythm.

(h) Coordinating and managing the JFS's office daily battle update assessment meeting.

(i) Coordinating with the joint force chief of staff to ensure that the appropriate functions of HSS and FHP are integrated into the joint force battle rhythm.

(j) Serving as the chief, joint medical operations center (JMOC) as required.

(k) Serving as member, joint planning group, and joint medical working group (JMWG) as required.

(2) **Plans and Operations.** The plans and operations section is the focal point for all medical operational matters within the JFS's office. Its primary functions are to plan and develop the medical infrastructure to protect the health of the joint force; mitigate the effects of illness and injury within the JOA; and serve as the hub for achieving medical situational awareness by establishing a JMOC for information management and the facilitation of medical synchronization, and assessment of activities and actions to determine effectiveness in meeting operational objectives via predetermined indicators and outcomes. Staffing may include medical operations/plans officers, patient movement (evacuation) officer, environmental science officer or environmental health officer, and senior medical operations noncommissioned officer.

(a) The medical operations/plans officers shall:

1. Develop medical plans.

2. Ensure that appropriate health care is provided for designated civilians, multinational military personnel, enemy prisoners of war (EPWs), and retained and detained personnel, per applicable agreements and US and international law.

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 joint force.

6. Coordinate disaster relief, FHA medical augmentation, and other health engagement activities, as required.

7. Establish medical communication requirements with the JTF communications system directorate of a joint staff (J-6).

8. Coordinate establishment of a layered medical communications network among component medical units with the joint force J-6, with consideration for interoperability with multinational medical partners.

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 points of contact (POCs).

12. Serve as a member of the joint planning group 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 team and HAST as required.

15. Coordinate support requirements with the J-4 and component logistic planners, as well as the medical planners to ensure synchronization of support requirements of general supply and services, as well as medical supplies.

(b) The medical operations/plans noncommissioned officer/chief petty officer shall:

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.

(c) The patient movement (evacuation) officer shall:

1. In coordination with the TPMRC (if applicable) GPMRC, organize and operate the JPMRC.

2. Provide oversight of the JPMRC in their role of directing medical regulating and patient movement 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 MTFs within the JOA to receive patients based upon medical regulating report.

5. Coordinate with TPMRC/GPMRC to obtain US bed designations for patients who will not be returned to duty within the theater patient movement policy.

6. Serve as patient administration liaison to patient administration departments/sections of component and multinational MTFs.

7. Obtain reports from component and multinational MTFs to consolidate requests for movement of patients out of the JOA.

8. Advise the JFS on a daily basis of specialty bed availability throughout the JOA and on capabilities and limitations of supporting patient movement 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. Maintain visibility of individual patients within the JOA from initial hospital admission to disposition.

11. Assist the JFS with the development and dissemination of theater patient movement procedures and guidance.

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

13. Monitor and coordinate with United States Transportation Command (USTRANSCOM) for patient movement item (PMI) requirements.

14. In concert with the joint force 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.

15. Monitor multinational and component MTF bed availability.

16. Coordinate with the USTRANSCOM Regulating and Command and Control Evacuation System for tracking patients in the evacuation system.

17. Develop procedures with the joint force J-1 for mutual exchange of information.

18. Serve as a member of JMOC and JMVG.

(d) The environmental science officer/environmental health officer should:

1. Provide the JFS with recommendations on policies, force structure, and priorities for use of PVNTMED resources.

2. Plan, monitor, and supervise FHP operations, to include:

a. Waste control and management.

b. Prevention and control of DNBI.

c. Vector control and management.

d. Distribution and/or administration of FHP prescriptive products, chemoprophylaxis, barrier creams, and immunizations.

e. Health surveillance to include medical and OEH surveillance.

f. Food and potable water services.

g. Conduct epidemiological investigations on DNBI outbreaks.

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

4. Monitor PVNTMED personnel, units, and equipment within the JOA.

5. Advise the JFS on a daily basis of PVNTMED activities throughout the JOA.

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

7. Serve as the medical intelligence officer.

8. Coordinate with the joint force J-2 to provide medical intelligence support input to the joint intelligence preparation of the operational environment.

9. Provide the JFS and subordinate medical units with situational awareness regarding the health threat of exposures to CBRN agents and OEH threats.

10. Prepare FHP and medical intelligence/threat estimates and annexes of JTF OPLANs/OPORDs, ensuring that medical intelligence requirements are included in the appropriate annexes.

11. Maintain PVNTMED overlay by coordinating with the force health protection section, PVNTMED detachments, and when necessary, other PVNTMED resources within deployed units and special teams.

12. Serve as a member of JMOC.

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

14. Assist in the development and delivery of health risk communications messages to military personnel and commanders.

(3) **Medical Logistics.** The MEDLOG section is the central point for MEDLOG within the JFS's office for planning, developing, and coordinating the MEDLOG infrastructure and support for the joint force. Staffing may include a joint MEDLOG officer, an area joint blood program officer, medical maintenance warrant or noncommissioned officer, and a joint force J-4 medical liaison officer.

(a) The joint MEDLOG officer should:

1. Prepare MEDLOG estimates and the logistic portion of annex Q (Medical Services) to joint force OPLANs.

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

3. Monitor availability and operational readiness of critical Class VIII (major end item) equipment as determined by the JFS.

4. Assist joint force medical units with maintenance and repair of medical equipment as required.

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

6. Develop and coordinate logistics recommendations as necessary and present to the JFS for approval.

7. Prepare and coordinate draft messages/correspondence and present to the JFS for approval and release.

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

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

10. Interface with the theater lead agent for medical materiel (TLAMM) and/or the single integrated medical logistics manager (SIMLM) and joint force J-4 medical liaison as required.

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

12. Monitor status and availability of medical CBRN equipment.

13. In coordination with the environmental science officer/environmental health officer, medical plans and operations section, and joint force J-4, identify available sites within the JOA to set up joint MTFs.

14. Maintain liaison and communications with the Defense Logistics Agency (DLA) as the executive agent and lead agent for MEDLOG and CCMD MEDLOG officer.

15. In coordination with the joint force 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. Implement policies and procedures for the removal of medical wastes with the JTF J-4.

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

18. Serve as a member of JMOC.

19. Serve as a member of the JMWG.

20. Review any applicable performance-based agreements which affect MEDLOG operations.

(b) The joint blood program office (JBPO) should:

1. Manage the joint blood as the single manager for blood products in the JOA.

2. Coordinate, monitor, and ensure component blood programs, blood product requirements, and capabilities within the JOA are managed and maintained in accordance with Food and Drug Administration (FDA) guidelines/requirements.

3. Assess need for an AJBPO and if required, form, organize, and operate the AJBPO.

4. Monitor the joint force blood inventory status as required and brief status through the daily blood report.

5. Prepare CONOPS and the joint blood program portion of annex Q (Medical Services) to joint force plans and OPORDs.

6. Advise the JFS regarding management, policies, and procedures for handling blood and blood products.

7. Coordinate blood distribution for and between component Services within the JOA.

8. Establish procedures and publish instructions for disposal or destruction of excess and outdated blood.

9. Maintain liaison with the blood support detachments, expeditionary blood transshipment centers (BTCs), and the JBPO at the CCMD surgeon's office for reporting and coordination purposes.

10. Plan the handling, storage, and distribution of blood components within JOA.

11. Consolidate and forward requirements for resupply of blood products to the JBPO based on the JFS's guidance.

12. Assist the JFS with the development and dissemination of JOA blood management policies, procedures, and guidance.

13. Compile area blood reports and forward as appropriate.

14. Be prepared to serve as a member of JMWG as required.

15. Serve as a member of JMOC as required.

(c) Conduit to the J-4 for MEDLOG issues in conjunction with the JMOC MEDLOG planner.

(4) **Force Health Protection.** The FHP section's primary function is to assist the JFS and component surgeons with establishing policies and procedures to deliver a healthy and fit force, prevent casualties, and maintain the health of the joint force while deployed. Staffing may include an industrial hygiene officer/bioenvironmental engineering officer, sanitary engineer, veterinary services officer, or PVNTMED/public health officer/public health nurse. The joint force FHP officer will normally be designated from the joint force FHP staff by the JFS.

(a) The FHP officer should:

1. Assist the JFS 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 of 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 JFS.

4. Collaborate with CCMD surgeon's FHP officer to assist the JFS with establishing predeployment 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 mitigating the risks. Provide an analysis to JFS.

6. Provide the JFS with recommendations on policies, force structure, and priorities of effort for sanitation, entomological, and sanitary engineering resources.

7. Assist the environmental science officer/environmental health officer in the plans and operations section in monitoring PVNTMED and environmental operations.

8. Establish and foster liaison relationships to include, but not limited to the joint force J-2, J-3; National Center for Medical Intelligence (NCMI); Centers for Disease Control and Prevention; Defense Threat Reduction Agency; USMC Chemical Biological Incident Response Force; USA Research, Development, and Engineering Command; Armed Forces Radiobiological Institute; USA Medical Research Institute of Infectious Disease; USA Medical Research Institute for Chemical Defense; and NGOs, IGOs, USG departments and agencies, civilian, and multinational personnel as required to facilitate support to civil-military operations.

9. Collaborate with CCMD surgeon's FHP officer and CBRN medical experts to provide the JFS with procedures for medical operations in a CBRN environment.

10. Communicate health risks and countermeasures for the JOA to deploying personnel and to redeploying personnel and their health care providers.

11. Develop population-based OEH exposure data summaries for archival in the Defense Occupational and Environmental Health Reporting System (DOEHRS) data portal per DODI 6490.03, *Deployment Health*, and DODD 6490.02, *Comprehensive Health Surveillance*. Individual health treatment for environmental or CBRN exposure should be documented in the individuals' medical records.

12. Be prepared to serve as a member of JMOC, JMWG, advanced echelon team, and HAST as required.

13. Incorporate a deployment health surveillance plan and readiness requirements and a theater medical surveillance capability into annex Q (Medical Services).

14. Establish procedures to submit OEH surveillance data and reports to the joint force and the Armed Forces Health Surveillance Center (AFHSC).

15. Prepare the concept of veterinary operations to the FHP portion of annex Q (Medical Services) to joint force OPLANs/OPORDs.

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

17. Provide the JFS 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.

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

19. Maintain liaison with veterinarians of higher HQ, those of US, multinational and foreign government departments and agencies, the joint force J-4 medical liaison, the joint force J-4 operational contract support coordination staff (could be in J-4 or supporting contracting command, if established), and joint force food service officer.

20. Provide the JFS, in coordination with the PVNTMED officer, recommendations on policies regarding the sanitation of all aspects of food service from procurement and transportation to disposal.

21. Advise the JFS on foreign animal diseases that may affect redeployment of military equipment back to the US or partner nations and coordinate with the appropriate governmental departments and agencies as required.

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

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

24. Conduct staff visits and inspections of joint force component veterinary facilities and units.

25. Serve as a member of JMOC.

26. Be prepared to serve as a member of the JMWG, advanced echelon team, and HAST as required.

(b) The PVNTMED officer/public health officer/public health nurse should:

1. Provide the JFS with required medical information 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 joint force FHP officer with designing and developing predeployment and post-deployment guidance.

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

6. Assist the joint force FHP officer with establishing procedures for reporting DNBI, reportable medical events, OEH surveillance data, and documenting all joint force 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 FHA and civil-military operations.

8. Be prepared to collaborate with other joint force medical 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 FHA and civil-military operations.

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

10. Provide technical consultative support on medical issues related to CBRN casualty care, to include development of plans for MASCAL operations.

(5) **Medical Liaison Officers.** Liaison officer section's primary functions are to monitor, coordinate, advise, synchronize, and facilitate multinational medical contributions. Its role is to foster effective coordination between multinational medical staffs, advise the JFS regarding the optimal utilization of multinational medical capabilities, and facilitate the appropriate use of health engagement activities that enhance short and long-term health sector goals. Staffing may include an international health specialist, HN medical liaison officer, multinational medical liaison officer, USG liaison officer, and/or an IGO/NGO liaison officer.

(a) The international health specialist on the joint force staff should primarily be prepared to provide advice and expertise to the JFS for economic and social factors support to medical planning by identifying potential opportunities for medical civil-military operations, humanitarian and civic assistance, humanitarian assistance program-excess property, and other related programs.

(b) HN and multinational force medical liaison officers should:

1. Monitor, coordinate, advise, and assist the JFS as required.
2. Advise the JFS on the medical 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 JFS as required.
8. Advise the JFS regarding the optimal utilization of their service or country's medical capabilities.
9. Attend JFS'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 Force Surgeon's Office Battle Rhythm

a. The JFS's office daily operations cycle or "battle rhythm" is developed by the deputy JFS and is normally maintained in the JMOC. The purpose of the JFS's office battle rhythm is to provide the JFS's staff with a daily schedule of events necessary to

support the joint force mission. The JFS's office battle rhythm reflects the times of the day for recurring events of interest to the JFS's 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 commander, CCMD surgeon, and JTF components are required. All JFS staff sections provide input to the deputy JFS in the development of the JFS 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 commander and higher HQ, and posted and maintained on the JFS's homepage. Changes to the JFS's office battle rhythm are typically announced during the JFS's daily update brief. Once the office battle rhythm is approved, the JMOC chief or the JMOC battle captain ensures the JFS's office battle rhythm is posted to the JFS's Web page (see Figure II-2).

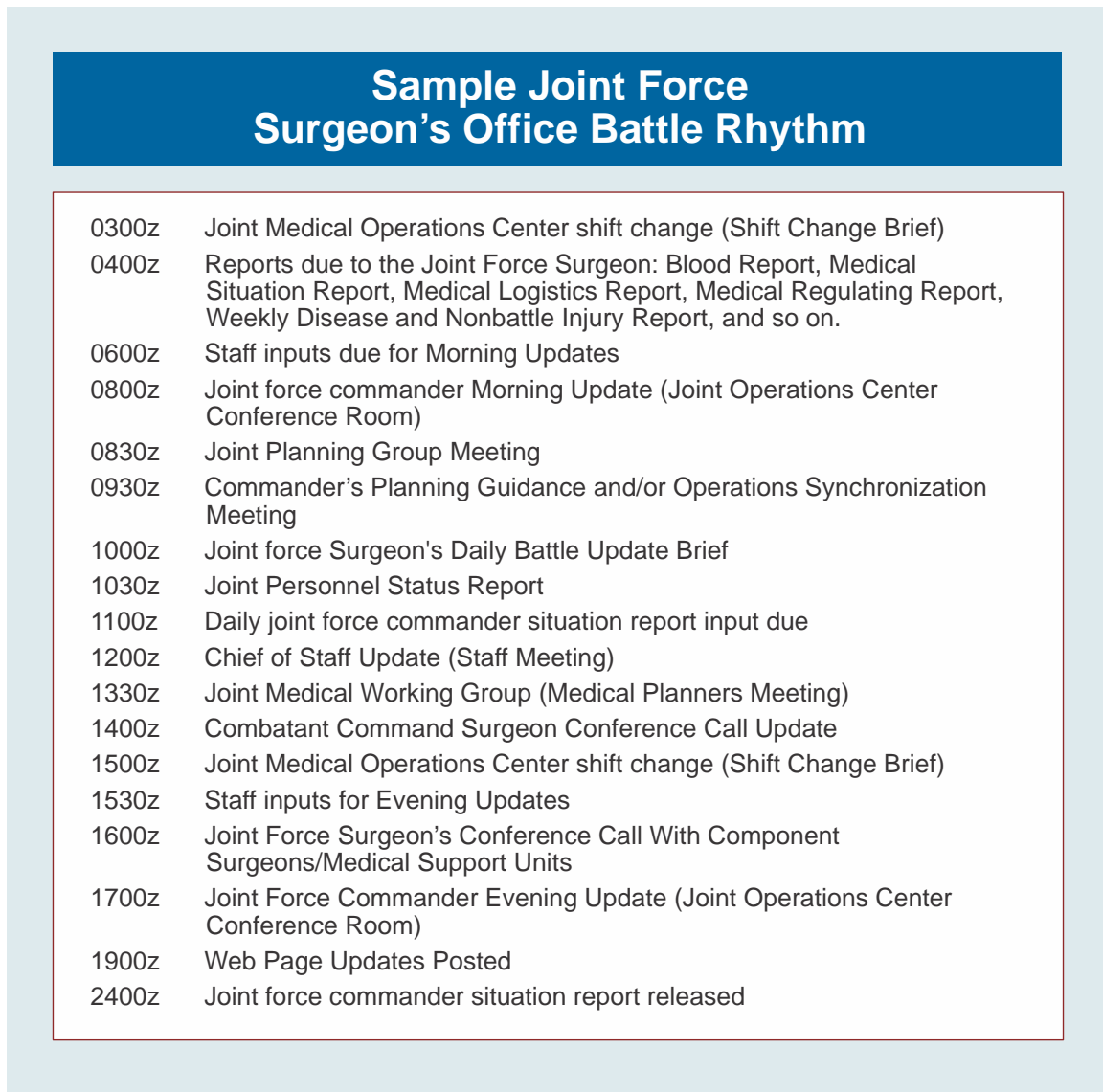


Figure II-2. Sample Joint Task Force Surgeon's Office Battle Rhythm

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

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

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

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

(a) Any requirements for staff updates prior to meetings with the JFC, chief of staff, CCMD surgeon, or component surgeons.

(b) Times for meetings with JFC, chief of staff, CCMD surgeon and component surgeons (video teleconferencing, telephone, other).

(c) Frequency and potential meeting times of JFS's office staff updates (such as, informal morning update and a more formal evening update).

(d) Nature of the updates (such as 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 joint force battle rhythm.

5. Staff Organizations

a. The JFS may establish staff organizations or may be asked to provide medical liaison relationships and membership to internal joint force organizations to coordinate medical issues. These staff organizations and internal joint force organizations may include and are not limited to: JPMRC, AJBPO, JMOC, JMWG, joint planning group, J-4 medical liaison cell, civil-military operations center, advanced echelon team, and HAST.

b. The establishment of staff organizations are described as follows:

(1) JPMRC

(a) The JPMRC provides the theater patient movement requirements capability for a joint force. It may be a "stand-alone" entity operating within a JOA or subordinate to and may receive direction from the GPMRC or the supporting patient movement requirements center (PMRC). The JPMRC performs integrated patient movement tasks for units assigned to the joint force or within the JOA and may coordinate through the TPMRC to request and schedule strategic AE support or work directly with the GPMRC as required. The JPMRC membership is coordinated between the CCMD surgeon and the GPMRC. Since patient movement requires intratheater and intertheater lift, it is critical that the JPMRC communicate requirements to the JFS J-4 liaison officer 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 MTF 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 patient movement requirements. The JPMRC provides TPMRC type, automated information system support and operations for a JTF. Normally, supporting activities will be established to support joint force patient movement operations within the designated JOA. When operating within an area that already has an established TPMRC, the TPMRC will maintain overall visibility for theater patient movement operations, but the JPMRC is responsible for patient movement operations within the JOA and coordinates with the TPMRC for intratheater patient movement and the GPMRC for intertheater patient movement. Information affecting overall theater operations will be reported to the respective TPMRC per procedures established in the specific OPOD. Elements potentially supporting joint force integrated patient movement operations are:

1. Joint force patient movement liaison officers established, as required, when the JPMRC is not colocated with or in close proximity to the JFS and staff. The joint force patient movement liaison officers:

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

b. Provide the JFS and staff with information regarding patient movement activities, issues, capabilities, and workload.

c. In coordination with the JPMRC and supporting TPMRC, obtain joint force staff coordination and approval on patient movement issues, as required.

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

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 patient movement information.

d. Provide data to the supported TPMRC.

For more information on the PMRCs, see Appendix B, “Patient Movement.”

(2) Area Joint Program Blood Office

(a) The CCMD 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 blood support medical detachments (MDBSs) and MTFs in the AJBPO area regardless of Service component. This includes defining the distribution system for blood and blood products at all roles from the supporting expeditionary BTC or MDBS down to the MTF and select Role 2 sites.

2. Evaluates in-theater emergency blood collecting activities, blood product depots, expeditionary BTCs, MDBSs, and MTF transfusion services within the operational area to ensure the requirements of the JBPO are supported or addressed in the CCCR and/or JTF OPLAN/OPORD.

See Appendix E, “Blood Management,” for more information on the Armed Services Blood Program Office.

(3) Joint Medical Operations Center

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

(b) The JMOC is organized with essential staff to plan, coordinate, and harmonize the joint force’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 JFS and JFC on the status of health support to the joint force.
5. Coordinate support requirements with the supported CCMD surgeon.

6. Maintain visibility of medical unit locations, capabilities, logistic status, and overall medical system readiness.

7. Coordinate with the joint force staff in all areas to include J-1 thru J-6, and personal or special staff.

8. Manage and maintain situation reports regarding joint force medical 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.

12. Synchronize health engagement activities with all operations and with functional stakeholders.

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

1. Patient movement (evacuation) officer.

2. Operations officer (chief).

3. Plans officer.

4. Senior medical plans noncommissioned officer/chief petty officer.

5. Medical operations noncommissioned officer/chief petty officer.

6. Environmental science officer/environmental health officer (also functions as medical intelligence officer).

7. Industrial hygiene officer/bioenvironmental engineering officer/sanitary engineer.

8. Joint MEDLOG officer.

9. HN liaison(s)/international health specialist.

10. International governmental organization/NGO and USG liaison(s).

11. Multinational forces liaison(s).

12. Administrative staff (clerk/typists and noncommissioned officer/chief petty officer support as required).

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

(4) Joint Medical Working Group

(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 joint force joint planning group, and from other joint force boards and centers as appropriate. Once established, the JMWG functions are integrated into the JFS's staff battle rhythm.

(b) JMWG core membership includes:

1. CCMD medical planner.
2. Joint force medical planner.
3. Joint force patient movement officer.
4. Joint force joint MEDLOG officer.
5. Joint force J-4 medical liaison officer.
6. Joint force component medical planners.
7. Chief medical officer, as necessary.

(c) JMWG supporting membership includes:

1. Deputy JFS.
2. Joint force industrial hygiene officer/bioenvironmental engineering officer/sanitary engineer.
3. Joint environmental science officer/environmental health officer.
4. Area joint blood program officer.
5. Joint international health specialist officer.
6. Veterinary services officer.
7. PVNTMED/public health officer/public health nurse.

(5) **J-4 Medical Liaison Cell.** The joint force J-4 medical liaison cell functions as a coordinating cell for health service logistic planning and operations and serves as a conduit from the JFS's staff to the joint force J-4 in support of medical sustainment

requirements as they relate to logistics to include contracting, engineering, transportation, medical supplies, Class I for hospitalized patients, and personnel services.

(6) Joint Planning Group

(a) The joint planning group is the joint force's planning organization consisting of designated representatives of the joint force HQ principal and special staff sections, joint force components, and other supporting organizations as deemed necessary by the JFC. The joint planning group is a task-organized team formed to conduct integrated planning for a specific mission. The role of the joint planning group 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 OPOD development, and planning for future operations (such as transitioning, termination, follow-on).

(b) The medical member to the joint planning group should:

1. Integrate joint force HSS and FHP effort as a medical representative on the planning group.

2. Evaluate and assess health support for various COA scenarios developed during joint planning group planning sessions.

3. Develop medical plans in support of various OPLANs and OPODs.

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

5. Establish the JMWG.

(7) Civil-Military Operations Center

(a) The civil-military operations center is an ad hoc organization, normally established by the CCDR or subordinate JFC, to assist in the coordination of activities of engaged military forces and other USG departments and agencies, NGOs, and IGOs. There is no established structure, and its size and composition are situation dependent. The JFS may be asked to provide medical liaison to the civil-military operations center.

(b) The medical liaison to the civil-military operations center should be prepared to:

1. Advise the JFS regarding the optimal use of joint force medical assets during civil-military operations.

2. Advise the JFS on civilian health care infrastructure, cultural factors, medical resources and interagency medical requirements, capabilities, and limitations within the JOA.

3. Provide the JFS with recommendations to develop policies regarding the use of military medical supplies for the treatment of displaced civilians with standards appropriate to HN or local area.

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

5. Maintain connectivity with the JFS and JMOC, and provide continuous coordination and ensure cooperation between civil-military operations center and the JFS'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 JFS for health support 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 the transition operations of military-run medical operations to civilian authorities.

13. Determine the capabilities and effectiveness of health and sanitation systems and the impact of those systems on civil-military operations.

14. Coordinate the use of foreign national government and private health resources for civil-military operations, 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 (such as 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 civil-military operations.

(8) Advanced Echelon Team/Humanitarian Assistance Survey Team

(a) An advanced echelon team or a HAST is often established to provide a minimum capability for C2 during the buildup of the joint force and to conduct a military assessment of the situation and obtain, develop, and communicate critical information to assist the CCDR and commander. These teams can assist in clarifying the joint force mission, determine force requirements to accomplish the mission, establish a sequence for force deployment, evaluate HN support, and determine if there are ongoing operations being conducted by other than military forces. Medical personnel assigned to augment the advanced echelon team or a HAST provide medical 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 joint force, validate the preliminary hazard assessment, and conduct an environmental health site assessment, as needed.

(b) Medical membership to the advanced echelon team or a HAST may consist of the following JFS staff:

1. Core membership:

a. Environmental science officer/environmental health officer; and/or industrial hygiene officer/bioenvironmental engineering officer.

b. Joint force medical planner.

2. Supporting membership:

a. Joint force international health specialist officer.

b. Veterinary services officer.

c. PVNTMED officer/public health officer.

See DODI 6490.03, Deployment Health, for more information on requirements for an environmental health site assessment.

6. Joint Force Surgeon Reachback

a. To make the best use of all available medical technologies and resources, the JFS may extend beyond the joint force's organic medical capabilities to identify and bring to bear resources not immediately available in the JOA. Reachback allows for medical 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

subject matter experts (SMEs) when a technical issue exceeds the joint force's medical SMEs' capability.

b. The JFS reachback capability network includes the Ccdr staff, supporting and other CCMD SMEs, Service SMEs, other USG departments and agencies, designated multinational partners, academic and industrial sources, and both technical linkages and personal relationships developed through training and habitual associations. The JFS should consider the following when employing reachback:

(1) Reachback can be accomplished through various means to include secure/unsecure 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 CCMD surgeon's protocols and SOPs if available, or JFS protocols and SOPs.

(5) Video teleconferencing reachback capability requires the joint force J-6 to plan and integrate video teleconferencing reachback support into its communications system support plans and structure, and provide the required/dedicated bandwidth to the JFS's staff.

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CHAPTER III HEALTH SERVICE SUPPORT

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

Admiral Lord Nelson, Letter to Dr. Moseley,
October 1803

1. Casualty Management

Roles of Medical Care. A characteristic of health support is the distribution of medical resources and capabilities to provide roles of medical care. Policy provides the framework from which the medical community derives the direction and identifies the requisite people, materiel, facilities, and information to promote, improve, conserve, or restore well-being.

a. Role 1

(1) The first medical care military personnel receive is provided at Role 1 (also referred to as unit-level medical care). This role of care includes:

- (a) Immediate lifesaving measures.
- (b) DNBI prevention and care.
- (c) Combat and operational stress preventive measures.
- (d) Patient location and acquisition (collection).

(e) Treatment provided by designated combat medics, treatment squads, or animal care specialists for working animals. (Major emphasis is placed on those measures necessary for the patient to return to duty or to stabilize him and allow for his evacuation to the next role of care. These measures include maintaining the airway, stopping bleeding, preventing shock, protecting wounds, immobilizing fractures, and other emergency measures, as indicated.)

(2) **Self-Aid and Buddy Aid.** All military personnel are trained in a variety of basic first-aid procedures. These procedures include aid for chemical casualties with particular emphasis on lifesaving tasks. This training enables the military personnel to apply first aid to alleviate potential life-threatening situations.

(3) **Combat Lifesaver.** The combat lifesaver is a nonmedical military personnel selected by their unit commander for additional training beyond basic first-aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit should be trained. The primary duty of this individual does not change. The additional duty of the combat lifesaver is to provide enhanced first aid for injuries based on his or her training before the medical care arrives. Combat lifesaver training is

normally provided by medical personnel assigned, attached, or in sustainment units. The senior medical person designated by the commander manages the training program.

(4) **Medical Personnel.** Role 1 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. SOF medical treatment is provided by medical personnel with enhanced medical skills, the physician, or the physician assistant.

b. Role 2

(1) Role 2 provides advanced trauma management and emergency medical treatment including continuation of resuscitation started in Role 1. Role 2 provides a greater capability to resuscitate trauma patients than is available at Role 1. If necessary, additional emergency measures are instituted, but they do not go beyond the measures dictated by immediate necessities. Role 2 care has the capability to provide packed red blood cells (RBCs) (liquid), limited x-ray, laboratory, dental support, combat and operational stress control, PVTMED, and Role 2 veterinary medical and resuscitative surgical support. Role 2 has a limited hold capability (i.e., no bed capacity). Role 2 is classified into Role 2 light maneuver (2LM) and Role 2 enhanced (2E).

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

(3) 2E provides basic secondary health care, built around primary surgery, intensive care unit, and ward beds. A 2E MTF is able to stabilize post-surgical cases for evacuation to Role 4 without the requirement to first route them through a higher Role 3 facility.

(4) Role 2 care should have the minimum capability for packed RBCs. Additional blood product support to include frozen plasma, cryoprecipitate, and platelets should be considered based on desired level of trauma management and availability of necessary supporting equipment and supplies.

c. **Role 3.** In Role 3, the patient is treated in an MTF or veterinary facility (for working animals) that is staffed and equipped to provide care to all categories of patients, to include resuscitation, initial wound surgery, and post-operative treatment. This role of care expands the support provided at Role 2. Patients who are unable to tolerate and survive movement over long distances receive surgical care in a hospital as close to the supported unit as the tactical situation allows. This role includes provisions for:

- (1) Evacuating patients from supported units.

(2) Providing care for all categories of patients in an MTF with the proper staff and equipment.

(3) Providing support on an area basis to units without organic medical assets.

d. **Role 4.** Role 4 medical care is found in US base hospitals and robust overseas facilities. Mobilization requires expansion of military hospital capacities and the inclusion of Department of Veterans Affairs and civilian hospital beds in the National Disaster Medical System to meet the increased demands created by the evacuation of patients from the area of responsibility. The support-base hospitals represent the most definitive medical care available within the medical care system.

2. Patient Movement

a. The patient movement mission consists of unregulated and regulated movement, via CASEVAC, MEDEVAC, and/or AE from the point of patient injury, illness, or wounding, through successive roles of care within the theater, to include evacuation to definitive care when warranted.

b. Patient movement is the system which provides the vital linkage between the roles of care necessary to sustain the patient during transport. This is accomplished by providing en route medical care and emergency medical intervention, if required, and to enhance the individual's prognosis and to reduce long-term disability.

c. Patient movement occurs at the tactical, operational, and strategic levels and requires the synchronization and integration of Service component patient movement resources and procedures.

d. Patient movement is a multifaceted mission accomplished by a combination of dedicated ground and/or dedicated or designated air evacuation platforms synchronized to provide direct support, general support, and area support within the JOA. At the tactical level, organic, or direct support CASEVAC and/or MEDEVAC resources locate, acquire, treat, and evacuate military personnel from the point of injury or wounding to an appropriate MTF where they are stabilized, prioritized, and, if required, decontaminated and prepared for further evacuation to an MTF capable of providing required essential care within the JOA.

e. Although the most recognized mission of MEDEVAC assets is the evacuation and provision of en route medical care to the wounded, the essential and vital functions of MEDEVAC resources encompass many additional missions and tasks that support the medical mission. MEDEVAC resources are used to transfer patients within the JOA and from MTFs to patient staging elements; emergency movement of Class VIII, blood and blood products, medical personnel and equipment; and serve as messengers in medical channels.

f. Medical Regulating

(1) Medical regulating is a casualty management system designed to coordinate the movement of patients from site of injury or onset of disease through successive roles of medical care to an appropriate MTF.

(2) The factors that influence the scheduling of patient movement include:

- (a) Patient's medical condition (stabilized to withstand evacuation).
- (b) Tactical situation.
- (c) Availability of evacuation means.
- (d) Locations of MTFs with special capabilities or resources.
- (e) Current bed status of MTFs.
- (f) Surgical backlogs.
- (g) Number and location of patients by diagnostic category.
- (h) Location of airfields, seaports, and other transportation hubs.
- (i) Communications capabilities (to include radio silence procedures).

See Appendix B, "Patient Movement," for more information on patient movement.

3. Medical Logistics

a. MEDLOG is an integral component of the Military Health System that provides capabilities to organize and provide life-cycle management of the specialized medical products and services required to operate an integrated health system anywhere in the world. MEDLOG provides intensive management for planning and executing MEDLOG support operations to include medical distribution (which includes transportation planning and coordination), medical equipment maintenance and repair, blood management, optical fabrication and repair, and the centralized management of PMIs. It also includes contracting support, medical hazardous waste management and disposal, and the production and distribution of medical gases. The appropriate command surgeon provides technical guidance. The system is anticipatory, with select units capable of operating in a split-based mode.

b. Figure III-1 describes the primary tasks and purposes of the MEDLOG function.

See Appendix D, "Medical Logistics Support," for more information on logistics support.

Primary Tasks and Purposes of the Medical Logistics Function	
Medical materiel management	Organize and provide life-cycle management of medical materiel, including pharmaceuticals, medical supplies, medical assemblages, and medical gases. Plan and execute the provision of medical supplies in compliance with all applicable national standards and ensure coordination among joint logistics partners for end-to-end distribution of medical supplies required to sustain health readiness.
Medical equipment and technology	Organize and provide life-cycle management of medical equipment, including the assessment and integration of medical technology and the acquisition, integrated logistics support, fielding, sustainment and disposition of medical equipment required for health readiness.
Medical equipment maintenance and repair	Organize and manage the maintenance of medical equipment. Plan for and execute the sustainment of medical equipment through preventive maintenance, repair services, and calibration at the organizational and support maintenance levels.
Optical fabrication and repair	Organize and manage the fabrication, repair, and delivery of spectacles and prescription protective eyewear. Plan and execute optical fabrication and repair services to meet the vision health and protection requirements of the force.
Blood management (distribution)	Provide collection, manufacturing, storage, and distribution of blood and blood products to echelons above brigade medical units and other operations.
Centralized management of patient movement items	Support in-transit patients, exchange in-kind patient movement items without degrading medical capabilities, and provide prompt recycling of patient movement items from initial movement, to the patient's final destination.
Health facilities planning and management	Organize and manage the life-cycle management of medical facilities required for delivery of health services in compliance with all applicable national standards.
Medical logistics services	Organize and provide medically unique logistics services and functions essential to the provision of health service support to the joint force including in compliance with all applicable national standards. Includes the proper collection, control, transportation, and disposal of regulated medical waste in conjunction with preventive medicine.
Medical contracting	Organize and manage the provision of contract support to acquire medical products and services in support of Military Health System requirements. Requires the ability to acquire and assess information for development of contract requirements or Performance Work Statement(s); the ability to administer appropriate contractual instruments for medical products and services and the ability to collect, monitor and analyze measures of medical contract performance.

Figure III-1. Primary Tasks and Purposes of the Medical Logistics Function

4. Health Information Management

a. The Secretaries of the Military Departments:

(1) Implement policy and follow implementing instructions, and report metrics in accordance with requirements established by the Assistant Secretary of Defense (Health Affairs) (ASD[HA]).

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

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

(4) Evaluate and recommend changes or improvements to the health support 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 behavioral 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 in accordance with 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.

(11) Provide the DOD executive agent for medical materiel with accurate requirements data for forecasting and sourcing the types and quantities of medical materiel to be procured for military Services' use in peacetime, wartime, homeland defense, contingencies, and exercises, the locations where these items shall be needed, and the periods in which they shall be required.

b. The Chairman of the Joint Chiefs of Staff:

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

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

(3) Develops joint medical doctrine and joint functional capabilities required to meet health support challenges.

(4) Designates theater lead agents for medical materiel for CCMDs based upon recommendations from DLA and in coordination with the Secretaries of the Military Departments.

c. The CCDRs, through the Chairman of the Joint Chiefs of Staff (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.

d. DLA is designated DOD executive agent for medical materiel for DOD pursuant to DODD 5101.9, *DOD Executive Agent for Medical Materiel*. As the executive agent, DLA will be the single DOD POC to:

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

(2) Improve the identification 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 CCMD 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, and Federal Emergency Management Agency (FEMA).

e. The DOD MEDLOG Executive Council, under the direction, authority, and control of the Secretary of Defense (SecDef), with policy guidance from the Office of the Assistant Secretary of Defense (Health Affairs) (ASD[HA]), shall provide oversight of the DOD MEDLOG. The DOD MEDLOG Executive Council is the focal point for medical standardization within DOD and:

(1) Provides oversight to the development and prioritization of functional requirements for DOD MEDLOG Standard Support applications and enterprise architecture.

(2) Provides oversight to DOD MEDLOG programs and initiatives to promote joint interoperability of medical capabilities, efficiency in the acquisition and life cycle management of non-developmental medical materiel, standardization of medical supplies and equipment, and responsiveness to health support requirements.

(3) Provides oversight for the development of future DOD MEDLOG concepts and capabilities necessary to support the Military Health System and DOD.

(4) Facilitates Military Health System support and collaboration in the development and maintenance of strategic partnerships necessary to synchronize supply chain strategies during all military operations.

f. The Defense Medical Material Program Office under the direction, authority, and control of the Director of the TRICARE Management Activity, with policy guidance from the Office of the ASD(HA), shall provide coordination and support for collaborative DOD MEDLOG policies and objectives with regard to the acquisition and life cycle management of medical supplies and equipment:

(1) In coordination with the heads of the Services' MEDLOG agencies, establishes and maintains a collaborative DOD Medical Materiel Standardization program.

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

(3) In coordination with the FDA, exercises oversight and direction of the DOD/FDA's Shelf Life Extension Program for strategically important pharmaceuticals.

(4) Exercises direction for development and maintenance of authoritative data relative to patient conditions and task, time, and treatment information for use in DOD medical modeling applications.

(5) Coordinates and facilitates medical materiel standardization, to include clinical monitoring of operational testing and evaluation for non-developmental medical materiel.

(6) Develops and maintains the Joint Deployment Formulary.

(7) Administer an integrated defense MEDLOG strategy management process in coordination with the Defense Medical Logistics Proponent Committee.

g. USTRANSCOM is the DOD's single manager for policy and standardization of procedures and information support systems for global patient movement.

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

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

h. USAF Air Mobility Command (AMC) is the DOD's lead agent for AE policy, training, and standardization of procedures.

(1) Reviews and advises of all CCDR's planning requirements for AE.

(2) Establishes the Aeromedical Evacuation Oversight Board to review, update, and approve all aspects of the AE mission.

(3) Executes the PMI Program.

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CHAPTER IV FORCE HEALTH PROTECTION

“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, 1812

1. Casualty Prevention

a. Casualty prevention supports military personnel 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 Service members and authorized dependents, organization, or force. Additionally, the Services will develop and enforce specific minimal physical and mental standards; these standards will ensure military personnel are free of diseases or medical and dental conditions that will not limit duty with expeditionary military service.

b. Casualty prevention includes all measures taken by commanders, leaders, individual military personnel, and the health care system to promote, improve, or conserve the mental and physical well-being of military personnel. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards.

2. Preventive Medicine

a. PVNTMED is the anticipation and prevention, control of communicable diseases, illnesses, and exposure to endemic, occupational, and environmental threats. These threats include nonbattle injuries (NBIs), environmental and occupational exposures, 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. PVNTMED include communication, education, 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. PVNTMED includes FHP measures taken against infectious, endemic, environmental, occupational, industrial, and operational health risks.

c. The early introduction of PVNTMED personnel or units into the JOA facilitates the protection of US forces from diseases and injuries. It also permits a thorough assessment of the health threat and operational requirements of the mission.

d. PVNTMED support to US and multinational forces, HN civilians, refugees, and displaced persons includes education and training on personal hygiene and field sanitation, personal protective measures, epidemiological investigations, vaccinations, communicable disease control, pest management, and inspection of food and water sources and supplies. PVNTMED also includes analyzing the complexities of epidemiologic interactions between disease-causing organisms, their reservoirs, and hosts in different geographic, climatologic, and cultural settings.

3. Health Surveillance

a. Health surveillance includes identifying the population at risk; identifying and assessing their potentially hazardous exposures (such as medical, food/water, occupational and environmental, psychological, and 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 JOA 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 HSS annex Q (Medical Services) to the 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 PVNTMED and stress control measures before, during, and after deployment.

b. 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).

c. The DOD system for documenting relevant occupational and environmental health risk assessment data is the DOEHRS.

4. Combat and Operational Stress Control

a. Combat and operational stress control includes programs and actions to be taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units. These programs optimize mission performance; conserve the fighting strength; and prevent or minimize adverse effects of combat and operational stress reaction on Service members and their physical, psychological, spiritual, intellectual, and social health. The goal of these programs is to return military personnel to duty as soon as possible. According to DODD 6490.02E, *Comprehensive Health Surveillance*, combat and operational stress control activities include routine screening of individuals when recruited; continued surveillance throughout military service, especially before, during, and after deployment; continual assessment and consultation with medical and other personnel from home station to the JOA. Military personnel who are

temporarily impaired or incapacitated with stress-related conditions are not necessarily diagnosed with behavioral health disorders. Combat and operational stress control promotes military personnel and unit readiness by:

- (1) Enhancing adaptive stress reactions.
- (2) Preventing maladaptive stress reactions.
- (3) Assisting military personnel with controlling combat and operational stress reactions.
- (4) Assisting military personnel with behavioral disorders.

b. Figure IV-1 describes the primary tasks and purposes of the combat and operational stress control function.

5. Preventive Dentistry

a. Preventive dentistry is an extremely important component of an effective dental program. The results of good preventive dental care practices are healthy teeth and gums and the absence of oral disease. Therefore, military personnel that incorporated good preventive dental hygiene practices are far less likely to become dental casualties due to disease while deployed.

b. Preventive dentistry incorporates primary, secondary, and tertiary measures to reduce or eliminate conditions that may decrease military personnel fitness in performing their mission and which could result in being removed from their unit for treatment.

c. The standards used to determine military personnel dental readiness and classification are outlined in the DOD Oral Health and Readiness Classification System. The purpose of this classification system is to standardize the dental readiness, prioritize dental care, and minimize the occurrence of dental emergencies among military personnel. It also aids the commanders in estimating how many military personnel are likely to require treatment for dental emergencies during a deployment.

6. Vision Readiness

a. Vision readiness is an essential component of an effective force. Vision readiness encompasses the Service member having optimal visual clarity in order to most effectively and efficiently complete their assignments as well as the optical devices needed for vision correction (if required) and for eye protection of all service members during hazardous activities, including deployment. Vision services should make sure that the Service member can see clearly, their eyes are protected, making them less likely to become ocular casualties due to disease or injury while deployed.

Primary Tasks and Purposes of the Combat and Operational Stress Control Function

Implement combat and operational stress control plan/program.	To prevent combat and operational stress reaction.
Perform combat and operational stress control unit needs assessment.	To provide command with global assessment of the unit, with considerations of multiple variables that may affect leadership, performance, morale, and combat effectiveness of the organization.
Conduct traumatic events management for potentially traumatic event	To assist in the transition of units and military personnel who are exposed to potentially traumatic event by building resilience, promoting post-traumatic growth, and/or increasing functioning and positive changes in the unit.
Screen and evaluate military personnel with maladaptive behaviors to rule out neuropsychiatric/behavioral health conditions.	To provide diagnosis, treatment, and disposition for military personnel with neuropsychiatric/ behavioral health problems.
Conduct combat and operational stress restoration and reconditioning programs.	To provide military personnel rest/restoration within or near their unit area for rapid return to duty and to prevent post-combat and operational stress reactions.
Perform command-directed evaluation for military personnel's behavioral health status.	To determine if a military personnel mental state renders them at risk to himself or others or may affect his ability to carry out his mission.

Figure IV-1. Primary Tasks and Purposes of the Combat and Operational Stress Control Function

b. Vision services include preventive eye care to reduce or eliminate conditions that may decrease personnel fitness in performing their mission and which could result in members being removed from their duty unit for treatment. Vision services also ensure that the service member has eye protection decreasing the occurrence of sight threatening injuries among military personnel. Ensuring the Service member has all needed devices and that their eyes are protected keeps the member with their unit in order to complete the mission and decreases the logistical burden of providing a replacement.

c. The standards to determine military vision readiness is Service specific. Service standardized vision classification systems should ensure military personnel meet the preventive eye care requirement and have all required corrective and protective devices.

7. Laboratory Services

a. Deployable environmental laboratory services include capabilities in identification and field confirmation of endemic diseases, OEH hazards, and CBRN agents. The focus of the laboratory is the total health environment of the JOA, not individual patient care. Studies in pest identification, the efficacy of pesticides, frequency of infectious agents, monitoring immune response and transmission of zoonotic diseases, and analysis of suspected CBRN samples in the JOA can be performed in deployable environmental laboratories. The laboratory personnel also function as consultants to hospital clinical laboratory services within the JOA. The laboratory may task-organize teams and employ them forward to troubleshoot a particular problem.

b. Figure IV-2 describes the primary tasks and purposes of the laboratory services function.

Primary Tasks and Purposes of the Laboratory Services Function	
Analytical, investigation, and consultative capabilities	To identify chemical, biological, radiological, and nuclear threat agents in biomedical specimens and other samples from the operational area. To assist in the identification of occupational and environmental health hazards and endemic diseases.
Special environmental control and containment	To evaluate biomedical specimens for the presence of highly infectious or hazardous agents of operational concern.
Data analysis	To support medical analyses and operational decisions.
Medical laboratory analysis	To support the diagnosis of zoonotic and significant animal diseases that impact on military operations.
Deploy modular sections or sectional teams.	To interface with preventive medicine teams, veterinary teams, forward deployed medical units, biological integrated detection system teams, and chemical, biological, radiological, and nuclear reconnaissance and surveillance assets in the operational area.

Figure IV-2. Primary Tasks and Purposes of the Laboratory Services Function

8. Veterinary Services

a. Adequate veterinary service support is an integral part of FHP, and it is imperative that medical planners consider veterinary support in medical operational planning. The USA is the DOD executive agent for veterinary support for the Services, and in some instances support is provided to multinational partners and HN agencies. USA Veterinary Corps and USAF Public Health provide for food wholesomeness, safety,

and defense. USA veterinary units are task-organized and tailored in order to support government-owned animal health care, veterinary PVNTMED, 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 military working dogs 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 PVNTMED capabilities reduce the vulnerability of US and multinational forces to DNBI. Veterinary personnel work closely with USA, USAF, and USN PVNTMED units to provide coordinated FHP support. Veterinary food inspection is necessary to ensure food safety and defense, quality assurance, and wholesomeness. 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, packaged water, ice, and beverages is supported by veterinary personnel through sanitation audits performed on local food establishments in the operational area. The veterinary staff officer and JFS, through the JFC, 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 joint forces supported in the JOA, the USA Veterinary Service personnel assist in ensuring the effectiveness of working animals as a force multiplier. Many biological 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 healthy and fit force in the JOA.

d. Veterinary services have an essential role in formulating FHP for the joint force. Early 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 Class I supplies, primary intratheater storage locations, anticipated stock levels, and the feeding plan for the JOA; estimated joint force strength; proposed use and location of government-owned and/or indigenous animals; and the size and type of civil-military action programs.

CHAPTER V

HEALTH SERVICE SUPPORT OPERATIONS

“Ill-health, of body or of mind, is defeat. Health alone is victory. Let all men, if they can manage it, contrive to be healthy!”

Thomas Carlyle (1795-1881), British historian and essayist

1. Combat Operations

a. Due to the necessity to perform lifesaving interventions for personnel suffering combat trauma within minutes of wounding or injury, medical resources must be arrayed in close proximity to the forces supported. This also permits the medical assets to rapidly clear the JOA of casualties and enhances the JFC’s ability to quickly take advantage of opportunities which present themselves during the battle.

b. Command surgeon staff should be included in the operations process for combat operations. To ensure effective and efficient health support within the operational environment, medical support plans must adhere to the supported joint functions. Within noncontiguous operations units must understand the various support relationships described in the OPORD to ensure that a seamless continuum of health support is established and can be maintained.

2. Stability and Civil-Military Operations

a. Stability operations encompass various military missions, tasks, and activities conducted outside the US 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. Military-military and civil-military operations are included and both may contribute to improving stability within a society.

For more information on stability operations, see JP 3-07, Stability Operations.

(1) Medical stability operations include supporting efforts to establish or restore medical support necessary to sustain the population until local civil services are restored; assessments of the civilian medical and public health systems such as infrastructure, medical staff, training and education, MEDLOG, public health programs, and promoting and enhancing the HN medical infrastructure. Identify fundamental medical deficiencies and key points where the available forces and resources can produce a desired military end state. The desired military end state in the health sector is indigenous capacity to provide vital health services.

(2) The JFC and JFS should ensure medical personnel and capabilities are prepared to meet not only military but also civilian health requirements to address patient populations similar to those encountered during FHA operations or humanitarian and civic assistance activities (e.g., children, elderly, pregnant females). 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 medical expertise, foreign language proficiency, and cultural understanding. For more information on HSS during FHA operations, see JP 3-29, *Foreign Humanitarian Assistance*.

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

b. Joint operational medical planning for stability operations should use Chairman of the Joint Chiefs of Staff Instruction (CJCSI) 3110.03D, *Logistics Supplement to the Joint Strategic Capabilities Plan*, as guidance. Considerations include:

(1) **Medical Intelligence Planning**

(a) Military 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 military personnel to diseases endemic to the HN. 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.

(b) When planning for and conducting HSS during stability operations, the JFC and JFS must consider the health threat posed by the regional and local factors including climate, geography, fauna, flora, and the indigenous population to the multinational force, 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, industrial hazards and exposures, and environmental extremes.

(2) **Medical Logistics Planning.** MEDLOG 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 special medical supply or equipment requirements, such as personal protective equipment like bed nets, permethrin insecticide, or insect repellent containing DEET (chemical name N,N-diethyl-meta-toluamide). In disaster response operations, the management of Class VIII materiel is critical to the successful completion of the mission. In FHA operations, the MEDLOG planner must obtain and coordinate for the delivery of MEDLOG support. In nation assistance operations, MEDLOG personnel can assist the international community and a 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 NGOs and IGOs may be essential.

(3) **Force Protection.** Insurgent or terrorist forces may not recognize the protection afforded to medical personnel by the Geneva Conventions. Health support 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 Class VIII supplies by any number of entities 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.

(4) **Legal Issues.** Medical obligations under international law will be particularly crucial to the management of nonmilitary personnel such as HN civilians or third country nationals, detainees, civilian refugees, and internally displaced persons. US military personnel 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 available and prepared to conduct and sustain the medical support task to these populations, US military forces will provide support as required or necessary.

(a) Medical obligations under international law will be particularly crucial to the management of personnel such as EPWs, detainees, refugees, or internally displaced persons. Medical plans must detail the degree of care offered to these groups and how continuity of care is to be provided, consistent with international law.

(b) Urgent medical treatment, not otherwise available, may be offered, in coordination with mandated IGOs, to refugees, internally displaced persons, and other civilians, and is dependent upon the operational situation.

(c) Detainees and EPWs may receive urgent medical treatment in MTFs, but are unlikely to remain in MTFs or be evacuated to definitive and rehabilitative care MTFs in the US. An alternative source of definitive treatment must be organized as part of the overall medical plan.

(d) National law may impact a range of issues, including the provision and use of medical evidence for inquires into deaths and severe injury.

c. 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 medical civil-military operations.

(1) Medical civil-military operations are health-related activities in support of a JFC that establish, enhance, maintain, or influence relations between the joint or

multinational 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. Medical civil-military operations will normally be performed by joint or multinational medical personnel and civil affairs forces, in coordination with other USG or multinational agencies. The subsets of medical civil-military operations include peacetime medical elements of security cooperation activities, FHA, 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. Medical personnel may be tasked to conduct or support medical civil-military operations in activities that build HN capacity in the public health sector. Close coordination between the JFS and civil affairs elements is essential to the success of medical civil-military operations. General guidance for civil-military operations is provided in JP 3-57, *Civil-Military Operations*. Medical civil-military operations' actions may be in addition to activities covered under Title 10, United States Code (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 medical civil-military operations that include: public health activities, to include PVNTMED, 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, preventive health measures for local/intrinsic industry, continuing medical education programs and medical 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 medical civil-military operations 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 medical civil-military operations should emphasize long-term developmental programs that are sustainable by the HN.

(2) Medical elements of security cooperation activities encompass military health-related peacetime activities with other nations that are projected to shape the security environment by building the capability and interoperability of partner nations. Programs include military-to-military exercises and operations that establish, shape, maintain, and refine relations with other nations and capacity-building projects in the military 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.

(3) In assigned medical civil-military operations missions, JFSs and joint medical planners must consider, in consultation with counterparts in civilian USG departments and agencies, the different types of medical resources required to conduct such operations. Medical personnel must coordinate closely with civil affairs elements

and information operations to ensure unity of effort. Every effort must also be made to ensure proper coordination with the USG department or agency 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 multinational 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 medical planning for medical civil-military operations missions include cultural awareness and should take measures to guarantee that these operations support and not detract from the legitimate authority of an HN government. Furthermore, the JFC and JFS should consider that the unique venue for medical civil-military operations 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 medical civil-military operations missions the medical 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 medical civil-military operations. Efforts should be made to support an equitable HN health system.

(4) The JFC and JFS should also organize medical 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. Medical representatives should seek to participate in all relevant civilian and military coordination mechanisms. Medical personnel should also interact with any existing coordination centers, such as the United Nations-Office for the Coordination of Humanitarian Assistance'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 V-1. Standards of care should be agreed upon with HN and the lead USG department or agency during mission planning; normally, HN standards or international consensus minimum standards (such as the Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response* and the *International Health Regulation*) should be used. The JFC, JFS, and civil affairs should monitor and assess medical civil-military operations 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 medical civil-military operations, the provision of health support 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:

Health Service Assessment Factors

- Population Demographics
- Sanitation and Personal Hygiene
- Endemic and Epidemic Disease Surveillance
- Available Medical Intelligence
- Availability and Accessibility of Health Care Delivery Systems and Process
- Cultural Factors Related to Medical Support
- Primary Care Capabilities
- General Health of the Population
- Baseline Health Indicators
- Political Impact of Providing Care to the Local Population
- Anticipated Type, Number, and Capabilities of Relief Organizations
- Secondary and Tertiary Hospital Facilities and Supporting Transportation
- Local Facilities for Production of Medical Equipment and Supplies
- Education and Training Levels of Medical Professionals and Technicians
- Ongoing International and Local Civilian Assistance Efforts
- Pandemic Response Capability
- Incidence Response Capability
- Host Nation Existing Military and Civilian Health Sector Plans and Goals

Figure V-1. Health Service Assessment Factors

(a) Assisting with the development and refinement of the HN medical infrastructure.

(b) Providing, assisting, and sustaining the basic necessities of life for the general population through development and/or enhancement of the HN civilian medical programs.

(c) Providing assistance in establishing, repairing, or improving basic health and sanitation services, especially if these have been degraded by military operations.

d. Significant health benefits can be derived from nonmedical interventions, such as improving the water supply, electrical grid, ensuring security of MTFs, waste management and disposal, and so on. JFSs and joint medical planners should coordinate with other sections of the JTF (such as the J-4 logistics and engineers, J-3 force protection operations, and so on), NGOs, IGOs, and other USG departments and agencies to accomplish this.

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

(1) Maintenance costs, particularly the provision of medical materiel, resupply, and patient movement.

(2) Medical supplies approved for donation, eligibility determination, credentialing, malpractice suits, and reimbursement procedures for health support and supplies.

3. Limited Contingencies and Crisis Response

a. Limited contingencies are operations that are inherently joint and require strategic reachback. Medical planning during limited contingencies must remain flexible to unique support arrangements which capitalize on the strengths of all units employed in the JOA. As the military forces transform to a contingency force, medical units will also transform to a more modular flexible structure capable of providing health care.

b. One of the keys to success in contingency medical operations is to ensure that command relationships are clearly defined in the OPLAN and OPORD. Another key to the successful accomplishment of the contingency mission is the synchronization of health care activities through medical C2 and the technical supervision of ongoing clinical operations. Medical C2 provides a conduit to obtain reachback medical technical support during early entry and expeditionary operations conducted in austere environments prior to deployment of some medical specialty care assets.

4. Defense Support of Civil Authorities

Requests for health support during disasters in the US will normally be initiated by Department of Health and Human Services through submission of a request for assistance or mission assignment. Requests typically flow from FEMA to Joint Director of Military Support and are processed forward to SecDef for approval. Additionally, DOD policy on immediate response addresses the authority delegated to military commanders to provide immediate assistance to civil authorities to save lives, prevent human suffering, or mitigate great property damage in the event of imminently serious conditions resulting from any civil emergency or attack. Immediate response is situation-specific and may or may not be associated with a declared or undeclared disaster.

For more information, see JP 3-27, Homeland Defense, and JP 3-28, Civil Support.

5. Special Operations Forces

a. Organic Medical Capability

(1) **Medical Planning.** The theater special operations command component commander coordinates conventional HSS packages to augment the SOF organic medical capability using the organic surgeon section.

(2) **SOF HSS.** SOF HSS includes limited quantities of medical, critical care management, CASEVAC, patient holding, and primary care capabilities. Special operations combat medics (SOCMs) enlisted 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, CBRN casualty treatment, PVNTMED, 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. SOF currently possess a very limited number of organic forward resuscitative surgical capabilities. Critical support requirements that SOF need from conventional forces include forward surgical support, blood and blood products, resupply, AE, and linkage to strategic air movement.

b. Special Operations Forces Operational Medicine

(1) SOF medics are all advanced tactical paramedic certified. In addition, some SOF personnel are state certified or national certified emergency medical technicians or paramedics. SOF advanced tactical paramedics are capable of providing advanced tactical combat casualty care. Additionally, SOF medical elements are comprised of advanced medics with Service independent duty designations. These enlisted medics are trained as independent, interoperable combat medics with the Service-/mission-unique medical capabilities (for instance, sea-based, small unit operations, veterinary, or aviation medicine). SOF medical and medical service personnel from all organizational levels can provide augmentation, advice, and synchronization for HSS operations in support of SOF at forward operating bases depending on the mission requirements and availability of conventional medical support. SOF medical capabilities include advanced trauma management, sick call, logistic support, blood, laboratory, patient hold, and transportation capabilities to support special operations bed down locations.

(2) **United States Air Force Special Operations Forces (AFSOF).** HSS for Army SOF is usually accomplished by unit-level organic HSS resources, Special Operations Support Battalion assets, and the theater or corps. A combination of organic and support resources are required for HSS. The special operations surgical teams and special operations critical care evacuation teams provided by Air Force Special Operations Command comprises a fraction of the total required capability to meet SOF forward resuscitative surgical requirements for each theater special operational

commands' mission to execute their respective regional plans. AFSOF medics uniquely provide aerospace medicine and CASEVAC support from forward areas to the SOF air-ground interface point. Pararescue jumpers (PJs)/specialists, because of their combat skills and training, are the most appropriate resource to render trauma medical support in threat environments and increased risk scenarios. PJs are specifically trained as crew members and for combat surface operations either independently or in conjunction with other SOF teams. USAF PJs are specifically organized, trained, and equipped to conduct the personnel recovery mission. PJs provide SOF and combat air forces with an air to ground personnel recovery capability and the ability for infiltration and exfiltration utilizing USAF (primary), USA, Navy, or partner nation vertical lift and fixed-wing aviation resources. USAF SOF medical elements and USA Special Operations Aviation Regiment medics provide SOF with a CASEVAC capability aboard USA special operations aviation assets.

(3) Navy Special Operations Forces (NAVSOF) Operational Medicine.

Medical assets assigned to NAVSOF SEAL platoons and vehicle delivery teams and special boat teams have first responder capabilities for basic clinical care, emergency medicine, trauma care, and other diverse types of casualties. NAVSOF units have no organic forward resuscitative care, AE, MEDEVAC, PVNTMED, laboratory, veterinary, or dental capabilities. Deployed NAVSOF rely on other conventional USA, USN, USAF, and sister SOF HSS for nonorganic medical capabilities. Medical personnel assigned to Naval SOF support units include undersea medical officers, physician assistants, independent duty hospital corpsmen, diving medical technicians, hospital corpsmen, and SOCM, providing first response capabilities.

(4) Marine Corps Special Operations Forces (MARSOF) Operational

Medicine. HSS for Marine Corps Forces Special Operations Command (MARFORSOC) is accomplished by unit-level organic HSS resources, Marine Special Operations Battalion assets, and Marine Special Operations Support Group resources. Marine special operations companies possess a limited number of Navy medical personnel with enhanced trauma skills including advanced tactical paramedics, PVNTMED, limited veterinary and dental capabilities, and are also capable of providing basic Role I care. All MARSOF elements are comprised of Navy Fleet Marine Forces reconnaissance independent duty corpsman or Navy Fleet Marine Forces reconnaissance corpsman. Recon independent duty corpsmen are independent duty corpsman qualified to practice independent of a physician in austere environments and provide advanced medical and trauma management to casualties. MARFORSOC has no organic forward resuscitative care. Navy medical personnel assigned to MARFORSOC support units include undersea medical officers, board certified physicians, physician assistants, surface force independent duty, diving medical technicians, and Fleet Marine Forces hospital corpsmen.

(5) Civil affairs units have a highly limited organic HSS capability.

Civil affairs medical sergeants provide a level of expertise between a SOCM and a special forces medical sergeant but are limited in number and typically assigned to the active duty brigades. USA reserve civil affairs units (battalion and higher) have Army Medical Corps and medical service personnel assigned to the public health functional specialty

teams. These personnel are organized to primarily provide advice and expertise to the supported mission's civil-military operations, not as HSS providers to the force. (Although ancillary benefits to the force may come through the regional expertise of civil affairs personnel on health and sanitation risks.) Medically trained personnel in civil affairs provide assistance in identifying gaps and capabilities and assessing foreign public and private health systems, to include health and sanitation systems, agencies, personnel, and facilities. Civil affairs personnel may work with NGOs and IGOs to rehabilitate or develop functional health care systems within the JOA. Much like other civil affairs specialists (typically members of the USA reserve) these Soldiers bring high levels of relevant skills to HSS.

c. Special Operations Forces 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 V-2). The SOF HSS must ensure that the conventional HSS planner understands these aspects. The conventional medical planner must translate SOF-unique requirements into the conventional HSS infrastructure best suited to support the mission.

(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 special operations command planning staff. HSS must be planned and coordinated with subordinate joint force elements by the theater JFS staff.

(3) The JFS and the theater special operations command and/or SOF component medical 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

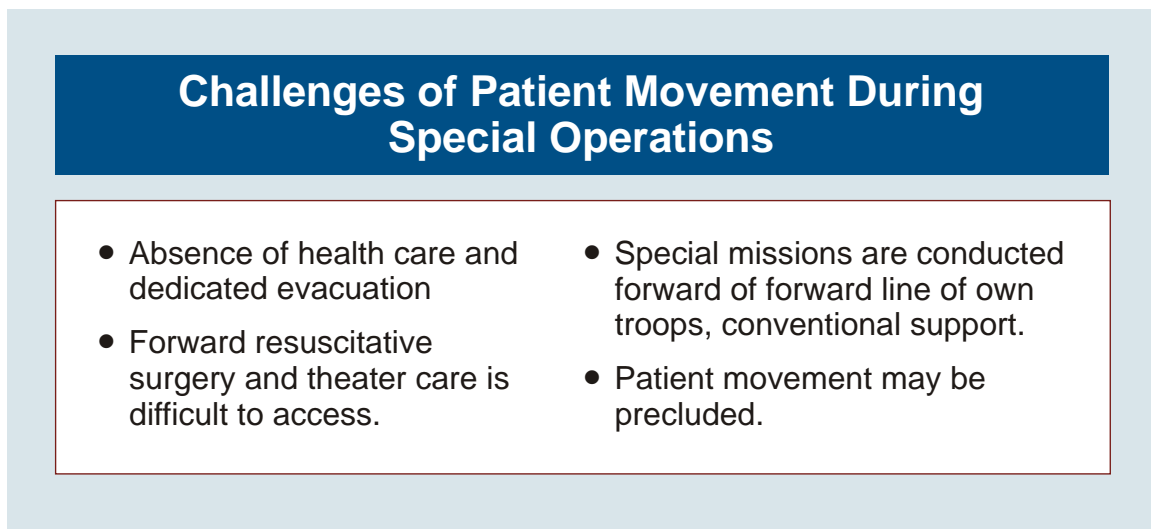


Figure V-2. Challenges of Patient Movement During Special Operations

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 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.

6. Multinational Operations

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

- (1) Unique nature of every individual operation.
- (2) 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) A medical staff 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 V-3.

(10) Medical 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.

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

Health Service Support Challenges in Multinational Operations

- Difference in doctrine
- Differing stockage levels
- Logistics mobility
- Interoperability concerns
- Competition between participants for common support
- Resource limitations

Figure V-3. Health Service Support Challenges in Multinational Operations

b. Principles of Multinational Operations

(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 multinational force commanders.

(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 Geneva Conventions shall, without discrimination, receive medical treatment on the basis of their clinical needs and the availability of HSS resources. Treatment will be provided gratis up to the point of stabilization.

(3) **Standards of HSS.** Operational HSS to multinational forces 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 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 multinational force 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 further MEDEVAC to Role 4 hospitals taking place as appropriate.

(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 US, Role 2 is a national responsibility.

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

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

c. Multinational Planning Considerations

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

(2) National medical systems should be retained as an organic force structure to the contributing nation's forces as much as possible. However, medical 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 HN support resources available in the operational area are the key to determining the size and capability of the medical organization that the multinational force must establish. The more HN support 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 HN support capabilities. A key issue will be the standards of HSS available, compared to the multinational force and national contingent criteria.

(4) HSS requirements are to be determined by the appropriate multinational force commander 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. Medical planners must find a balance of capabilities. An example may be to organize a single nation to provide a particular function, such as lead agent, 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 patient movement policy is a command decision of each nation. Medical and logistic staffs will advise. The CCMD surgeon will promulgate recommendations and will monitor the established patient movement 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 medical planning team at the multinational force 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 HN support and any NGOs in theater.

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

(a) The size of the multinational force 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 PVNTMED 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 multinational force 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 multinational force 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. The 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 PVNTMED 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 patient movement 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 patient movement assets. The provision of resources will be coordinated by the multinational force HSS planning staff but will comprise assets from a number of sources, including HN support. Theater medical patient movement requires careful planning and an acquisition and cross-servicing agreement.

(1) Patient movement from point of injury to Role 1—National responsibility.

(2) Patient movement from Role 1 to Role 2/3—National, force, and lead nation.

(3) Patient 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 personnel such as EPWs, detainees, refugees, internally displaced persons, and other civilians. Medical 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 internally displaced persons in conjunction with HN or United Nations High Commission of Refugees.

(a) Detainees and EPWs 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 medical 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. **Medical Logistics in Multinational Operations.** The holding, issuing, and accounting for all medical, dental, and veterinary supplies (equipment, pharmaceutical, and consumables) to a multinational force are a major undertaking. It is a joint responsibility of the chief medical officer and the MEDLOG 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 forward resuscitative care 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 medical 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.

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.

7. Detainee Operations

a. During the conduct of joint and multinational operations, the JFS and component medical forces must be prepared to provide health support to a wide array of individuals

that may be detained by US forces. Joint publication (JP) 3-63, *Detainee Operations*, provides detailed guidance for planning and executing detainee operations.

b. 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.

c. It is DOD policy that all DOD personnel (military and civilian personnel) and contractors authorized to accompany the force who obtain information about a reportable incident (such as abuse) as set forth in DODD 2311.01E, *DOD Law of War Program*, and DODI 2310.08E, *Medical Program Support for Detainee Operations*, 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.

d. 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; and sanitary and PVNTMED measures to include isolation areas, as necessary to prevent epidemics, routine sick calls, 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 are not assigned to MTFs and employ their professional training not in a provider-patient relationship. Therefore, behavioral science consultation team members should not consult with the detainee medical treatment team on issues of detainee medical care.

(8) Advises the detention facility commander on the caloric content and dietary suitability of detainee rations. Account will also be taken of the habitual diet and religious/cultural requirements of the detainees.

For more information, see JP 3-63, Detainee Operations.

e. The JFS in conjunction with the staff judge advocate should develop detainee medical care policy recommendations for the JFC according to applicable laws and regulations. Additionally, the JFS should consider the following when developing medical plans for supporting detainee operations:

(1) Ensuring that the medical annex (Medical Services) of OPLANs and OPORDs, and appropriate concept plans (CONPLANs) and fragmentary orders (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 US. Medical support should specifically include: emergency and essential medical care that provides for restoration of functional health, prevention of disease, and establishing policy for the medical repatriation of detainees. Services include professional medical services, medical supply, and medical nutrition therapy. Medical support should have oversight of all sanitary aspects of food service including provisions for potable water, field hygiene and sanitation, pest management, and entomological support, PVNTMED (to include immunizations as directed and established by applicable policies), and review/coordination of use and assignment of medically trained detainees and medical materials.

(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 detainees' 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) Developing plans for prisoners who refuse meals and plans for prisoners who refuse medical 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.

8. Operations in a Chemical, Biological, Radiological, and Nuclear Environment

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" refers to the conditions found in an area resulting from immediate or persistent effects of CBRN attacks or unintentional releases, including toxic industrial material. The threat of having to conduct operations in a CBRN environment poses unique challenges to medical forces worldwide.

b. The component command surgeons, working with the appointed JFS, are responsible for guiding and integrating all medical capabilities available to the command to support mission accomplishment in a 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. CBRN contamination mitigation may require the efforts of specialized military forces. Medical 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 contamination at any point, including the transition from a 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 incidents. The ability of domestic and HN MTFs to handle MASCALs from CBRN effects should be assessed and factored into US joint and multinational planning. Close coordination with health support 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. In planning CBRN defensive measures, the JFC 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.

e. Adversary use of weapons of mass destruction can create large numbers of casualties who have been exposed to CBRN hazards, pathogens, toxins, and radioactive matter. The fact that the exposure was deliberate does not alter the basic principles of treatment. Medical treatment 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. PVNTMED specialists play an important role in assessing the health threat posed by a CBRN incident. They can identify potential health threats and determine when to use immunizations, prophylaxis, and other prevention measures. Following any CBRN incident, 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 incident 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 incident's effects.

g. One of the first considerations following a CBRN incident is to determine to what extent evacuation assets will be committed to contaminated areas. In rare cases, transport may be essential to preserve life or continue critical missions. Patients with known or suspected contamination with CBRN agents should be treated in-place and not be moved within the AE system. In rare cases, movement may be essential to preserve life or meet critical operational objectives. Prior to movement, decontamination must be performed to the extent possible and all efforts made to prevent the spread on contamination during movement. Concurrence for medical movement of contaminated patients is granted by referring and receiving geographic combatant commander (GCC), the USTRANSCOM Commander, and SecDef in consultation with medical authorities.

h. Decontamination of patients serves three purposes: it reduces the amount of contaminant that is absorbed by the patient, prevents the potential spread of contamination, and protects medical assets (including medical personnel). 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. 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. 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.

For more information, see JP 3-11, Operations in Chemical, Biological, Radiological, and Nuclear Environments.

9. Contractor Support

a. Contracted support spans the spectrum of support functions and may include interpreter, communications, infrastructure, and other non-logistic-related support.

b. This section provides the basic doctrine for DOD contractors and their subcontractors at all tiers under DOD contracts, including third country nationals and local national 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 contract personnel, which are provided with an appropriate identification 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-stationed US organizations and facilities located outside any declared contingency area.

c. Prior to deploying, certain medical readiness requirements must be satisfied for contingency contractors authorized to accompany the force 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 contractors authorized to accompany the force 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 or approved contractor run process. Medical and dental screening of contractors authorized to accompany the force should be accomplished prior to deploying to avoid returning medically unfit individuals from the theater. Similar to military personnel, contractors authorized to accompany the force 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, contractors authorized to accompany the force 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. The 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 contractors deploying with the force personnel performing essential DOD contractor services per DODI 6205.4, *Immunization of Other Than United States Forces for Biological Warfare Defense*.

(2) Any contractors authorized to accompany the force deemed unsuitable for deployment due to medical or dental reasons should not be authorized to deploy with the military force. Additionally, contingency contractors authorized to accompany the force 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, with associated contractors authorized to accompany the force employees, contain minimum medical and dental requirements and a requirement for contractors to provide these records for their deploying personnel.

(4) The CCMD surgeon and subordinate JFSs should ensure that HSS, either as a responsibility of the contractor or the GCC/JFC, is fully delineated in OPLANs, OPORDs, and operational specific policy to assure appropriate medical staffing in the area of responsibility/JOA; and should also include contractors authorized to accompany the force that are providing essential contractor services, in their medical surveillance plans. The supporting contracting office is responsible to ensure these requirements are documented in the contract.

d. The austere environment that contractors authorized to accompany the force 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. Contractors authorized to accompany the force who become unfit to perform their contractor duties in theater through their own actions (such as 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. Medical treatment facilities 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 patient movement system; and assist with patient movement 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 USG 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 contractors authorized to accompany the force are not authorized primary and routine medical or dental care unless specifically authorized under the terms of the DOD contract and approved by the supported JFC. 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/JFC based on recommendations from the JFS and existing capabilities of the forward-deployed MTFs. Contractors authorized to accompany the force must make non-DOD arrangements to obtain all of their chronic prescription therapy.

(4) In instances where contractor personnel require patient movement for medical reasons from the area of responsibility/JOA to a MTF funded by the Defense Health Program, normal reimbursement policies would apply for services rendered by the facility. Should contractor personnel require MEDEVAC to the US, the sending MTF should assist the contractors authorized to accompany in coordinating arrangements for transfer to a civilian facility of their choice. When US forces provide emergency medical care to non-contractors authorized to accompany the force hired under theater or external support contracts, these patients should be evacuated/transported via national means (when possible) to the nearest local medical care facility.

(5) Non-contractors authorized to accompany the force are not authorized to receive medical and dental support from US MTFs, 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 the vicinity of US troops on a reimbursable basis. When resuscitative care is provided to non-contractors authorized to accompany the force personnel, they should be transferred to a local medical facility as soon as medically feasible.

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CHAPTER VI JOINT HEALTH PLANNING

“A good battle plan that you act on today can be better than a perfect one tomorrow.”

George S. Patton (1885-1945)

1. Introduction

This chapter presents an overview of joint health planning for the JFS and staff when faced with a specific contingency. More detailed guidance on joint planning is provided in JP 5-0, *Joint Operation Planning*.

2. Health Support Planning Considerations

a. Timely, effective planning and coordination are essential to ensure adequate and sustainable health support in a JOA. 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] 3122.03C, *Joint Operation Planning and Execution System Volume II, Planning Formats*.) Organization of the health support system is determined by the joint force’s mission, the threat, intelligence, anticipated number of patients, duration of the operation, the theater patient movement policy, available lift, MEDLOG capabilities, and hospitalization requirements (see Figure VI-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.

(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 joint force command with information to attain situational understanding of health threats; enable the development of HSS and FHP policies and strategies that mitigate natural, accidental, and intentional incidents; provide information to assist in the deterrence, prevention, mitigation, and destruction of CBRN threats and

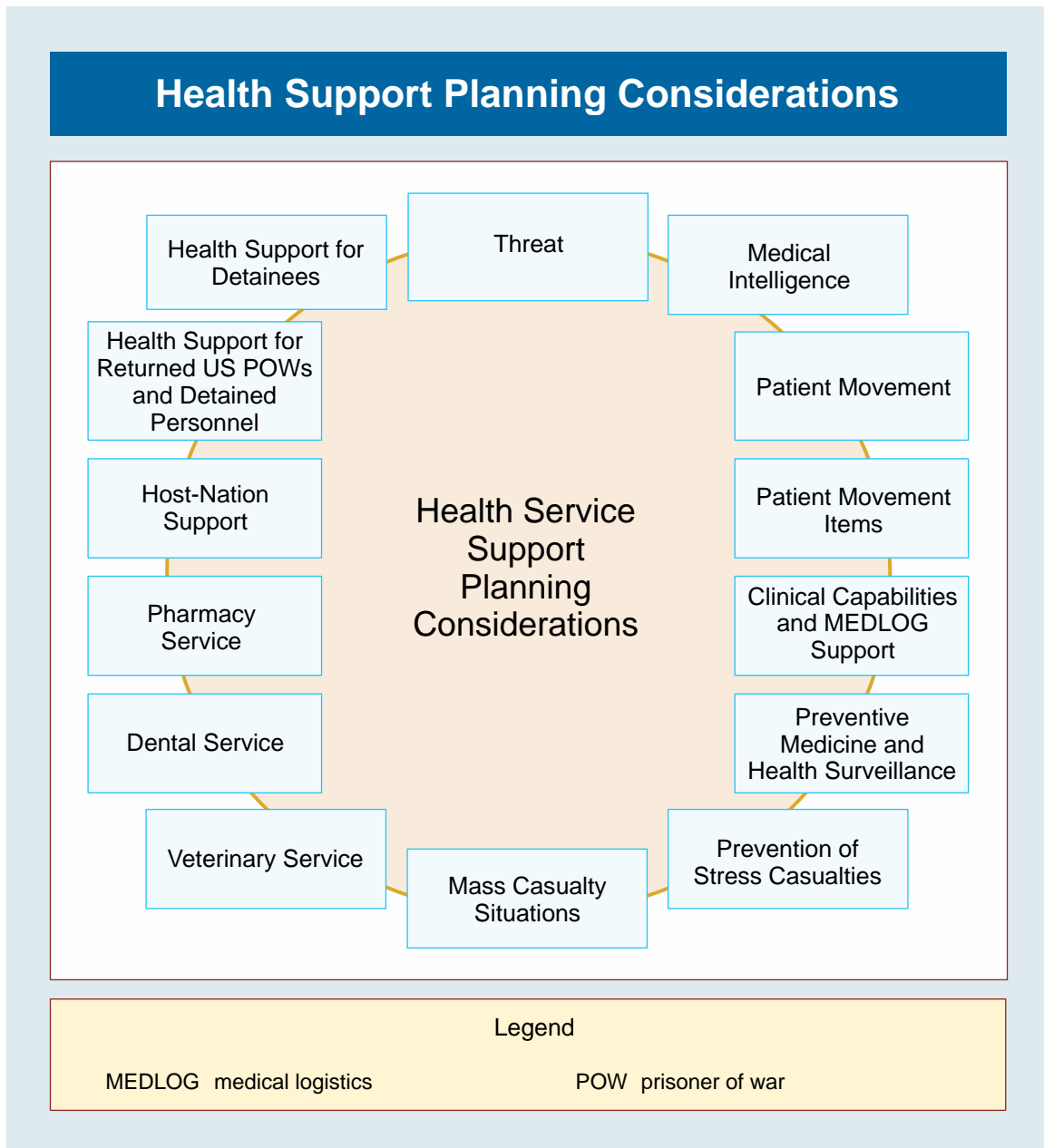


Figure VI-1. Health Support Planning Considerations

aggression; and redefine the operational environment from a medical perspective by employing strategic and PVNTMED response planning.

(b) The JFS and medical planner must consider the entire scope of the threat to affect HSS and FHP, and make allowances for the medical intelligence preparation of the operational environment. Medical intelligence preparation of the operational environment is a component of the joint intelligence preparation of the operational environment process, and it assists JFSs and medical planners in analyzing enemy, environmental, and medical threats in the JOA. It includes data not only on health and disease threats in the JOA but also intelligence information on enemy

capabilities (to include medical); the terrain; weather; the local medical infrastructure; potential humanitarian and displaced personnel situations; transportation issues; political, religious, and cultural beliefs; and social issues.

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

(4) **Patient Movement Items.** PMIs are specific medical equipment and durable supplies that must be available to support patient movement. Examples of PMIs include ventilators, litters, patient monitors, and pulse oximeters. The purpose of the PMI system (see Figure VI-2) is to support patient movement through pre-positioning, exchanging, and recycling of PMIs so that MTF medical capability is not degraded. The originating MTF will identify, on the patient movement request, any special medical equipment for transport. The MTF cannot necessarily provide PMIs for patients. 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 USAF). PMI centers, cells, and nodes are established at aerial ports of embarkation/debarkation, AE hubs and/or Role 3 facilities to support patient movement. Levels will be established based on the worst three days of patient movement, either based on planning factors for initial setup or six-month historical data for continuous operations. Centers, cells, and nodes track, receive, and refurbish (based on local capability) PMIs to ensure availability for patient movement. Patient movement 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 patient movement request requiring PMIs, the PMI center, cell, and/or node will initiate action for the replenishment or exchange of in-kind PMIs.

(5) **Clinical Capabilities and MEDLOG Support.** Specific clinical capabilities, location, MEDLOG supportability, and bed requirements must be considered when planning health support and must be detailed in the respective OPLAN. Medical 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.

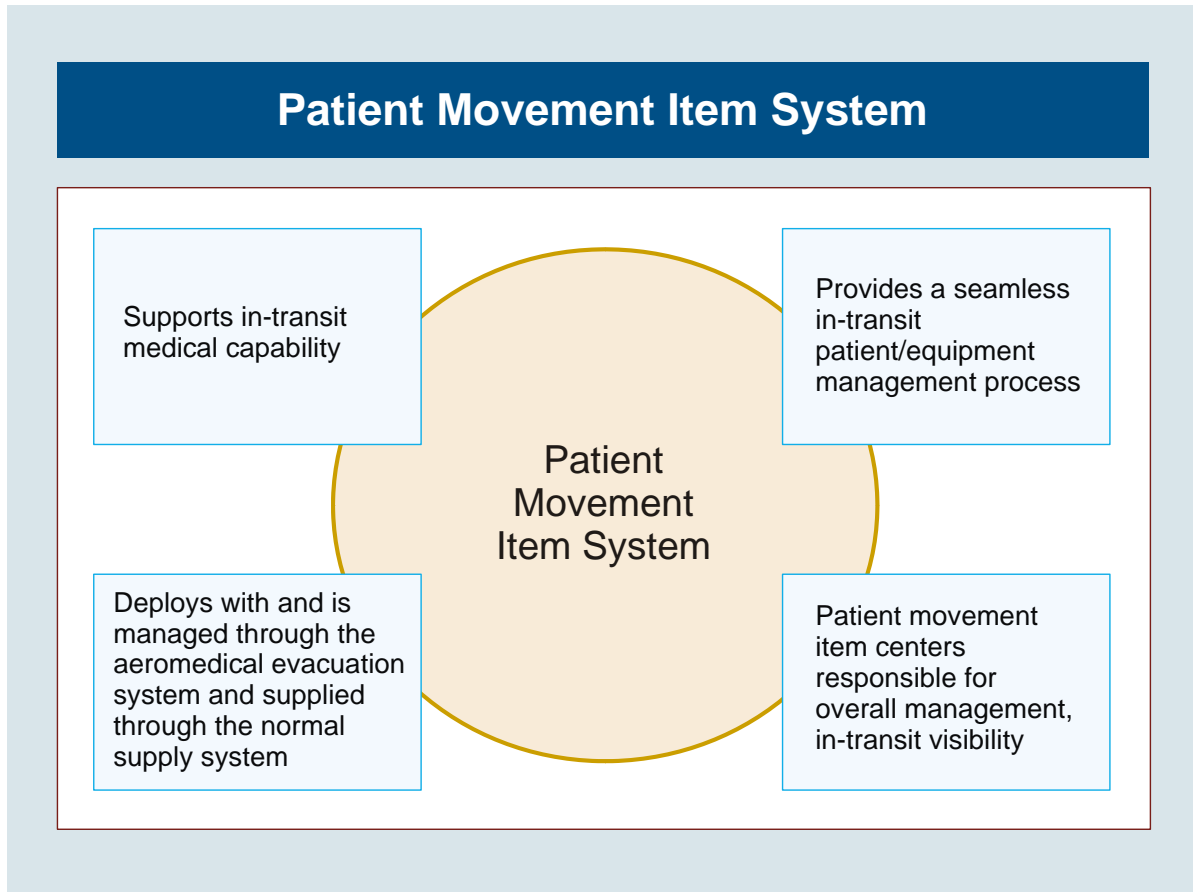


Figure VI-2. Patient Movement Item System

(d) Medical logistic issues, including:

1. Standardization.
2. Use of a theater SIMLM.
3. Establish liaison with the TLAMM.
4. Items requiring special handling and storage.
5. Transportation and distribution.
6. Assessment and use of PMI asset tracking.
7. Type and quantity of medical supplies needed.
8. Supply procedures and sustainment requirements.
9. Medical equipment maintenance and support requirements.

10. Disposition of medical waste in accordance with health and environmental considerations.

11. Optical fabrication.

12. MEDLOG information management systems.

13. Medical facility planning and management.

(e) Blood product supply and distribution.

(6) **Preventive Medicine and Health Surveillance.** Risk assessment and analysis as well as PVNTMED measures must be included early in medical planning. The deployment health surveillance program is initiated and the means to counter the health threats in the operational area are identified to the greatest extent possible, before the forces arrive. Specific PVNTMED procedures are generally the responsibility of the component commands. The JFS advises the CCDR on specific PVNTMED procedures to be implemented, typically accomplished through the component commands.

(7) **Prevention of Stress Casualties.** Prevention of stress casualties and control of combat and operational stress is a command and leader responsibility. Medical and other personnel at all levels play important supporting roles. A coordinated program must be planned for the prevention, treatment, and return to duty of combat stress reaction casualties. Active education, training, and prevention programs assist with controlling stress and preparing unit leaders and medical 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 CBRN incidents (including the employment of weapons of mass destruction), combat, or other military operations. Particular emphasis is placed on the flexibility of medical 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, patient movement, and MEDLOG 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 Services.** See Chapter IV, “Force Health Protection,” Paragraph 8, “Veterinary Services.”

(10) **Dental Service.** As a functional category of health support, 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 and include the treatment, restoration, and maintenance of oral health.

(a) **Dental Readiness.** Dental readiness and dental health should be in accordance with policy requirements and available resources.

1. A healthy and fit force provides the commander with optimally fit military personnel 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 protection.

3. Dental's secondary mission is to augment medical assets during MASCAL situations. Proper planning and training are 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 military personnel. 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 pulp therapy (pulpectomy), pain medication, and temporary restorations.

b. **Essential Nonemergency Care.** Care necessary to intercept potential emergencies to prevent lost duty time and preserve fighting strength is considered essential nonemergency care. Personnel in Dental Class 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 nonemergency care are basic restorations, extractions, definitive pulp therapy (pulpectomy, obturation), treatment of periodontal conditions, and simple prosthetic repairs. Essential nonemergency 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. Joint task force dental units should provide essential nonemergency care to those in Dental Class 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 medical support 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 MTFs.

(11) **Pharmacy Service.** Ensure a pharmacy capability is established as required by the mission and any requirement to support recurring prescriptions for deploying forces.

(12) **Host-Nation Support.** HN support can be a significant force multiplier. HN support must be equivalent to US standards for services provided to US forces. 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 NCMI (<http://www.intelink.gov/ncmi> or analogous classified site), Foreign Clearance Guide (<http://www.fcg.pentagon.mil/fcg.cfm>), 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 United States-approved sources even if HN MTFs are planned to support the deployed force. HN support may reduce the lift requirements necessary to deploy health support to the JOA.

(13) **Health Support for Returned United States Prisoners of War and Detained Personnel.** The CCDR establishes a theater plan on the proper handling and provision of health support for returned US prisoners of war (POWs) and detained personnel.

(14) **Health Support for Detainees.** The JFS and medical planner in conjunction with the staff judge advocate should develop detainee medical care policy recommendations for the JFC in accordance with 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 CONPLANs and FRAGORDs. Additionally, when developing medical 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 US. Additional considerations should include, but are not limited to appropriate intervention procedures for prisoners on hunger strikes or who refuse treatment; appropriate procedures that manage 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.

b. Additional Health Support Considerations

(1) **Health Support 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 to support medical operations.

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

(c) **Medical Intelligence.** Members of the multinational force 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 may determine what information can be shared with multinational forces.

(2) **Health Support in JRSOI Operations.** JRSOI operations encompass all of the activities needed to receive a unit's equipment and personnel at aerial ports of debarkation and seaports of debarkation. The JFS and medical planner's scope of responsibilities during JRSOI activities typically begins prior to the reception of units at the aerial port of debarkations and seaport of debarkations. Medical planning for JRSOI operations should include an assessment of HN medical facilities and services for potential HN support, predeployment planning activities for FHP, and planning for medical capabilities to sustain health support operations during the four phases of JRSOI operations. The JFS and medical planner should also ensure JRSOI, HSS, and FHP requirements are appropriately detailed in the appropriate OPLANs and OPORDs.

(3) **Health Support for Contractors Authorized to Accompany the Force.** The JFS and medical planner should ensure that health support, either as a responsibility of the contractor or the JFC, is fully delineated in OPLANs, OPORDs, and contracts to assure appropriate medical support in the JOA for contractors deploying with the force. 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 CBRN, and environmental and/or industrial threats are identified in the medical annex of OPLANs and OPORDs.

(4) **Health Support for Medical Civil-Military Operations.** The JFS may be tasked to support or execute civil-military operations, in coordination with civil affairs elements. If assigned medical civil-military operations missions, the JFS and medical planner must consider the different types of medical resources required to conduct such operations and must coordinate closely with civil affairs elements, information operations, the USG department or agency or other agencies such as multinational 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 medical civil-military operations missions, consideration is given to ensuring the medical 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.

(5) **Medical Waste and Other Environmental Considerations.** The JFS, medical planner, and PVNTMED personnel in conjunction with the J-4, should develop plans to address the disposal of regulated medical 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 multinational forces 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.

(6) **Interagency Coordination.** As the US military increasingly integrates its operations with other organizations and nations, joint medical operations will require an increased contact and collaboration between the US military, USG departments and 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 medical 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.

For additional doctrine on interagency coordination, see JP 3-08, Interorganizational Coordination during Joint Operations.

c. **Other Planning Considerations.** Other planning considerations that the medical planners must take into account to support joint operations include:

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

(2) **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, medical planning consideration may include many different populations, such as DOD civilians, contractors (including third country nationals and contractors deploying with the force), indigenous civilians, multinational forces, 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 staff judge advocate, establish medical engagement protocols recommendations for the CCDR/JFC. 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.

(3) Coordinate medical requirements in support of natural disasters. (Such coordination can be facilitated by conferring with the United Nations Office for Coordination of Humanitarian Affairs, <http://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.)

(4) 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.

(5) **Amphibious Task Force.** Amphibious task force medical 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 medical planning responsibilities that are detailed in JP 3-02, *Amphibious Operations*.

(6) **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 joint force commander. Each surgeon of these commands has specific medical planning responsibilities that are detailed in JP 3-17, *Air Mobility Operations*, and JP 3-18, *Joint Forcible Entry Operations*.

(7) During planning and while supporting joint operations coordinate with the joint force chaplain's office, the J-1, component commands, Service HQ, and others as required, to provide pastoral care and religious support at hospitals and MTFs.

3. Planning Joint Medical Logistics

a. Health support is reliant upon the specialized materiel and services provided by MEDLOG; therefore, the joint MEDLOG plan is an integral and critical component of annex Q (Medical Services). Medical units as well as maneuver units usually begin requesting MEDLOG 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.

See Appendix D, "Medical Logistics Support," for MEDLOG planning factors.

b. The MEDLOG planner must understand the CCDR's CONOPS and the medical concept of support. This includes understanding any requirements to provide or receive MEDLOG. This includes anticipated medical risks and planned countermeasures for environmental and occupational threats and contingency plans to respond to a CBRN incident. The MEDLOG planner should also assess the possibility for mission expansion into FHA or 'nation building' and identify the additional capabilities that may be required to support these missions.

c. The MEDLOG planner must coordinate with the command J-4 and other designated movement control organizations. Medical materiel will typically flow through the same distribution channels and is subject to the same movement controls as all other classes of supply. MEDLOG 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 at an aerial port of debarkation that has access both to strategic and intratheater distribution channels.

d. The MEDLOG planner must consider several key aspects of support to ensure the appropriate supplies, equipment, and MEDLOG services will be available to meet medical requirements.

See Appendix D, "Medical Logistics Support," for key aspects of support considerations.

e. The MEDLOG planner and JFS must identify the MEDLOG capabilities that are necessary to support the medical plan for incorporation into the CCDR'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 CCDR establishes guidance on movement priorities. The arrival of MEDLOG capabilities must be phased to permit the accomplishment of all theater preparatory tasks and enable support to forces as they arrive in theater.

4. Systems and Planning Tools

a. In addition to coordinating joint force medical requirements, medical planning for joint operations involves other major considerations, including coordinating health support requirements with other CCMDs and other friendly forces. The tool approved for calculating medical requirements is the Joint Medical Planning Tool (JMPT). The JMPT will take Service-specific casualty rates, admission rates, and population at risk from TPFDD, contingency planning, theater patient movement 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. The JMPT estimates medical requirements for beds, patients to be evacuated, Class VIII (both medical resupply and blood), losses to be replaced, and numbers of hospital admissions. In addition, it provides medical requirements for population at risk reports, planning factors used, and bed capabilities (as compared to bed requirements) report. The JMPT can input a population at risk 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 CCMD.

b. Theater Patient Movement Policy

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

(2) The theater patient movement policy is executed by the GCC. The theater patient movement policy delineates the maximum number of days that patients may be held within the command for treatment prior to further movement or return to duty. Patients who cannot return to duty 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 patient movement policy is flexible and can change as the tactical situation dictates.

(3) The theater evacuation policy is established by SecDef with the advice of the Joint Chiefs of Staff, and upon the recommendation of the GCC. The policy establishes, in number of days, the maximum period of non-effectiveness (hospitalization and convalescence) that patients may be held within the theater for treatment. This policy does not mean that a patient is held in the JOA for the entire period of non-effectiveness. A patient who is not expected to be ready to return to duty within the number of days established in the theater evacuation policy is treated, stabilized, and then evacuated out of theater. This is done providing that the treating physician determines that such evacuation will not aggravate the patient's disabilities or medical condition. For example, a theater evacuation policy of seven days does not mean that a patient is

held in the theater for seven days and then evacuated. Instead, it means that a patient is evacuated as soon as possible after the determination is made that he cannot be return to duty within 7 days following admission to a Role 3 MTF.

c. Planning Factors for Blood Products

(1) Blood planning factors, which are historically founded, are resident in the JMPT. Those planning systems can be utilized by the respective CCMD's medical planners to generate daily blood product requirements for the theater.

(2) Theater-wide blood planning factors are:

(a) RBCs; 3.0 units for each initial admission of wounded in action (WIA) and NBI.

(b) Fresh frozen plasma (FFP)/PF24 [plasma frozen within 24 hours]; 1.60 units for each initial admission of WIA and NBI.

(c) Platelet concentrates; 0.15 units for each initial admission of WIA and NBI.

(d) Cryoprecipitate; 0.40 units for each initial admission of WIA and NBI.

(3) The heads of the DOD components shall apply current casualty rates to forces at risk for each OPLAN. Those numbers shall be used with the appropriate planning factors listed above, to determine the blood product requirements and are incorporated in the respective OPLANs, as appropriate.

(4) The blood product requirements calculations are performed utilizing an JMPT. Manual calculations are most appropriate for time-sensitive planning calculations used during execution periods or for a joint force requirement.

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APPENDIX A HOSPITALIZATION

1. This capability delivers health support via modular hospital configurations and/or a hospital ship required to medically sustain forces in a theater. This medical 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 from Role 1 to Role 3 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 policy) and/or stabilization to ensure the patient can tolerate evacuation to a definitive care facility outside the theater.

2. 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.

3. Theater hospitalization capabilities can vary from theater to theater according to the regional infrastructure, JOA, and operating tempo. However, a robust theater capability would contain the following additional services not normally resident at the lower levels in the continuum of care: advanced burn management; optometry and ophthalmology; pediatric, obstetric, and gynecological; dental and PVNTMED; veterinary services; internal medicine and cardiology; eye surgery, maxillofacial surgery, and neurosurgery; intensive/critical care beds and nursing; blood bank service; pathology; infectious disease; medical nutrition therapy; behavioral health; occupational health; MEDLOG; and other medical specialties.

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APPENDIX B PATIENT MOVEMENT

Annex	A	Aeromedical Evacuation
	B	Patient Movement Items

1. Introduction

a. The primary mission of the DOD patient movement system is to transport US military casualties from within the JOA to the appropriate role of care provided in or out of the theater, as required. Timely patient movement plays an important role in health support and supports the JTF CONOPS and evacuation requirements. Patient movement 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 roles of care, to a MTF that can meet the needs of the patient. Each Service component has an organic patient movement capability and is responsible for evacuation from point of injury to initial treatment at an MTF.

b. CASEVAC, a term used by all Services, refers to the unregulated movement of casualties aboard ships, vehicles, or aircraft. MEDEVAC traditionally refers to USA, USN, USMC, USAF, and USCG patient movement using predesignated tactical or logistic aircraft (both fixed-wing and rotary), boats, ships, and other watercraft temporarily equipped and staffed with medical attendants for en route care. The USA is the only Service that has dedicated air MEDEVAC assets. AE refers to the Air Force system providing time-sensitive en route care to regulated patients to and between MTFs. The Civil Reserve Air Fleet (CRAF) and contracted civilian aircraft carriers will not be used to airlift contaminated patients in the AE system.

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 JOA for advanced medical services and rehabilitative care. The decreased medical footprint and the increased patient movement 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, sets the theater patient movement policy for contingency planning. USTRANSCOM, as Distribution Process Owner (with the exception of intratheater patient movement) and single “point” manager for patient movement shall coordinate with the GCCs and the Services on the implementation and enforcement of patient movement policies. Upon execution, the GCC adjusts the theater patient movement policy as required. All changes shall be coordinated through the affected, supporting, and gaining theaters.

b. GCCs are responsible for patient movement within their theater. The joint command validates theater requirements for peacetime and contingency patient

movement and identifies potential channel movement to USTRANSCOM transportation validation process. CCMD OPLANs will include appropriate information to support Service planning for patient evacuation.

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

d. USTRANSCOM is responsible for patient movement in the US and worldwide. This includes support for natural disasters, terrorist activities, and the redistribution of normal support through a direct support relationship rather than transferring forces. USTRANSCOM will most likely not transfer operational control (OPCON) of Service assets to United States Northern Command, as is typical with other CCDRs.

e. Each Service is responsible for organizing, training, and equipping their forces to ensure the capability to meet their patient movement requirements. Evacuation 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 (such as, 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, CONOPS, modernization and sustainment of equipment and platform capabilities, and interoperability of PMIs.

f. PMRCs are a joint activity responsible for patient movement management, validation, and coordination in their respective theaters. PMRCs should normally exist at the joint level to ensure visibility of joint assets for patient movement. The PMRC validates patient movement requests, maintains visibility of bed availability and medical capability within the theater, regulates patients to the appropriate MTFs 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 transportation service component to execute the patient movement mission. A theater validating flight surgeon is assigned, or delegated by the theater command surgeon, to provide physician medical direction and oversight of patient movement validation and transfer/en route care, as needed, during evacuation. Patients that require transportation, but do not require en route care (such as those requiring 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 patient movement requirement and reduces the stress on Service lift.

(1) **Global Patient Movement Requirements Center.** The GPMRC is a joint activity reporting directly to the Commander, USTRANSCOM, through the command surgeon. The PMRC provides medical regulating services, including clinical validation, limited patient in-transit visibility and evacuation requirements planning for intertheater

patient movement and intratheater for the US. The PMRC 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 United States Pacific Command and United States European Command have a permanent PMRC that manages the validation and regulation of intratheater patient movement within their respective theaters. The TPMRC is responsible for theater-wide patient movement (e.g., medical regulating and, in coordination with the AE control team, 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 PMRC coordinates with the TPMRC for intertheater patient movement.

(3) **Joint Patient Movement Requirements Center.** The JPMRC is a deployable PMRC, under the OPCON of the JFC. The PMRC 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 (such as voice, radio, and message) are used by each Service to request initial evacuation. To request further evacuation, a patient movement request is normally submitted by the Service MTF patient administration or medical regulating office to the appropriate PMRC. The PMRC evaluates the request for necessity, acuity, eligibility, precedence, and mode (see Figure B-1). Patient movement requests are normally submitted through transportation command regulating and C2 evacuation system for patient in-transit visibility. Patient movement requests may also be submitted by facsimile (FAX), voice telephone, radio and/or satellite communications, using a standard patient movement request worksheet, when transportation command and regulating and C2 evacuation system is inaccessible. Patient information items required to request patient movement 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 area of responsibility, 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 patient movement request is validated, it is passed to the appropriate Service component for execution.

Patient Movement Requirements Center Component Lift Interface

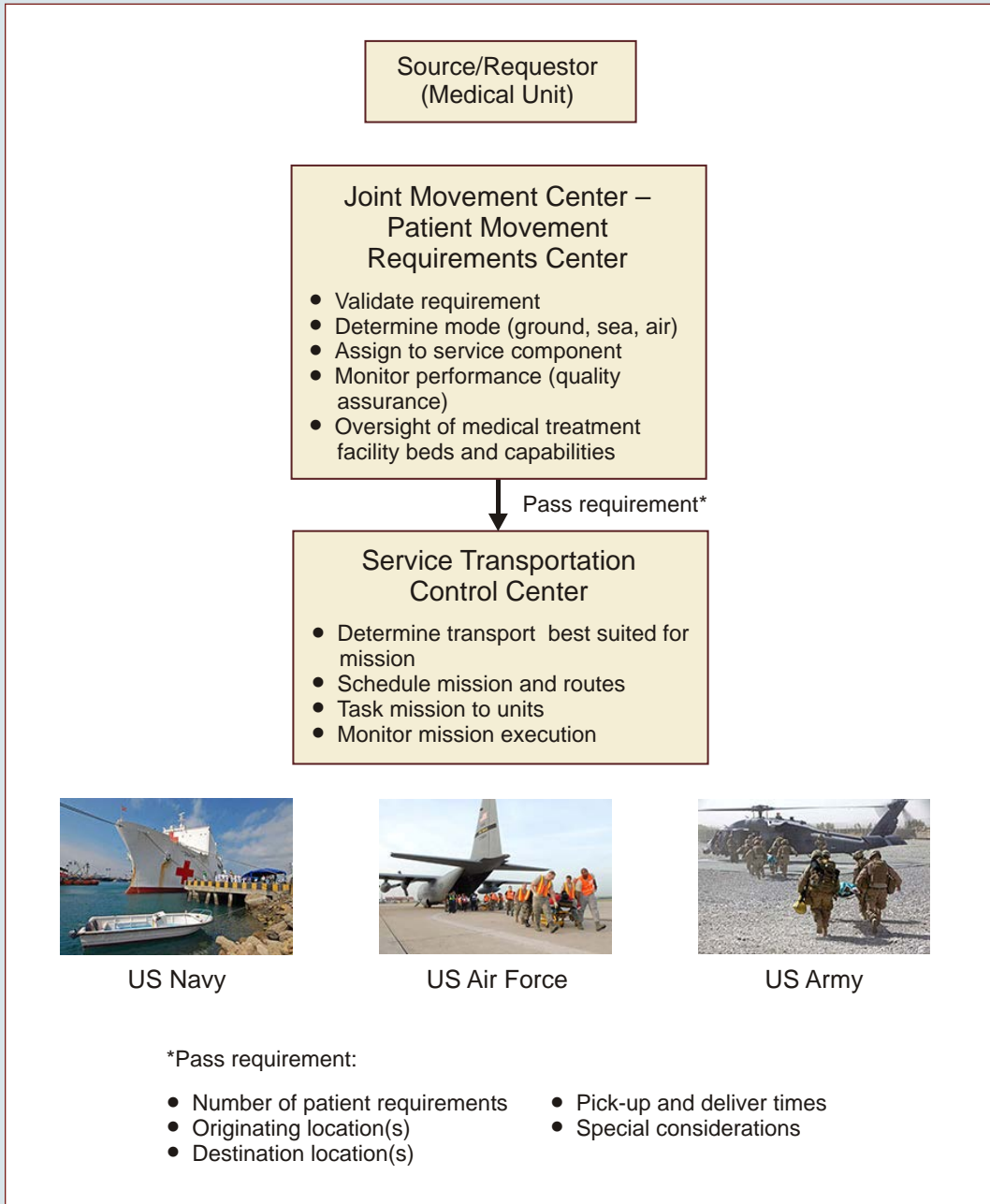


Figure B-1. Patient Movement Requirements Center Component Lift Interface

c. The PMRC coordinates patient movement, validates requirements, and maintains in-transit visibility. 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 to ensure patient care is not compromised.

d. Patient administration director (clerk/officer) or the medical regulating officer is responsible for contacting the PMRC with patient movement requirements and submitting patient movement 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 patient administration director/medical regulating officer is responsible for inputting patient data for patient movement requests and serves as the liaison between the referring physician and medical staff, the patient, and the patient requirements center.

e. Unregulated casualties due to being in imminent danger that require immediate movement may be moved without prior PMRC validation. However, a validating flight surgeon or medical authority will be identified to clear the patients for evacuation.

4. Patient Movement Operations

a. Movement of patients between points within a GCC's area of responsibility is referred to as intratheater, while movement of patients between GCC's area of responsibility to points outside the area of responsibility, is referred to as intertheater.

(1) Intratheater operations are regional in nature and serve a single CCDR's requirements. These operations are normally conducted using forces assigned, attached, or made available for tasking to the CCDR's requirements. 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 forward resuscitative care capability, depending on the type of operation and forces supported. Intratheater patient movement 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 policies in coordination with Service component evacuation representatives.

(2) Intertheater operations are generally global in nature and serve the transportation needs of the CCMD outside the JOA that support the conduct of operations within the JOA. USTRANSCOM directs policies and procedures for intertheater patient movement and identifies transport resources. Currently intertheater patient movement is primarily conducted utilizing airlift assets as long evacuation distances may preclude other modes of patient movement in supporting rapid evacuation out of the CCMD area of responsibility. However, circumstances permitting other modes and lift assets may be used for intertheater patient movement. 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 the US. Intertheater patient movement 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 Forward Resuscitative Care Capability Operations. Generally, the component commands are responsible for evacuation of the casualty from point of injury or illness to MTFs and casualty movement from the first responder care capability to forward resuscitative care 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 MEDEVAC 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) Forward Resuscitative Care Capability to Theater Hospitalization Capability Operations. Movement within and from forward resuscitative capabilities is normally a Service component responsibility; however, some operations may require evacuation by the joint common-user patient movement 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 units with first responder and forward resuscitation care capabilities and evacuate them to the theater hospitalization capability. Requests to the joint common-user patient movement system are submitted to the PMRC 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 patient movement policy, the originating MTF will normally request patient movement to another MTF for more definitive care and disposition. The originating MTF will submit a patient movement request, in accordance with prescribed procedures, using USTRANSCOM Regulating and C2 Evacuation System. Patient movement requests are submitted to the appropriate PMRC, if a JPMRC is established. The JPMRC validates and regulates movement requirements and coordinates the requirements with the TPMRC for intratheater patient movement or with the GPMRC for intertheater patient movement. The JPMRC will identify intratheater patient movement requirements through the theater Air Force air and space operations center (AOC) or joint air operations center (JAOC), air mobility division's (AMD's) AE control team, and the TPMRC will coordinate with the theater air mobility operations control center to identify theater airlift assets available and with the GPMRC to identify intertheater patient movement requirements through the USTRANSCOM's Joint Mobility Control Group.

(4) First Responder/Forward Resuscitative Care Capability to Definitive Care Capability or US 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 patient movement 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 patient movement request to the JPMRC. Continental US 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 patient movement requirements are documented in CCMD OPLANs using casualty output from the approval medical planning tool (see Figure B-2). The CCMD validates Service-projected casualties and merges them into one integrated casualty stream. A key component in determining the casualty stream is the theater patient movement policy.

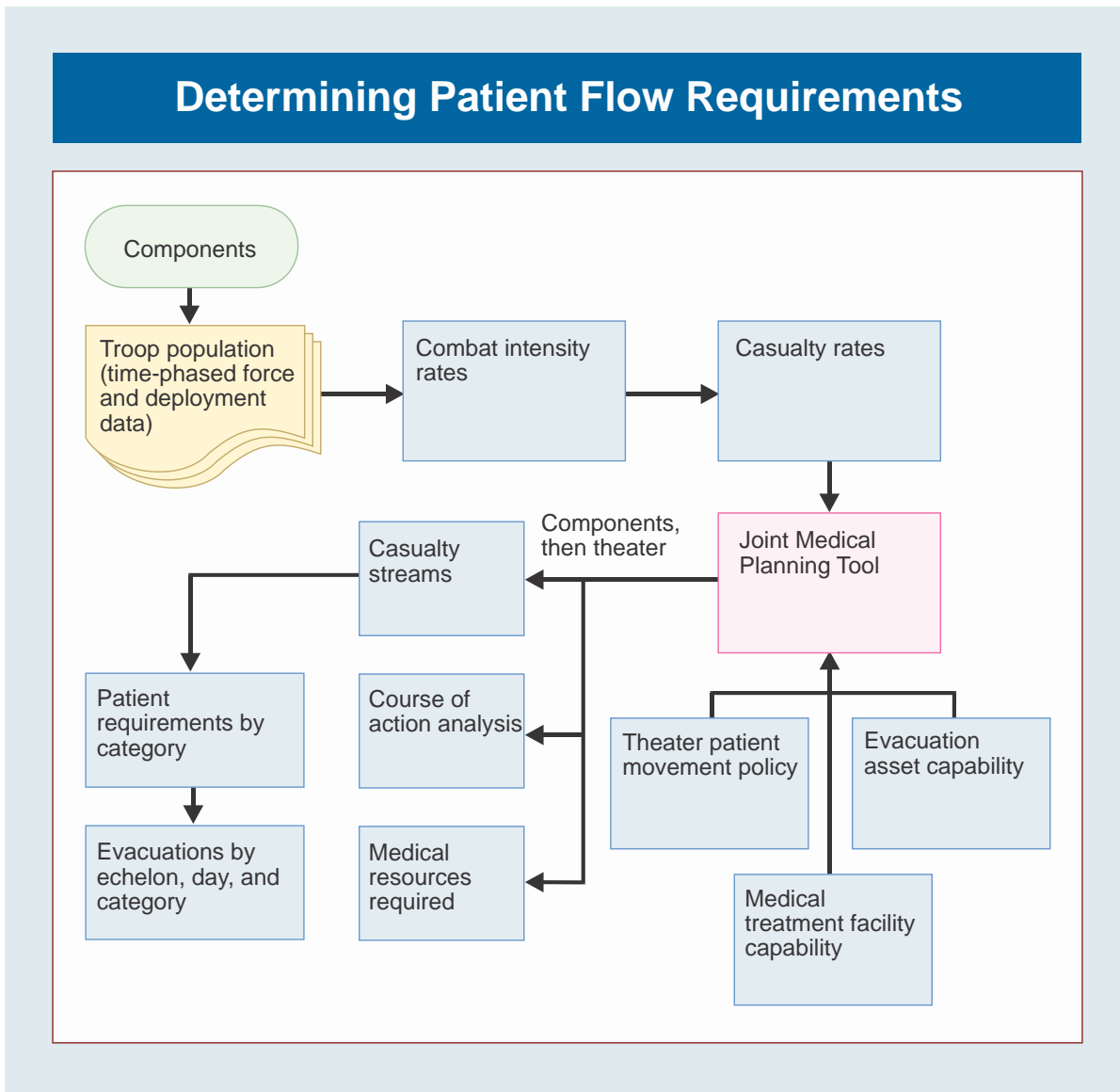


Figure B-2. Determining Patient Flow Requirements

(1) The theater patient movement 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 return to duty. Patients who cannot be returned to duty within the specified number of days are moved to the next higher role of care for further treatment. The length of the patient movement 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 patient movement policy increases the forward medical footprint and requires fewer evacuation missions.

(2) The theater patient movement policy is set by the GCCs and approved during the deliberate planning cycle prior to OPLAN execution. Upon execution, the GCC adjusts the theater patient movement policy as needed. In accordance with SecDef policy and CJCS guidance, the theater evacuation policy is normally seven days. This does not imply that the patients must be held in theater for the entire period. Patients not expected to return to duty 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 patient movement means have been coordinated.

b. Each OPLAN also identifies the infrastructure necessary to support medical care, MEDEVAC, and CASEVAC. Planners use infrastructure lay down data, population at risk, 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: WIA, DNBI, NBI, combat and operational stress control, and CBRN rates. The planners use the JMPT to combine the user-defined population at risk 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 role. The JMAT 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 patient movement system can support US/domestic patient movement requirements identified under activation of the National Disaster Medical System (NDMS) and the National Response Framework under the auspices of defense support to civil authorities. USTRANSCOM is the validating authority for patient movement requirements as the supporting command to United States Northern Command in its civil

support mission under the National Response Framework. The Services provide patient movement assets from existing active, reserve, and National Guard forces in execution of the National Response Framework in the US. 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 patient movement assets may be mobilized as part of their state's emergency management plan, or executed through an emergency management assistance compact with a requesting state, and deployed/employed in a state activated status prior to federalization. If federalized, in response to the National Response Framework, the National Guard will coordinate the lay down of patient movement assets with United States Northern Command in order to facilitate coordinated patient movement.

d. **Medical CONOPS.** Each Service component is responsible for all functions of the Service-specific patient movement system, including operational guidance, intelligence, medical direction, logistics, and communications support. From initial injury to definitive care, the treatment and evacuation of patients from the battlefield transcends many levels of communication and coordination, routinely crossing Service boundaries. Thorough knowledge of the patient movement systems will expedite casualty care and save lives. Patient evacuation must be planned to support any operation. JFCs should integrate and coordinate the use of evacuation resources towards the common purpose of reducing mortality while maintaining the medical continuum of care. It is therefore critical that each Service component properly plan to operate its portion of the overall patient movement system. Planning ensures a coordinated effort in providing timely and effective patient movement 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 to include reconstitution/reintegration of PMIs.

(2) The USA is responsible for providing medical rotary-wing support for ship-to-shore and shore-to-ship patient transport operations in support of patient movement requirements for the hospital 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 AE. The AE system provides time sensitive mission critical en route care to patients to and between medical treatment facilities MTFs. Care is delivered by specially trained USAF medics to operate within a global AE system. The USAF's AE capability comprises a system of systems including ground and airborne forces providing and supporting medical care within MTFs, patient staging platforms, and in the air. AE personnel—crews, critical care air transport team and other specialty teams—execute patient movement predominately on mobility air force aircraft, as well as aboard sister Service, contracted, and international partner airframes. AE forces operate as far forward as air operations occur in support of full range of military operations, humanitarian assistance, and disaster response. The system is designed to be flexible to enable it to operate across the spectrum of potential scenarios and interface with joint, multinational, and SOF.

(4) The Commander, USTRANSCOM, with approval of SecDef, is the activation authority for all three stages of CRAF. The activation and utilization of the USAF AE segment of the CRAF should be considered when CRAF Stage II (major theater war) is implemented. AE CRAF should be planned for if appropriate. Planners should note, however, that per USTRANSCOM policy for movement of CBRN-contaminated or contagious casualties/personnel, CRAF will not be used to support movement of contagious biological casualties.

e. Integration of Multinational Evacuation Support. Other Services and multinational forces use various ground transportation and rotary- and fixed-wing aircraft for patients. They also use their own medically trained crew members or medical attendants. US medical personnel may perform appropriate duties on non-US evacuation platforms if it is in the interest of the USG and approved by the GCC. Conversely, multinational forces may also integrate with US medical forces. Planners 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 C, "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 patient movement assets are configured for patient evacuation, externally marked with a Red Cross and specifically dedicated to support the patient movement mission (a 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 patient movement assets 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 patient movement. While patients are protected under the Geneva Conventions, these conveyances are not. Movement of

patients with designated assets must have medical personnel and medical equipment aboard commensurate with patient condition to provide appropriate care for the patient.

(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 JOA 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 that require transportation but do not require medical en route care (such as those requiring transportation for further medical care, recuperation, transport to home of convalesce or unit of record to be reintegrated with the unit) may also 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 patient movement requirement and reduces the stress on DOD organic lift.

For more information on how the Geneva Conventions affect health support, see Appendix K, “Impacts of the Law of War and medical Ethics.”

h. Patient Movement Items. 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. A plan for PMI recycling, replacement, and the return of evacuation equipment and PMIs to the originating theater should be addressed in the respective theater OPLAN. Large MEDLOG units will support smaller units (MEDEVAC and special operations) without an organic MEDLOG capability.

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

i. Categories of Evacuation Precedence. The process of patient categorization determines how quickly a patient will be evacuated within the patient movement system and has a significant impact on lift assets. Patient movement priorities will be derived from situational factors and/or individual patient clinical conditions. Refer to Joint Operation Planning and Execution System (JOPES) Annex Q directives for specific joint operation priorities. Senior medical personnel or if no medical personnel are present, the senior military personnel recommends the precedence for patient movement to the PMRC based on each patient’s condition/status. Patient condition/status may be upgraded or downgraded at each succeeding role of care. Timeframes to provide evacuation assets on-site ready to conduct patient movement begin once a patient movement request is passed to the responsible PMRC. The tables in Appendix C, “Service Component Transportation Assets,” identify these timeframe objectives within which the patient movement system should respond.

(1) **Priority I—URGENT.** Patients requiring emergency, short notice evacuation (within a maximum of one hour for MEDEVAC or immediately for AE) 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 forward resuscitative care for life and limb saving measures, and to attain stabilization for further evacuation within a maximum one hour. (Not used for AE.)

(3) **Priority II—PRIORITY.** Patients requiring prompt evacuation (within a maximum of four hours for MEDEVAC or within 24 hours for AE), 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 are not expected to deteriorate significantly. They should be evacuated within 24 hours for MEDEVAC or 72 hours for AE.

(5) **Priority IV—CONVENIENCE.** Patients for whom evacuation by medical vehicle is a matter of medical convenience rather than necessity. (Not used for AE.)

6. Multinational Considerations

a. **Patient Movement in Multinational Operations.** GCCs are responsible for intratheater patient movement. This may include the movement of multinational forces, neutrals, and even EPWs/detainees. The GCC's policy should be recorded in his patient movement policy.

(1) The theater patient movement policy, known in some nations as a holding policy, is the key to balancing the treatment capability available at each role of care against the required patient movement assets. The provision of resources will be coordinated by the multinational force planning staff and will be comprised of assets from a number of sources, including HN support. Theater patient movement requires careful planning and is dependent on whether the US partners and other partner 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 United Nations or the North Atlantic Treaty Organization. Establishing the patient movement policy is a command decision of each nation. Medical and logistic staffs will advise. The CCMD surgeon and/or JFS will provide recommendations and monitor the established patient policy.

(2) Contributing nations bear ultimate responsibility for ensuring the provision of health care 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 multinational and HN support to meet patient movement requirements. Partner nations/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.** See Chapter VI, “Joint Health Planning,” paragraph 2.a.(12) “Host-Nation Support.”

7. Patient Stability

Patients validated for movement must be stabilized (secure airway, controlled hemorrhage, treated shock, and immobilized fractures) as much as the local situation and resources allow. Interventions (such as, intravenous 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 care requirements to provide this capability. The USAF AE en route care system provides qualified flight nurses and AE technicians. Critical care air transport team or other medical attendants can be added based on patient acuity, 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 that 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

a. Decontamination and processing procedures must be in place to prevent the spread of contamination and ensure the appropriate protection for patients, medical and support staff, and evacuation platforms. Patients exposed to CBRN agents must be decontaminated prior to entering the intertheater patient movement system unless the applicable GCC and Commander, USTRANSCOM, and SecDef approve. 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.

b. Patients with known or suspected or highly contagious diseases will not be transported within the patient movement system. These include infections with any agent that may pose a potential threat to national security, require special public health action, and/or have the potential to cause public panic and social disruption. Patients known or suspected to be infected with a highly contagious disease should be treated “in place” or with minimal transportation to medical authorities. In extreme circumstances there may be a requirement to move index cases (approximately two) for evaluation or critical medical care. If patient movement is required, prior approval must be given by the involved GCCs, Commander, USTRANSCOM, and SecDef in consultation with medical authorities. The preferred solution is to treat contagious or potentially contagious patients in place to reduce transmission risk.

c. Radiologically contaminated casualties must be decontaminated before admission to an MTF. Although casualties may have received substantial radiation exposure, this exposure alone does not result in the individual being contaminated. Normally, contaminated casualties do not pose a short-term hazard to the medical staff; rather the contamination is a hazard to the casualty’s health. Radioactive decontamination is simple: removing all outer clothing and a brief washing or brushing of exposed skin will reduce 99 percent of contamination; vigorous bathing or showering is unnecessary. Radiological contamination should not interfere with immediate lifesaving treatment or the best possible medical care.

9. Communications System Support

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

b. Service component commanders are responsible for C2 of their respective transportation agencies involved in joint patient movement. However, the JFS is responsible for establishing a joint patient movement CONOPS and identifying communications requirements necessary to integrate the functional aspects of the joint patient movement, medical regulating, and evacuation protocols out of the theater. This

may include defining the requirements needed for intratheater and intertheater support. Effective patient movement 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 patient movement 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 patient movement operations. Early identification of a theater's communications system requirements for evacuation connectivity is essential. At a minimum, medical communications in support of patient movement must provide reliable, real time and, when possible, redundant communications within a theater and from theater to the US. They must also provide a link between the most forward point where the patient enters the patient movement system, long haul communication to PMRC, and each role in the medical system to the destination MTF or medical element.

d. The degree of success of patient movement 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 patient movement mission. If no commonality exists, the JFC develops 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 (DSN), 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 3150.01, *Joint Reporting Structure General Instructions*, outlines responsibilities and message text format requirements for operational patient movement requests and evacuation procedures. User Services should have the communication equipment and personnel to identify their requirements to the PMRC. These messages include the following:

- (1) Medical regulating report.
- (2) Patient movement request.

j. Transportation command regulating and command and control evacuation system (TRAC2ES) provides a responsive communications system essential to the conduct of patient movement. TRAC2ES is a web-based system, which maximizes the internet while maintaining and protecting patient privacy and troop strength information. TRAC2ES provides global support throughout the full operational medical continuum: fixed and deployable MTFs and a GPMRC and PMRCs. TRAC2ES links the global, theater, and joint PMRCs through global communications.

ANNEX A TO APPENDIX B AEROMEDICAL EVACUATION

1. Introduction

a. The USAF AE system provides a critical patient movement 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 the AMC. The 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. The USAF AE provides fixed-wing movement of patients requiring in-flight care and supervision by AE crew member to locations offering appropriate roles of medical care. AE can significantly improve casualty recovery rates by providing rapid transportation of the sick and wounded to MTFs 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) Specialty trained aircrew clinicians and operational support personnel.
- (3) Equipment for in-flight supportive medical care and ground support operations.
- (4) Critical care air transport team 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.
- (6) **AE Categories of Evacuation Precedence.** Due to the nature of AE operations and the use of mobility airframe to provide this expeditionary patient movement asset, the AE precedence categories are different than those utilized for other patient movement options. AE patient movement categories:
 - (a) Urgent: Patients who must be moved immediately to save life, limb, or eyesight, or to prevent complication of a serious illness.
 - (b) Priority: Patients requiring prompt medical care who must be moved within 24 hours.

(c) Routine: Patients who should be picked up within 72 hours and moved on routine/scheduled flights.

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 (Operations) of the OPOD and general patient movement guidance should be outlined in annex Q (Medical Services). Aeromedical 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 enhance 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 operations will be conducted through operational wing C2 channels. Intratheater air mobility operations are defined by geographic boundaries. **Air mobility forces assigned or attached to that GCC normally conduct these operations.** Intratheater common-user air mobility assets are normally scheduled and controlled by the theater Air Force AOC or JAOC if established. The ability to identify and coordinate movement requirements (visible in Joint Deployment and Distribution Enterprise-common systems) is critical to providing theater reachback support from the AMC 618th Air and Space Operations Center (Tanker/Airlift Control Center) (618th AOC/TACC). When intratheater air mobility requirements exceed the capability of assigned or attached forces, other mobility forces can support intratheater airlift using a support relationship. The supported commander may also request augmentation from SecDef through the request for forces process. 618th AOC/TACC serves as the 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.

c. **JTF Air Mobility Operations.** During joint operations, it may be necessary to establish a JTF within a GCC's area of responsibility. This allows the GCC to maintain a theater-wide focus and at the same time respond to a regional requirement within the theater. When this occurs, a JTF force will be designated and forces made available for this operation. The commander Air Force forces (COMAFFOR) will normally be delegated OPCON of Air Force assets, and if designated the joint force air component commander (JFACC), will typically exercise tactical control over air mobility forces made available to the JFACC. If the JTF requires additional air mobility forces beyond those already made available for tasking, additional augmentation may be requested.

(1) The COMAFFOR may appoint a director of mobility forces (DIRMOBFOR) to function as coordinating authority for air mobility with all commands and agencies, both internal and external to the JTF, including the JAOC, the 618th TACC, and the JDDOC and/or the joint movement center.

(a) The DIRMOBFOR is normally a senior officer who is familiar with the operational area and possesses an extensive background in air mobility operations. The DIRMOBFOR serves as the designated agent for all air mobility issues in the operational area, and for other duties as directed. At the discretion of the JFC, the DIRMOBFOR may be sourced from the theater's organizations or USTRANSCOM. The DIRMOBFOR should be colocated with the JAOC AMD to maximize effectiveness.

(b) The DIRMOBFOR will ensure the effective integration of intertheater and intratheater air mobility operations, and facilitate intratheater air mobility operations on behalf of the COMAFFOR. The DIRMOBFOR provides guidance to the AMD on air mobility matters, but such guidance must be responsive to the timing and tempo of operations managed by the JAOC director.

(2) **DIRMOBFOR also has distinct responsibilities in relation to JFC staffs.** Air mobility requirements do not originate in the AOC. They originate at the component level and are validated by either the theater joint movement center/JDDOC (when established) or by the GCC's J-3 in coordination with the J-4. This may vary slightly in different theaters. Consequently, **an essential role for DIRMOBFOR is to serve as the principal interface between the AOC, the theater's J-4, and the joint movement center/JDDOC** to obtain appropriate prioritization of air mobility tasks while balancing requirements and air mobility capability.

For more discussion of the DIRMOBFOR, see JP 3-17, Air Mobility Operations.

d. **Routine Operations.** To assist in the employment of mobility forces, each of the GCCs has a USTRANSCOM transportation liaison officer. GCCs with assigned air mobility forces have combatant command (command authority) over those forces and normally delegate OPCON over those forces through Service component commanders. The COMAFFOR executes the C2 of USAF air operations in the theater or operational area through the AOC. One of the AOC divisions, AMD, usually oversees intratheater air mobility operations.

e. **Contingency AE Structure (see Figure B-A-1).** Deployed expeditionary air forces are organized to ensure unity of command. Deployed AE forces will be organized within the constructs of the air 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) When a JTF is formed, command relationships for air mobility forces will be established by the JTF establishing authority. The command relationship established for these forces will normally be exercised through the JFACC and/or COMAFFOR. The JAOC director is charged with the effectiveness of joint air operations and focuses on planning, coordinating, allocating, tasking, executing, and assessing air operations in the operational area based on JFACC guidance and DIRMOBFOR coordination.

mobility forces supporting, but not attached to, the JTF or subordinate command will remain with AMC. This expansion of C2 systems requires the AMD to interface with the 618th TACC, other AMDs if required, and the JAOC combat operations and combat plans divisions to ensure air mobility missions are included in the air tasking order. Figure B-A-1 illustrates the arrangement of the JAOC and associated command relationships with respect to air mobility operations.

For more information on air mobility operations, see JP 3-17, Air Mobility Operations.

3. Aeromedical Evacuation Operations

a. The AMC 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 the US. The USAF in Europe and United States Pacific Air Forces 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 the US, 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 MTF (see Figure B-A-2).

c. The airlift agency (AOC/JAOC/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 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 critical care transport teams 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. AE and airlift elements are tasked through the air and space expeditionary wing using an air tasking order. The air and space expeditionary wing 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 JOA for rapid response.

See Appendix C, "Service Component Transportation Assets," for more information on air transportation assets.

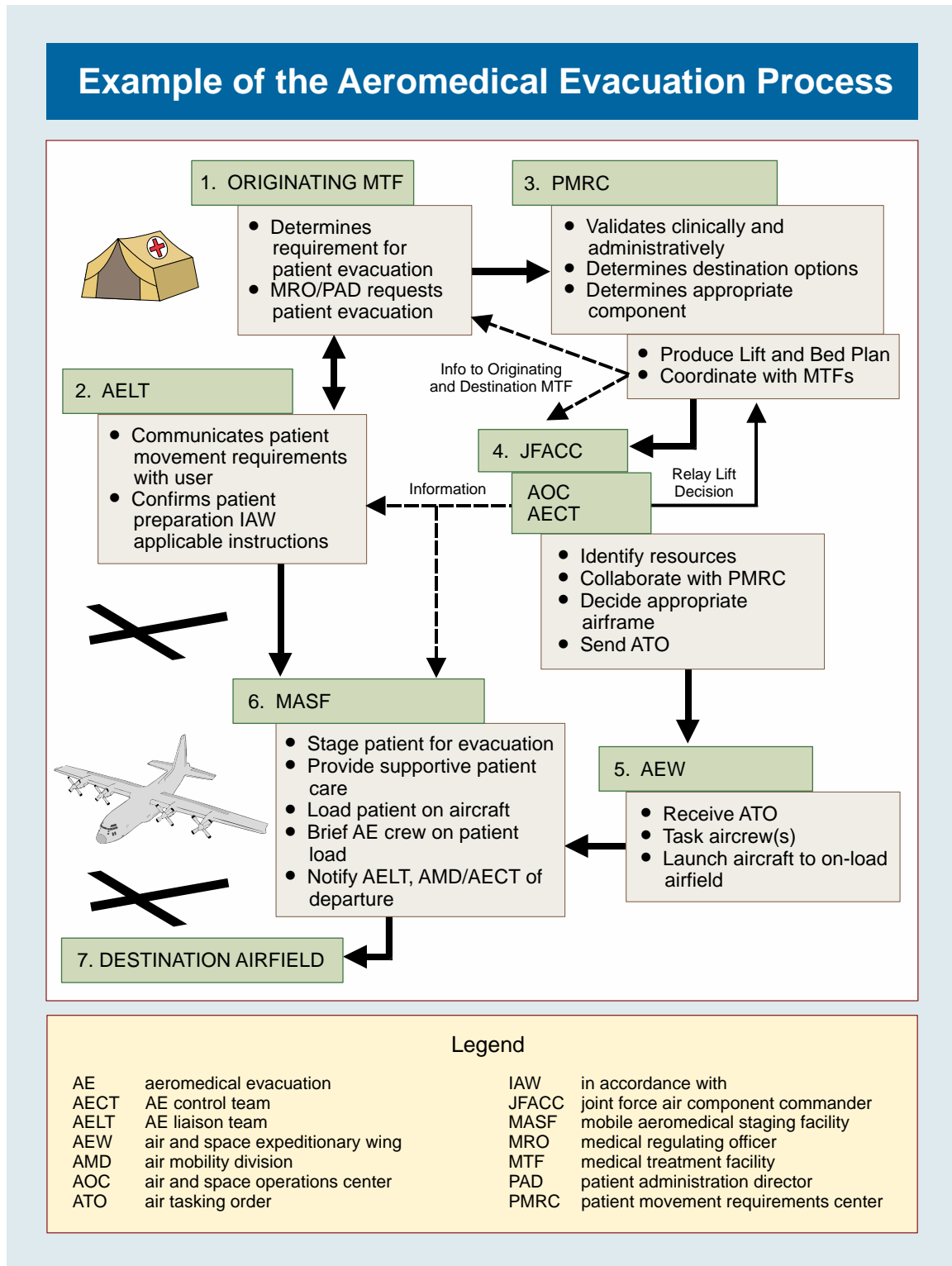


Figure B-A-2. Example of the Aeromedical Evacuation Process

d. AE interface with special mission operations and rescue. Some special mission operations and expeditionary forward deployed operations, such as USMC expeditionary

forces (to include MARSOF), and combat search and rescue at times may not possess organic AE capability augmentation support and must identify requirements to obtain conventional AE support at forward airbases. Supporting SOF requires the HSS planner to understand both MEDEVAC and CASEVAC platforms (sea, air, and land) and be prepared for unconventional transport methods.

(1) The 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) The United States Air Force Special Operations Critical Care Evacuation Team is a specially trained and equipped form of critical care air transport team; special operations critical care evacuation teams are organic to USAF SOF to meet their unique mission requirements. These teams provide care to casualties transiting the SOF casualty evacuation system and provide continued trauma and post-operative casualty management aboard organic SOF aircraft and other opportune evacuation platforms.

e. 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 processes 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. The 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, multinational 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, Service component commands 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 codes 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.** AE crews are specially trained to 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.** Critical care air transport teams provide specialized care, in conjunction with AE crews, to evacuate critical patients requiring advanced care during transportation. Critical care air transport teams represent 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. AE missions that require the addition of a critical care air transport team will be validated by the PMRC and tasked by the AE control teams.

c. **Mobile Aeromedical Staging Facility (MASF).** The MASF provides rapid response patient staging in support of small-scale contingencies, humanitarian/disaster response, and initial stages of major theater war. The MASF is designed to provide forward support with the smallest footprint and is usually the AE interface with SOF. MASF facilities will be located at or near airheads capable of supporting conventional mobility airlift. A critical care air transport team can be assigned to forward-based MASF to enhance rapid evacuation of high acuity 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.

e. **Aeromedical Evacuation Liaison Team (AELT).** The 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. Establishing a communication network with airlift operations is essential for rapid evacuation.

f. **Expeditionary Aeromedical Evacuation Squadron (EAES).** The EAES may be assigned to an expeditionary wing, air expeditionary operations group, or expeditionary operations support squadron. The EAES provides command functions for all AE personnel assigned to the air and space expeditionary wing. The EAES ensures all elements are prepared to conduct AE operations as tasked by the AOC and will provide AE assets to support the wing operations center. The EAES can arrange support

requirements for follow-on AE forces, as required. In larger contingencies, there may be more than one expeditionary AE squadron assigned to an air and space expeditionary wing or air expeditionary group.

g. **Aeromedical Evacuation 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 provides direct supervision and crew management for assigned, attached, and transiting AE crews and critical care air transport teams in conjunction with the air mobility operations control center, AE control team and base operations, as applicable. The AEOT coordinates requirements to include launch and recovery, life support, billeting, food service, transportation, and administration for AE crew members/critical care air transport teams. 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 provide oversight and operational support on flight line activities, patient loading and unloading, and aircraft arrival and departure times.

h. **Aeromedical Evacuation Support Cell (AESC).** The AESC provides communications and air and space ground equipment maintenance support to all unit type codes assigned to the theater AE system. The AESC should be staged with equipment at key locations, normally with the expeditionary AE crew member support, within the area of responsibility to support AE requirements. Communications networks will be integrated with airlift operations.

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. **Aeromedical Evacuation 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 CCMD OPLANs/CONPLANs will include beddown of AE capable airlift, strategic aerial port of debarkations and/or aerial ports of embarkation, planned mission routing, availability of intra/intertheater retrograde airlift for AE missions, and planned patient movement requirements (evacuees) by C-Day (the unnamed day on which movement for forces, support, and transportation from origin begins).

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 JOA and may divert a mission, in-system select, to support the patient request.

(2) **Aeromedical Evacuation Civil Reserve Air Fleet.** The AE CRAF program provides airlift platforms, upon contract activation, from commercial airlines specifically to perform/support AE missions. The Aeromedical CRAF is the intertheater AE solution in contingency planning. Aeromedical CRAF aircraft will not be used to move contaminated patients.

c. **Airfield Capability.** The mobility en route structure and proximity of MTFs 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.” AE crews 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 USAF 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 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. **Medical Equipment Technician Support.** Equipment repair is essential in the theater for routine maintenance and minor repair. Deployed MTFs (and potentially civilian and multinational facilities) can support AE equipment repair and maintenance in steady state but not surge periods. Therefore, the AE planner should insert AE medical equipment technician capability into airlift hubs and align with local medical treatment facilities to ensure AE equipment is processed to meet mission requirements.

g. **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 a USAF wing.

h. **Ground Transportation.** Most AE units deploy with integral transportation capability specifically designated for the movement of assigned equipment packages with limited capability to transport AE personnel. AE planners should ensure proper aircraft support equipment is available at the airfield, such as, 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 HN support.

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ANNEX B TO APPENDIX B PATIENT MOVEMENT ITEMS

1. Patient Movement Item System

a. The objective of the PMI system is to sustain the patient movement/evacuation system without diminishing the capability of forward medical units. This is done by pre-positioning or providing in-kind exchange of equipment for treatment continuity or by using Service specific GPMJAB approved PMI equipment. Determination of the specific items that make up the PMI asset pool are identified by the Services as medical equipment items required for patient movement and facilitated through USTRANSCOM Surgeons Office. 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 equipment management process from initial entry to the equipment's final destination. The PMI system will deploy with the AE system, be managed and supplied through the AE system, and collocated with AE intratheater and/or intertheater interfaces in order to provide initial AE operational capability, sustainment of AE operations, and minimize equipment turnaround time.

b. USTRANSCOM is the PMI system manager. HQ AMC/Headquarters, AMC/Surgeon (SGXM) is the program execution office. All Services will fund their original initial quantities of approved PMI in-kind assets. PMI in-kind assets are defined as the exact medical equipment by type and model approved for AE patient movement. All Services will maintain initial quantities of approved PMI in-kind equipment in their medical assemblages, kits/sets/outfits, table of allowance, or allowance standards. This will ensure equipment standardization and the PMI programs ability to seamlessly support patient movement. This capability is critical to enabling the PMI system to properly recycle/replace medical equipment in medical assemblages and to ensure their designed operational capability is not diminished due to equipment shortfalls. The USAF manages and receives Defense Health Program funds to support DOD operational plan patient movement requirements and is responsible for life cycle management of those equipment assets that reside in the PMI centers.

c. PMI center levels are based on projected casualty flow and prompt recycling of PMI assets. Timely recycling is essential to maintain and manage our total inventory investment. Key to successful patient treatment and movement is ensuring PMI medical equipment assets are available for patient treatment, tracked during in-transit, and recycled to medical treatment facilities. All Services are responsible for tracking and returning PMI assets to the closest PMI Center.

d. PMI equipment is tested and certified for use on applicable service rotary and fixed-wing aircraft by the joint airworthiness certification-testing agency. An Air Force (AF) Form 4033 (PMI/AE Certification Label), is required to designate airworthiness certification for all PMI equipment. This is a joint label and must be affixed to each piece of PMI certified equipment.

e. Service en route care teams (i.e., USAF AE crews and critical care air transport teams) will be trained to operate PMI equipment items.

f. The USAF is the PMI program execution agency responsible for resourcing, maintaining, and recycling PMI to support contingency operations for patient movement. Headquarters AMC/SGXM is the program management, execution, and action office for the Air Force. Pre-positioned PMI equipment is placed on the patient by the sending MTF. PMI centers will recycle or replace particular PMI equipment removed from the Service medical facilities to support a patient movement event. The PMI system provides the capability to track medical equipment from initial entry to the patient's final destination. This is accomplished by responsible personnel scanning the PMI out with hand held scanners at the originating MPF and scanning it back in at the receiving MTF to update the Patient Movement Item Tracking System (PMITS). If the equipment is not scanned as it leaves one MTF and scanned again when it arrives at the next location, in-transit visibility is lost. The PMI system will deploy with the Air Force AE system, be managed and supplied through the Air Force AE system, and co-locate with AE intratheater and/or intertheater interfaces in order to provide initial AE operational capability, sustainment of AE operations, and minimize equipment turnaround time. Levels will be established based on the worst three days of patient movement, either based on planning factors for initial setup or six-month historical data for continuous operations.

g. PMIs are tracked using PMITS. The use of PMITS is mandatory for asset visibility and tracking of PMIs to provide accurate information to allow proactive support to deployed organizations. HQ AMC/SGXM is responsible for PMITS operational control, advice, and counsel. PMITS utilizes bar code technology to scan PMIs and share PMI data with other authorized users of the system. Bar codes will be issued only at PMI centers and designated units or by HQ AMC/SGXM using established bar code guidelines in accordance with PMI Bar Coding Methodology and Codes. All users will ensure bar code labels are attached to all PMI equipment assets prior to use and or patient movement. The bar code label should have the HQ AMC/SGXM phone number, 1-877-286-1931, for easy return if found. If the label is worn or does not have the phone number, contact the nearest PMI center or AMC/SGXM to obtain a new label immediately. Non-PMI equipment will not be tracked in this system unless coordinated with USTRANSCOM Command Surgeon and HQ AMC/SGXM.

h. PMIs must be returned promptly, particularly from US MTFs to the closest PMI center to prevent equipment shortages in theater. Once patient care is transferred from the patient movement system to an MTF or other such provider, it is critical that the PMI equipment be immediately returned for inspection and redistribution. Services must ensure all medical personnel are trained to not only recognize PMIs but to also understand and execute recycling PMIs back to PMI centers. MTFs will decontaminate and clean PMI equipment before returning it to a PMI center, PMI cell, or transportation point. To reduce medical equipment shortfalls experienced within the theater, the JFC must ensure detailed procedures are established to resupply, refurbish, and properly recycle PMIs. MTFs recycling PMIs to PMI centers will obtain the transportation access code to pay for shipping from their Service MEDLOG office.

2. Patient Movement Item Centers

a. Establishment of theater PMI centers is a Service and CCMD responsibility. Air Force medical units will be tasked, trained, organized, and equipped to perform AE missions, including PMI operations. The USAF has established six 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 the US and outside the continental US that best support patient movement/evacuation/treatment plans as identified in CCMD OPLANs and Service/agency support plans (e.g., National Disaster Medical System activation). PMI centers are responsible for the overall management, in-transit visibility, tracking, and recycling of PMIs. These centers will receive, refurbish (i.e., technical inspection, calibration, repair), provide one day of expendable supplies, redistribute, and quickly return PMIs collected from MTFs to their origination. The US Army Medical Materiel Agency may be required to provide the same level of maintenance support in the US 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. Intratheater movement of PMI equipment is the responsibility of the GCC.

b. Contingency PMI cells can also be established and augmented with personnel from all services in the event of surge and sustained requirements. These cells will be equipped to provide the same maintenance and tracking support capability as permanent PMI centers. If required, Services can coordinate with USTRANSCOM and HQ AMC/SGXM to request a deployable biomedical maintenance package (equipment only) to outfit a contingency PMI cell with required maintenance test equipment assets.

3. Patient Movement Item Teams

a. PMI teams are composed of medical material and biomedical equipment repair specialists. Combined, this logistics team provides manpower for operational management of a PMI center. Medical material teams will manage PMI equipment and supplies, maintain asset accountability, acquisition replacement material, and facilitate equipment recycling/tracking. 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 update the PMI information system.

b. The host medical equipment maintenance activity may request repair-and-return maintenance support from the GCC TLAMM or PMI center by telephone, e-mail, or letter. If the GCC TLAMM or PMI center approves shipment of the equipment, send the equipment through auditable and insurable transportation channels. Include a thorough description of the problem and identification of the organization originating the shipment.

c. The medical equipment maintenance activity will ensure AF Form 4033 (PMI/AE Certification Label), and AF Form 4368 (Scheduled Maintenance and Certification), or Department of Defense (DD) Form 2163 (Medical Equipment Verification Certification),

are affixed to each PMI medical equipment item to designate its airworthiness certification and maintenance record.

d. During any maintenance of PMI equipment, the servicing biomedical electronics technician (BMET) will coordinate with the closest PMI center to verify equipment ownership, ensure the equipment location is current in the PMITS, and provide the latest calibration date for update in the tracking system.

e. The closest medical equipment maintenance activity performs all corrective maintenance required for equipment being used on a patient mission. The medical equipment maintenance activity documents the work performed on a manual work order and forwards it to the owning activity.

f. The local BMET who works on equipment belonging to another organization records it as an unscheduled work order with no index number/equipment control number to account for time and parts.

4. USAF Patient Movement Item Centers

- a. 60th Medical Support Squadron PMI Center Travis Air Force Base (AFB), CA

Shipping Address:
60th MDG Travis PMI Center
102 Bodin Circle Bldg 795
Travis AFB, CA 94535-1800
DSN Phone: 799-2379
Commercial Phone: (707) 423-2379
FAX: (707) 423-3638

- b. 374th Medical Support Squadron PMI Center Yokota Air Base (AB), Japan

Shipping Address:
374th MDG Yokota PMI Center
Building 4145 Unit 5225
Yokota AB, JAPAN 96328-5225
DSN Phone: 315-225-5234
Commercial Phone: 011-81-311-755-5234
FAX: 011-81-425-30-3352

- c. 18th Medical Support Squadron PMI Center Kadena AB, Japan

Shipping Address:
18th Kadena PMI Center
Unit 5268 FM5270 Davis Ave, Bldg 625
Kadena AB, AP 96368-5268
DSN Phone: 315-630-4467
Commercial Phone: 011-81-611-730-4467
FAX: 011-481-611-730-4681

d. 375th Medical Group PMI Center Scott AFB, IL

Shipping Address:
375th MDSS/SGSL/PMI Center
120 South Adams Street, Bldg 4020
Scott AFB, IL 62225-5300
DSN Phone: 576-1173
Commercial Phone: (618) 256-1173
FAX: (618) 256-1175

e. 86th Medical Group PMI Center Ramstein AB, Germany

Shipping Address:
435th MDG Ramstein PMI Center
Lincoln Blvd Bldg 2497
Ramstein-Flugplatz, Germany 66877
DSN Phone: 314-479-2437
Commercial Phone: 011-49-6371-46-2437
FAX: 011-49-6371-46-2569

f. 779th Medical Group PMI Center Andrews AFB, MD

Shipping Address:
779th MDG Andrews PMI Center
3244 Tennessee Avenue
Andrews AFB, MD 20762-5184
DSN Phone: 857-7957
Commercial Phone: (240) 857-7957
FAX: (240) 857-7951

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APPENDIX C SERVICE COMPONENT TRANSPORTATION ASSETS

1. General

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 HN support agreements. The majority of the Service transportation assets listed in Figures C-1–6 are not dedicated patient movement platforms, and when they are employed for patient movement, 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 theater AE system 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 unit type codes were developed based on the building block principle, which allows planners to select specific unit type codes required to support a pending joint force operation or those used for developing OPLANs. Each unit type code 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 theater AE system to exist, unit type codes 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 unit type codes that are deployed to meet a unique or enhanced capability requirement. Aeromedical unit type codes are specifically designed to provide the maximum amount of flexibility to commanders and planners to meet the requirements of AE. The unit type codes are divided into three categories, C2, patient care, and AE support. The following sections provide a brief description of these unit type codes.

SECTION A. SUPPORTING UNITED STATES AIR FORCE AEROMEDICAL EVACUATION ELEMENTS AND TRANSPORTATION ASSETS

2. Aeromedical Evacuation Command and Control Assets

a. **Aeromedical Evacuation Command Squadron.** Provides C2 of assigned AE forces. The AE command squadron can deploy in advance of other AE unit type codes to establish the support required for AE forces and establishment of a theater AE system. The AE command squadron will advise wing and operations group commanders, as well as other appropriate personnel/agencies, on AE CONOPS, doctrine, capabilities, and requirements. This unit type code provides procedural guidance, technical guidance, and management oversight for assigned, attached, and transiting AE elements. The AE command squadron may be augmented by other AE unit type codes (UTCs), such as the AE support cell, based on operational requirements.

SERVICE COMPONENT FIXED-WING AIRCRAFT TRANSPORTATION ASSETS					
NOMENCLATURE	SERVICE	CONFIGURATION	LITTER	AMBULATORY (SEATED)	ATTENDANTS
C-5 GALAXY	USAF	MAXIMUM	NOT EQUIPPED	70	2 FLIGHT NURSES 3 AEROMED EVAC TECHS
KC-135 STRATOTANKER	USAF	MAXIMUM	8	24	2 FLIGHT NURSES 3 AEROMED EVAC TECHS
KC-10 EXTENDER	USAF	MAXIMUM	8	24	2 FLIGHT NURSES 3 AEROMED EVAC TECHS
C-21 LEARJET	USAF	MAXIMUM	1	2	1 FLIGHT NURSE 1 AEROMED EVAC TECH
C-130 HERCULES	USAF	MAXIMUM	74	92	2 FLIGHT NURSES AND 3 AEROMED EVAC TECHS
	USMC	COMBINED	50	24	
C-17 GLOBEMASTER	USAF	MAXIMUM	36	54	2 FLIGHT NURSES 3 AEROMED EVAC TECHS
C-27J SPARTAN	USAF, USA	MAXIMUM	24	34	4 MEDICAL ATTENDANTS
CIVIL RESERVE AIR FLEET (CRAF) (STAGE II ACTIVATION)	CRAF	MAXIMUM	87	Carrier Specific	4 FLIGHT NURSES 6 AEROMED EVAC TECHS
C-23 SHERPA	USA	MAXIMUM	18	30	2 MEDICAL ATTENDANTS
MV-22 OSPREY	USAF	MAXIMUM	12	24	2 MEDICAL ATTENDANTS
	USMC, USN				
C-12 HURON	USAF, USA USN/USMC	MAXIMUM	2	8	1 MEDIC
		COMBINED	NOT EQUIPPED	8	
C-2 (COD)	USN	MAXIMUM	NOT EQUIPPED	28	2 CORPSMEN
P-3 (SUB HUNTER)	USN	MAXIMUM	10	19	2 CORPSMEN
LEGEND					
AEROMED	aeromedical		TECHS		technicians
COD	carrier onboard delivery		USA		US Army
EVAC	evacuation		USAF		US Air Force
			USMC		US Marine Corps
			USN		US Navy

Figure C-1. Service Component Fixed-Wing Aircraft Transportation Assets

SERVICE COMPONENT ROTARY-WING AIRCRAFT TRANSPORTATION ASSETS					
NOMENCLATURE	SERVICE	CONFIGURATION	LITTER	AMBULATORY (SEATED)	ATTENDANTS
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 CH53E SUPER SEA STALLION	USMC/USN	MAXIMUM	24	37 (65 WITH CENTER LINE SEATING)	2 CORPSMEN
		COMBINED	8	19	
UH-60A/L/M	USA	MAXIMUM	2	11	2 CREWMEMBERS
		COMBINED	1	4	
UH-60A BLACKHAWK AIR AMBULANCE CAROUSEL EQUIPPED	USA	MAXIMUM	6	7	1 MEDIC
		COMBINED	3	1	
HH-60L/M BLACKHAWK AIR AMBULANCE	USA	MAXIMUM	6	6	
		COMBINED	3	3	
UH-1H/V IROQUOIS AIR AMBULANCE	USA	MAXIMUM	6	9	
		COMBINED	3	4	
CH-47 CHINOOK	USA	MAXIMUM	24	31	
		COMBINED	8	19	
UH-72 LAKOTA	USA	MAXIMUM	2	4	
		COMBINED	1	2	
UH-1Y	USMC		6	12	
LEGEND					
USA	US Army		USMC		US Marine Corps
			USN		US Navy

Figure C-2. Service Component Rotary-Wing Aircraft Transportation Assets

SERVICE COMPONENT MEDICAL GROUND VEHICLES TRANSPORTATION ASSETS					
NOMENCLATURE	SERVICE	CONFIGURATION	LITTER	AMBULATORY (SEATED)	ATTENDANTS
M996 TRUCK, 4X4 AMBULANCE ARMORED HMMWV-MINI	USA	MAXIMUM	3	6	2 MEDICS
		COMBINED	1	3	
M997 TRUCK, 4X4 AMBULANCE ARMORED HMMWV-MAXI	USA	MAXIMUM	4	8	2 MEDICS
		COMBINED	2	4	
M1035 TRUCK 4X4 AMBULANCE SOFT-TOP HMMWV-MINI	USMC	MAXIMUM	2	3	DRIVER ONLY
		COMBINED	1	3	1 CORPSMAN
M113 CARRIER, PERSONNEL, FULL-TRACKED ARMORED, WITH LITTER CONVERSION KIT	USA	MAXIMUM	4	10	1 DRIVER, 1 MEDIC, 1 TRACK COMMANDER
		COMBINED	2	4	
M1133 STRYKER-MEDICAL EVACUATION VEHICLE (MEV)	USA	MAXIMUM	4	6	1 DRIVER, 1 MEDIC, 1 TRACK COMMANDER
		COMBINED	2	3	
MRAP MAXX PRO-PLUSE (AMB)	USA	MAXIMUM	2	4	1 DRIVER, 1 MEDIC, 1 TRACK COMMANDER
		COMBINED	2	1	
MRAP RG33L HAGA	NOT SERVICE - UNIQUE	MAXIMUM	3	6	1 DRIVER, 1 MEDIC, 1 TRACK COMMANDER
		COMBINED	1	3	
MRAP COUGAR (AMB) CAT2A2	USMC	MAXIMUM	2	3	1 DRIVER, 1 MEDIC, 1 TRACK COMMANDER
		COMBINED	1	3	
BUS, AMBULANCE	NOT SERVICE - UNIQUE	MAXIMUM	20	44	2 MEDICS
		COMBINED	CAPACITY VARIES BY SIZE OF BUS		
Legend					
AMB	ambulance				
HAGA	heavily armored ground ambulance		MRAP	mine-resistant, ambush-protected	
HMMWV	high mobility multipurpose wheeled vehicle		USA	US Army	
			USMC	US Marine Corps	

Figure C-3. Service Component Medical Ground Vehicles Transportation Assets

SERVICE COMPONENT NONMEDICAL GROUND VEHICLES TRANSPORTATION ASSETS					
NOMENCLATURE	SERVICE	CONFIGURATION	LITTER	AMBULATORY (SEATED)	ATTENDANTS
LAV 25, LIGHT ARMORED VEHICLE	USMC	MAXIMUM	0	4	CREW ONLY
LAVL, LIGHT ARMORED VEHICLE, LOGISTICS VARIANT	USMC	MAXIMUM	4	7	1 CORPSMAN
AAV, LAPT-7 AMPHIBIOUS ASSAULT VEHICLE, LANDING VEHICLE PERSONNEL	USMC	MAXIMUM	6	21	1 CORPSMAN
M998 4X4 TRUCK CARGO/TROOP CARRIER	USA, USMC	MAXIMUM	5	6	1 MEDIC OR CORPSMAN
M1078 LIGHT MEDIUM TACTICAL VEHICLE (LMTV) 4X4 2.5 TONE CARGO TRUCK	USA	MAXIMUM	7	12	1 MEDIC
M1083 MEDIUM TACTICAL VEHICLE (MTV) 6X6 5 TONE CARGO TRUCK	USA	MAXIMUM	8	14	1 MEDIC
M1083 MTV, LONG WHEELBASE	USA	MAXIMUM	12	22	1 MEDIC
M813, M923 5-TON 6X6 CARGO TRUCK	USA	MAXIMUM	12	32	1 MEDIC OR CORPSMAN
M977 HEAVY EXPANDED, MOBILITY TACTICAL TRUCK (HEMTT) 8X8, CARGO	USA, USMC	MAXIMUM	9		
LEGEND					
USA	US Army				
USMC	US Marine Corps				

Figure C-4. Service Component Nonmedical Ground Vehicles Transportation Assets

SERVICE COMPONENT RAIL TRANSPORTATION ASSETS					
NOMENCLATURE	SERVICE	CONFIGURATION	LITTER	AMBULATORY (SEATED)	ATTENDANTS
SLEEPING CAR	NATO/HOST-NATION SUPPORT (HNS) (CAPACITY VARIES BY NATION)	MAXIMUM	32	32	1 NURSE
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	
LEGEND					
NATO North Atlantic Treaty Organization					

Figure C-5. Service Component Rail Transportation Assets

SERVICE COMPONENT WATER CRAFT TRANSPORTATION ASSETS					
NOMENCLATURE	SERVICE	CONFIGURATION	LITTER	AMBULATORY (SEATED)	ATTENDANTS
SLEEPING CAR	NATO/HOST-NATION SUPPORT (HNS) (CAPACITY VARIES BY NATION)	MAXIMUM	32	32	1 NURSE
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	
LEGEND					
NATO North Atlantic Treaty Organization					

Figure C-6. Service Component Water Craft Transportation Assets

b. **Aeromedical Evacuation 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 AE control team receives the transport-to-bed plan from the PMRC, the AE control team coordinates airlift to meet AE requirements, tasks the appropriate AE elements, and notifies the patient movement requirements center when mission taskings are scheduled in order to maintain full patient in-transit visibility. The AE control team also monitors execution of AE missions and coordinates/communicates with theater planning cells and AE command elements as necessary. The AE control team advises the DIRMOBFOR and liaises with joint force/component surgeons on AE issues. The AE control team must be able to establish communication links with other AE components and PMRC.

3. Aeromedical Evacuation Patient Care Assets

a. **Aeromedical Evacuation Crew.** The AE crew is an AE building block unit type code 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 roles of care using intertheater or intratheater fixed-wing airlift.

b. **Critical Care Air Transport Team.** Critical care air transport teams provide a highly specialized capability to AE missions 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 medical crew director and aircraft commander. The critical care air transport team physician is clinically responsible for care given to critical care air transport team-assigned patients and may be asked to assist or advise on the care of the other patients.

Aeromedical missions that require critical care air transport team augmentation will be identified and validated by PMRC/AE control team. The theater validating surgeon, in conjunction with the critical care air transport team director, designated by the AE squadron command center, normally coordinates individual critical care air transport team mission requirements.

c. **Mobile Aeromedical Staging Facility.** The MASF provides rapid response patient staging in support of small-scale contingencies, humanitarian/disaster response, and initial stages of major theater war. 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 administrative personnel, communications, and patient care teams. For contingency planning, patient throughput is 40 patients per 24 hours. Critical care air transport teams can be assigned to forward-based mobile AE staging facilities to enhance rapid evacuation of stabilized patients.

d. **Contingency Aeromedical Staging Facility.** The CASF may be used at major intertheater hubs to support military operations. The CASF provides patient staging support to the MTF and differs from the mobile staging facility in that the CASF is fixed, not mobile.

4. Aeromedical Evacuation Support

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 AE crews, critical care air transport teams, and associated equipment. AEOT equipment includes office, communications, and logistical support items to accomplish the mission. The AEOT unit type code supports AE operations at inter- or intratheater hubs including those at forward operating airfields. The team works directly with airlift C2 agencies to coordinate AE missions and ensure on-time launch and recovery. The AEOT works closely with other theater AE system elements, including MASFs and CASFs, along with Service component medical treatment elements, to accomplish its mission.

b. **Aeromedical Evacuation Liaison Team.** The 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. An AELT may be geographically separated from the other USAF assets.

c. **Aeromedical Evacuation Communication Team.** The AE communications team provides communication augmentation to any AE UTC (primarily the AELT, AEOT, and any patient staging UTCs) when mission needed communications are unavailable.

5. Air Force Airlift Resources

a. Preplanned AE can be scheduled in either as preconfigured or retrograde (opportune) airlift at the discretion of the GCC and the theater's joint movement center.

When using retrograde (opportune), the aircraft flies into an airfield, off-loads the cargo and/or passengers, and then is quickly 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 airlift for the AE mission. These aircraft can then be configured for AE prior to mission origination. 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 (such as, increased flexibility with aerial port of debarkation and/or its selection), and permit an increased litter AE configuration and decreased ground times. However, using preconfigured preplanned AE does reduce the number of airframes available to the GCC for other missions.

b. 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.

(1) The C-130 is the primary USAF intratheater AE capable airlift aircraft available to support the GCC. This is a high wing, four engine turboprop cargo aircraft that can be fully pressurized, heated, and air conditioned. The C-130 aircraft 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 aircraft can be readily configured for AE by using seat and litter provisions stowed in the cargo compartment. The AE planning factor is for 50 patients. The C-130 aircraft 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.

(2) The C-17 aircraft is the nation's newest operational strategic airlifter capable of transporting patients. The C-17 aircraft has 3 AE stations stowed on the sidewall to accommodate 9 litters. If additional litter stanchions are added to the aircraft, the C-17 aircraft can transport a total of 36 litter patients. The C-17 aircraft can also be configured with patient support pallets. Five therapeutic oxygen outlets are provided, and there are 12 designated AE utility receptacles for electrical power.

(3) KC-135 tanker aircraft are also routinely used to conduct AE missions. While the number of patients able to be transported is limited, the extended range makes it possible to fly non-stop to the US from many theaters of operation. The KC-135 has no inherent capability to convert to an AE configuration. It requires either patient support pallets or stacking litter systems be available in order for it to be configured for AE.

(4) Instances may occur that require the use of aircraft other than those normally used to support AE operations (C-5, KC-10, and C-21 aircraft). 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 AE crew members may be required to accompany patients on nontraditional aircraft, AE crew members 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. AE crew members should refer to AE regulations for further guidance on utilizing specific aircraft.

6. 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 AE airlift is the Boeing 767 aircraft. Once activated, each Boeing 767 aircraft would be reconfigured from its passenger configuration to an AE 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. Planning factors to be used when moving patients is 87 patients per mission. Each Boeing 767 so configured would remain in the AE system until such time that the operation no longer requires it.

7. Ambulance Bus

The ambulance bus is organic to the table of allowance for contingency hospitals and aeromedical staging squadrons. The ambulance bus has an inherent capability to transport 12 litters or a combination of litter and ambulatory patients from 4 litters and 24 ambulatory or up to 12 litters and zero ambulatory.

SECTION B. SUPPORTING NAVY/MARINE CORPS/COAST GUARD EVACUATION ELEMENTS

8. United States Navy

a. Currently, the USN 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 USN as well as other JTF resources as identified during the planning process.

b. **Casualty Receiving and Treatment Ships.** Designated ships of the amphibious task force that can provide forward resuscitative care capability and medical and dental support to the landing force. General-purpose amphibious assault ships are suitable for use as casualty receiving and treatment ship. Aeromedical to casualty receiving and treatment ship is by USN or USMC lift of opportunity or in some cases by USA helicopter.

c. A Navy expeditionary medical facility (EMF) consists of health services, construction and support personnel as well as deployable medical system equipment, materials and consumables configured to support and provide up to theater hospitalization capability. The EMF mission is to set up, operate, and maintain a deployable medical facility ashore in an advanced base environment. The EMF will receive patients from forward medical facilities or directly from combat areas in order to provide full resuscitation and emergency stabilizing surgery within the prescribed evacuation policy throughout the range of military operations.

d. **Hospital Ships.** Two hospital ships operated by Military Sealift Command are designed to provide emergency, on-site care for US forces during military operations. No USN or USMC dedicated evacuation support currently exists for USN ships. The *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. The actual patient capacity will vary based on the type and severity of casualties anticipated, as well as mission tasked. For further information, see the Chief of Naval Operations Instruction 3501.161D, *Required Operational Capabilities and Projected Operational Environment for the T-AH 19 Mercy Class Hospital Ships*.

For more information on hospital ship capabilities, see NTTP 4-02.6, Hospital Ships.

e. The USN currently has no dedicated AE resources at definitive care capability MTFs. Therefore, USN doctrine relies on the collocation of a staging facility with FHP elements to facilitate patient evacuation. Although movement assets are primarily provided by the USAF, Figure C-1 depicts fixed-wing USN assets which could be employed on a case-by-case basis.

9. United States Marine Corps

The USMC depends on USN and other JTF evacuation assets for support. The USMC has no theater hospitalization capability assets.

10. Coast Guard

The USCG depends on USN and other JTF evacuation assets for support. The USCG has limited first responder care capability and no forward resuscitative care capability or theater hospitalization capability.

SECTION C. SUPPORTING UNITED STATES ARMY EVACUATION ELEMENTS AND REQUEST PROCEDURES

11. General

a. The USA typically is the primary provider of air and ground MEDEVAC assets to the CCDR. The USA has dedicated assets specifically organized to provide this function.

USA MEDEVAC provides forward patient movement to members of the joint force as well as HN, interagency, NGOs, detainees, and DOD and non-DOD civilians and contractors.

b. USA MEDEVAC in a theater may be provided in a general support or direct support role based on the requirements of the joint force. If available and allocated, team or company sized elements of USA air or ground ambulances can be tasked to directly support those elements of the joint force that do not have sufficient organic evacuation assets.

c. The support roles and allocation of MEDEVAC units are directed through the CCMD joint patient movement system (appendix 1 [Joint Patient Movement System] to annex Q [Medical Services] of the OPLAN or OPORD). 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 joint force units, missions, and theater geography.

d. USA 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.

12. Evacuation Through the Joint Capabilities of Care

a. Within the area JOA, 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. USA patient evacuation of casualties in the JOA occurs from point of injury or illness to the appropriate capability of care. The USA uses this system to move its patients from point of injury through theater hospitalization capabilities of care and coordinates with the PMRC to ensure a seamless and cogent integration with the joint intertheater patient system. CASEVAC is a part of the USA doctrine. However, when utilized it requires deliberate and distinct planning used when dedicated patient movement assets are overwhelmed.

13. United States Army Medical Evacuation Units

a. Air Ambulance Company

(1) **Configuration.** An air ambulance company consists of 15 MEDEVAC HH-60/UH-72A's and approximately 109 assigned personnel. An air ambulance company is assigned to a general support aviation battalion.

(2) **Search Helicopter/MEDEVAC HH-60 Air Ambulance.** Each MEDEVAC 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 15 MEDEVAC HH-60 aircraft results in a total lift capacity of 90 litter or 84 ambulatory patients.

(3) **UH-72A Air Ambulance.** Each LUH-72 is capable of carrying two litter patients resulting in a total lift capacity of 24 litter patients.

(4) **Mission.** The air ambulance company's mission is to conduct MEDEVAC within an operational area.

(5) **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 and one area support MEDEVAC platoon consisting of three aircraft.

(c) Air crash rescue support, less fire suppression, in combat search and rescue operations.

(d) Rapid delivery of blood and blood products, 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 percent mobile and normally consists of 24 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 vehicle and high mobility multipurpose wheeled vehicle derivatives are used. Each has a four-litter or eight ambulatory patient capacity. For airborne or high mobility operations the mechanized M996 derivative is used, with a two 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

USA 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, or seaports.
- (c) Emergency movement of medical supplies.

14. Evacuation Request Procedures

a. **General Instructions.** Procedures for requesting MEDEVAC are derived from an established joint patient movement system (appendix 1 [Joint Patient Movement System] to annex Q [Medical Services] of the OPLAN or OPORD). The same format is used for requesting both air 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. **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.

c. **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 six and nine in Figure C-7. 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.

d. **Transmission of the Request.** Medical evacuation 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 pickup site.
- (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 C-7, line two of the request) in order to receive contact from the evacuation vehicle.

(2) **Receiver Acknowledgment.** After the opening statement is made, the transmitter breaks for acknowledgment.

e. **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.

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 C-7. 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 C-7. 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) Chemical, Biological, Radiological, or Nuclear Contamination	Include this line only when applicable. Encrypt the applicable brevity codes. C – Chemical. B - Biological. R - Radiological. N - Nuclear.	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.
Legend Pnt patient RTO radio/transmitter operator SOI signal operating instructions SURG surgical				

Figure C-7. Description of Medical Evacuation Request Preparation (cont'd)

15. 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 C-8.

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 C-8. 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 C-8. 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 C-8. Medical Evacuation/After-Action Record (cont'd)

APPENDIX D MEDICAL LOGISTICS SUPPORT

1. Introduction

a. MEDLOG provides life cycle management for the specialized products and services required to support HSS and FHP. These products and services are used almost exclusively by the medical 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 US. MEDLOG functions are managed within the health system using DOD standard business processes and medical information systems, and are supported by organizations and business processes that are adaptable, scalable, and tailored to the medical mission. Primary MEDLOG functions provided in support of the CCDR include:

- (1) Medical supply chain management (Class VIIIA), including gases.
- (2) Medical equipment and technology management.
- (3) Medical equipment maintenance and repair.
- (4) Optical fabrication and repair.
- (5) Blood storage and distribution (Class VIIIB).
- (6) Medical facility planning and management.
- (7) Medical logistic services.
- (8) Medical contracting support.

b. MEDLOG support requires intensive management and close collaboration among medical logisticians and clinicians throughout all roles of care to ensure that MEDLOG is responsive to clinical demands. The vast majority of medical supplies and equipment used in health support are commercial, non-developmental items that are subject to rapid changes in technology and clinical practice. MEDLOG support is characterized by a lean, intensively managed supply chain that extends from the national supplier network 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 MEDLOG capabilities.

2. Organization for Medical Logistics 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.

b. The Military Departments provide fully equipped and provisioned operational medical units, to include the necessary force structure to provide MEDLOG support for their respective Services. The Services also provide the requirements data necessary to forecast and source the types and quantities of medical materiel to be procured by DLA for health support across the range of military operations.

c. The GCC is ultimately responsible for the MEDLOG and the required medical materiel and equipment for their assigned and attached units.

(1) A designated CCMD surgeon advises the GCC on all MEDLOG support matters and provides the following MEDLOG functions:

(a) Prepares the detailed MEDLOG guidance, tasks, and joint MEDLOG CONOPS.

(b) Develops the theater pharmaceutical formulary in conjunction with the senior pharmacy officer and other medical materiel policy guidance and planning factors for the GCC, to include:

1. Preparatory requirements for pre-positioning of medical materiel, including medical biological chemical defense materiel, medical countermeasures (such as 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 GCC on the joint application of MEDLOG resources to promote efficiency and minimize the MEDLOG footprint. This includes recommendations for establishment or designation of a SIMLM and coordination with the DLA for designation of a TLAMM.

(d) Maintains liaison with component surgeons and resolve MEDLOG conflicts surfaced by component commands.

(e) Maintains liaison with attached medical units responsible for execution of the MEDLOG mission(s), as well as theater MEDLOG organizations, to include the DLA and its regional command, TLAMM (if designated), the JDDOC, the joint mobility control group, and the MEDLOG management center.

(f) Monitors MEDLOG support, to include status of critical and/or special interest materiel or systems, MEDLOG staffing, and supply chain performance.

(g) Supervises the activities of the AJBPO.

(h) Advises the GCC on the disposition of captured enemy medical materiel in accordance with the Geneva Conventions.

(2) The GCC establishes capabilities for theater MEDLOG by requesting the operational MEDLOG forces required to support the medical plan. To the extent possible, theater MEDLOG leverages distribution capabilities and information technology to minimize layers of storage and MEDLOG management, and employ MEDLOG capabilities that support all Service components and designated multinational partners to minimize unnecessary redundancy and promote supply chain efficiency. Theater MEDLOG is employed as part of the integrated medical system typically under the management control of the Service component. MEDLOG support functions are performed at every role of the medical system and are dependent upon integrated plans and processes that are fully synchronized with theater medical operations.

(a) First responder and forward resuscitative care capabilities are the theater's most far-forward, highly disbursed, and fast-moving medical 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 MEDLOG functions are management of organic medical sets and equipment, and initiating and managing requests for replenishment or maintenance support. Management and replenishment of organic medical equipment sets relies heavily upon end users who have clinical or other primary responsibilities that are non-logistics functions. Forward resuscitative care also includes limited medical supply and maintenance provided by organic Service component tactical MEDLOG elements. Successful MEDLOG is reliant upon processes and supporting systems that are simple to use and reliable. The MEDLOG system also relies heavily upon intratheater distribution capabilities that provide time-definite delivery and timely and accurate in-transit visibility. First responder and forward resuscitative care MEDLOG capabilities are controlled by the medical or maneuver unit of which they are an organic part.

(b) Theater hospitalization units include hospitalization as well as modular, specialty capabilities that comprise an integrated, multifunctional medical system. It represents the most complex supply and equipment requirements for MEDLOG. Most of these units include organic MEDLOG capabilities to manage unit-level inventory and medical maintenance, support internal customers, and provide limited area support to external customers or attached medical teams. These units are supported by theater-level and/or strategic MEDLOG units or organizations provided by the Services in response to the GCC plan.

(c) Theater level MEDLOG is tailored to the mission, supported force, threat, and geography of the supported theater. It is comprised of operational MEDLOG units requested by the GCC and task organized within the theater medical system to

responsively and efficiently sustain all supported forces. Theater-level MEDLOG capabilities reach directly into national commercial supplier networks or institutional MEDLOG organizations of the Military Health System. Theater MEDLOG 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 MEDLOG to supported forces.

d. The SIMLM responsibility is assigned, as required, by a the GCC to a Service component command or element of a JTF to provide MEDLOG support to other Services and designated multinational partners. Single integrated MEDLOG management is established to promote supply chain efficiency and minimize the theater MEDLOG footprint. When directed, the SIMLM, in coordination with the JFS, DLA, and supporting TLAMM (if designated), will develop a MEDLOG plan and identify additional requirements necessary to provide MEDLOG support to all designated customers and effectively extend MEDLOG 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 MEDLOG operations in order to meet expanded mission requirements.

(2) The assignment of the SIMLM is mission-specific and depends upon the composition of the supported force (such as, one Service versus multiple Service components) and the complexity of intratheater distribution (such as, 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 MEDLOG capabilities provided by other Services at the direction of the GCC, or by the other Services providing forces to the GCC. SIMLM supports optimization of supply chain management without claim to authority.

(4) A MEDLOG 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) Class VIII storage and distribution, to include storage and management of critical items and other materiel of special interest to the JFS.

(b) Coordinating Class 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 JFS.

(d) Assessing Class VIII readiness and advising the JFS.

(e) Planning and synchronizing medical maintenance and repair support, including contracted maintenance services.

(f) Planning and coordinating medical assemblage production, optical fabrication and repair, 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 FHA or civil affairs 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, the SIMLM will coordinate the flow of logistics information/flow of Class VIII materiel from US sources of supply and the US based Class VIII national inventory control point and Service item control centers. It will also coordinate the distribution/transportation of Class VIII (A & B) materiel to US forces deployed to the operational area. As the operation continues and the theater matures, the SIMLM will also maintain visibility of materiel critical to the treatment and evacuation of patients. When appropriately equipped, the SIMLM will maintain total asset visibility/in-transit visibility of all theater Class VIII assets.

e. The DLA is the DOD executive agent for medical materiel pursuant to DODD 5101.9, *Executive Agent for Medical Materiel*. The executive agent supports the CCDR within the following broad operational framework:

(1) The Services organize and equip fully capable medical personnel and may be tasked to deploy Service unique MEDLOG personnel to accomplish medical operations in support of the CCDR.

(2) The 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 medical operations.

(3) Designated lead agents provide the operational capability to execute executive agent strategic programs and end-to-end supply chain management in support of the CCDR. There are 2 types of lead agent:

(a) Functional lead agents, such as the Defense Medical Logistics Proponent Committee and the Defense Medical Materiel Program Office, develop functional requirements to support best business processes and promote materiel standardization, respectively.

(b) Theater lead agents for medical materiel are organizations designated by the CJCS to provide medical materiel distribution and assistance the CCDR in requirements and medical supply chain planning.

(4) The CCDR in coordination with the DOD executive agent establishes the overall medical supply chain strategy as part of the MEDLOG plan for annex Q (Medical Services). 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. The supply chain strategy may incorporate discrete MEDLOG capabilities provided by one or more Services or the joint augmentation of MEDLOG 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 MEDLOG and supply chain management. It provides a support operations structure that has habitual relationships with medical customers, supporting MEDLOG organizations, transportation and distribution managers, and the supported JFS. A TLAMM may be an existing organization that provides routine medical materiel support to theater medical operations, or an organization that is created as required for a specific OPLAN by deployment of the necessary MEDLOG capabilities. It is normally operated by a Service component command as part of the integrated medical 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 MEDLOG functions required to support medical operations. These include medical supply, medical equipment maintenance and repair, optical fabrication and repair, 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 MEDLOG agencies are responsible for managing MEDLOG programs that support the projection and sustainment of their respective Services' operational forces. These agencies include the USA Medical Materiel Agency, the USN MEDLOG Command, the USAF Medical Operations Agency, and USMC Systems Command. While each of these agencies has Service-specific responsibilities and chains of command, they perform similar functions that support theater medical 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 MEDLOG information relative to medical assemblages and equipment.
- (5) Medical materiel fielding programs.
- (6) Management of pre-positioned unit sets and sustainment materiel.

h. The MEDLOG Management Center is a USA MEDLOG organization that supports theater MEDLOG operations. Its responsibilities include monitoring critical medical items and systems and assessment of medical supply chain performance. The MEDLOG Management Center maintains close coordination with all theater MEDLOG units, the TLAMM, the JFS and other Service components as well as with the DLA and its strategic network supplies to facilitate effective MEDLOG support to the CCDR.

(1) The Army MEDLOG Management Center is designed to provide centralized theater-level commodity management of Class VIII materiel in accordance with the JFS's policies. It is a modular organization designed to operate in a split-based mode. Its US strategic base provides centralized medical materiel and linkage to national-level capabilities and readiness programs. On order, it deploys a forward support team to each theater to manage and synchronize theater-level MEDLOG support for the JFC. When deployed, the MEDLOG Management Center forward support team is assigned to the USAs medical command (deployment support).

(2) The MEDLOG Management Center forward support team coordinates with the distribution management center of the USA theater sustainment command or JDDOC established by the GCC to manage theater distribution. This MEDLOG Management Center remains under the control of the medical commander, but works closely with theater distribution and movement managers to coordinate medical requirements and promote efficient and effective use of distribution resources.

(3) The MEDLOG Management Center provides technical direction to all Army operational MEDLOG units that comprise the theater MEDLOG system, to include those that fall under the OPCON of subordinate medical HQ. This is to ensure synchronization and visibility of MEDLOG activities throughout the theater and to ensure that supply chain management is not fragmented by MEDLOG unit boundaries. Its scope includes all aspects of theater materiel and medical maintenance support as well as other MEDLOG functions such as optical fabrication and repair, equipment reconstitution, materiel fielding, assemblage management, and provision of medical gasses, and local contracting support for medial materiel and services. It may also plan and coordinate support from local, foreign sources of supply (when required), as well as MEDLOG provided to, or received from, multinational partners.

(4) The MEDLOG planner should address the need for early deployment of a MEDLOG Management Center forward support team into the theater to assist the

medical commander and JFS in establishing, managing, and assessing MEDLOG operations in support of arriving forces.

i. Defense Logistics Agency Commands and Agencies

(1) The DLA Troop Support 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. DLA Troop Support also establishes national maintenance contracts for major medical equipment systems, particularly diagnostic imaging, that may be accessed by theater MEDLOG managers. DLA Troop Support is the lead organization within DLA for implementation of DOD executive agent for medical materiel and the synchronizing of medical supply chain activities among the Services, other DLA commands, and designated lead agents.

(2) DLA distribution centers provide storage and distribution of medical materiel that is held in DOD national-level inventory. DLA distribution centers also provide “kitting” and assembly operations for the production of medical assemblages and configured supply packages in support of Service MEDLOG.

(3) Defense Logistics Information Service manages DOD MEDLOG data, providing data products used to update MEDLOG catalogs and disseminate MEDLOG catalog information to DOD users. The Universal Data Repository is the primary Defense Logistics Information Service information product used by MEDLOG activities.

j. The resourcing of medical materiel requirements is a key factor in execution of MEDLOG plans, particularly with regard to the acquisition of medical materiel necessary to initially deploy medical units, to pre-position medical materiel in theater for medical sustainment, and to conduct theater supply operations within a working capital fund. DLA Troop Support, 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 required, 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 CCMDs. 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 MEDLOG units as well as strategic and theater distribution assets.

(2) **Department of Defense Executive Agent Responsibilities.** DLA, as the DOD executive agent 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 pre-position materiel in strategic locations to support CCDR requirements. The requirement to pre-position medical materiel in theater is determined by the CCDR in coordination with the executive agent and supported Service component, and made a part of the negotiated performance-based agreement between the executive agent and the CCDR. Performance based agreements will be established between DLA and each CCDR, formalizing performance standards, metrics, and operational roles and responsibilities for medical supply chain support to the CCDR and medical operations.

3. Theater-Level Medical Logistics

a. Theater-level MEDLOG refers to the functions that manage, coordinate, and synchronize the execution of the MEDLOG plan in support of theater medical operations. Theater-level MEDLOG typically includes support to all Service components and designated multinational forces. MEDLOG functions are usually provided by operational MEDLOG units (including the MEDLOG Management Center) that are tailored and scaled to the mission and phase of the operation and operate in close coordination with a designated TLAMM and the DLA. Theater-level MEDLOG operations may be under the control of the operational medical HQ assigned responsibility for theater MEDLOG support and may be under the oversight of the JFS. These operations include intermediate-level medical supply operations that provide theater storage and distribution of medical materiel. Primary MEDLOG functions accomplished at the theater level that must be addressed in the medical plan include:

- (1) Execution of theater preparatory tasks for MEDLOG.
- (2) Port operations and reception, staging, onward movement, and integration.
- (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.
- (7) MEDLOG information systems management.

b. **Execution of Theater Preparatory Tasks for MEDLOG.** 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 MEDLOG capabilities necessary to support reception, staging, onward movement, and integration and initial entry medical operations. Pre-positioned materiel may include stocks for initial sustainment, medical operations during reception, staging, onward movement, and integration, and special medical materiel such

as medical biological chemical defense materiel, special vaccines, and other medical materiel under control of the JFS.

c. Port Operations and Reception, Staging, Onward Movement, and Integration. Health support must be capable of operations immediately upon arrival of initial entry of forces (even with permissive entry); therefore, MEDLOG must be included in planning for port opening and early entry operations. In almost every operation, lessons learned reflect that theater MEDLOG units must also provide Class VIII materiel for unit shortages that were not filled prior to unit embarkation. Planning for MEDLOG operations during early entry/reception, staging, onward movement, and integration 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 equipment sets.

(2) The issue of medical unit sets from pre-positioned stocks or war reserve materiel.

(3) Coordination for movement of medical materiel, to include medical equipment sets, from the sea or aerial port of debarkation 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 medical equipment sets or sustainment shortages.

d. Area Support to First Responders and Forward Resuscitative Care Capabilities. First responders and forward resuscitative care 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. MEDLOG support to these units is generally provided on an area basis by theater MEDLOG 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 aerial port of debarkations to facilitate patient movement as well as resupply, and be made direct customers of the most capable MEDLOG organization at the theater or strategic level.

f. **Direct Support to the Maneuver Force.** MEDLOG elements organic to maneuver forces are reliant upon supply chain capabilities that are provided by theater level MEDLOG organizations. Theater level MEDLOG organizations Class VIII support should be tailored to provide Class VIII support with customer wait times that are acceptable to the maneuver forces.

g. **Support to Redeployment/Retrograde Operations.** The redeployment of forces presents MEDLOG requirements for command policy as well as MEDLOG operations. During prolonged operations with force rotations, redeployment/retrograde operations may occur simultaneously with reception, staging, onward movement, and integration 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 medical biological chemical defense materiel and drugs issued for use as 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 MEDLOG units/organizations will support medical 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” or “left behind equipment” as well as retaining equipment purchased with theater funds).

(d) The collection point for medical materiel and equipment identified as no longer required by the DOD for final disposition. Final disposition of medical materiel and equipment from the DOD inventory includes transfers to other governmental agencies, support to US allies and humanitarian assistance missions through Department

of State programs, transfers to DLA Distribution Services for disposition, or sales onto secondary markets or disposal.

h. Time Phasing of MEDLOG. The MEDLOG 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 MEDLOG plan should permit flexibility to scale capabilities up or down as appropriate to adapt to medical requirements during every phase of an operation. The flexibility to scale MEDLOG will be enhanced by establishing an overarching concept for theater medical supply chain management and placing theater-level MEDLOG capabilities under the control of a senior medical commander charged with execution of the MEDLOG plan. Flexibility may also be achieved by integrating support from all sources to include reachback into the MEDLOG plan.

(1) Health support must be available to support initial entry forces (even with permissive entry); therefore, MEDLOG must be planned for port opening and early entry operations. During the early phase, Class VIII sustainment may rely upon preconfigured packages shipped from the national level or pre-positioned theater stocks. Preconfigured “push packages” of Class VIII historically produce a great deal of wasted materiel, therefore, sustainment should transition as quickly as possible to line item requisitions. MEDLOG capabilities will build in the theater with the arrival of forces sufficient to ensure effective support of medical operations.

(2) As communications and movement capabilities mature, theater MEDLOG should be able to leverage more reliable distribution capabilities to satisfy most customer orders from theater or even from strategic-level stocks. The MEDLOG footprint should be driven by customer wait time; that is, MEDLOG capabilities should be positioned in the supply chain to be able to deliver the support required within a time-definite standard set in the MEDLOG plan and theater performance-based agreements.

(3) Maturing theater communications and distribution channels may allow the MEDLOG footprint to be reduced to achieve greater efficiency. To the extent possible, customer orders should be filled from the highest level of MEDLOG 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 medical JFS. Plans to ‘right-size’ the theater MEDLOG footprint will be developed by the medical commander charged with executing the MEDLOG plan with the oversight of the JFS.

(4) During retrograde operations, MEDLOG capabilities may have to be increased to effectively manage additional work associated with recovery, inspection, refurbishment, and/or packing for shipment or return to war reserve materiel storage.

4. Distribution of Medical Materiel

a. The DLA and the 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 MEDLOG managers within the theater medical system. The medical 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. MEDLOG managers must work closely with the movement control elements at all levels to make the most effective use of transportation resources to meet medical requirements.

c. National-level distribution of medical materiel is primarily accomplished by commercial partners, including medical prime vendors, manufacturers, and other third-party 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. Materiel not available through DLA Troop Support prime vendor or ordering systems is locally managed by individual medical facilities; these facilities coordinate delivery of locally managed materiel to the forward operating base.

d. Strategic distribution to overseas theaters is primarily accomplished through commercial tenders arranged by DLA in coordination with the 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 Deployment and Distribution Operations Center and movement management elements within the theater. MEDLOG units do not provide transportation of materiel. Priorities for movement of Class VIII material are established by the CCDR and supported maneuver commanders. MEDLOG managers must recognize that, historically, Class VIII has had a lower priority for movement than other commodities; therefore, supply chain activity and the medical materiel status of medical 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 medical operations.

f. Special considerations for storage and distribution of medical materiel. These requirements will pose special challenges during early operations when MEDLOG 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 degrees Celsius/41-86 degrees Fahrenheit). Most laboratory reagents and vaccines as

well as blood require storage and transport temperatures be maintained within a specified range. This poses a challenge for storage at operational MEDLOG 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 during transit require special quality control procedures by MEDLOG personnel to interpret, report, and act upon the information provided.

(2) **Storage and Shipping.** Most operational MEDLOG 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 MEDLOG 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 MEDLOG personnel appropriately trained in packing procedures for wet and dry ice shipments (improper packing has destroyed many medical shipments).

(e) The training of MEDLOG 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. MEDLOG planning must include the provision of appropriately secure storage, the availability of appropriately trained MEDLOG 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. MEDLOG planning should consider the placement of small teams of MEDLOG 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.** Class VIII sustainment shipments for most medical customers typically are relatively low weight/cube. This poses a challenge because aerial ports try to make maximum use of aircraft capacity, leading to Class VIII materiel being held until there is sufficient volume to justify an aircraft. This increases customer wait time and increases the risk that medical materiel will be lost or will deteriorate while being held pending movement. MEDLOG planning should work closely with the Deployment and Distribution Operations Center and aerial port managers, especially for remote/dispersed customers, and establish customer wait time 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. MEDLOG planning must work closely with the deployed distribution and operations center office to ensure awareness of customer requirements and to develop distribution strategies that meet medical 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 MEDLOG 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.** MEDLOG 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 MEDLOG personnel as well as appropriate storage facilities and containers/placards for shipment. MEDLOG unit training must include the certification of personnel to sign movement documentation for hazardous cargo. MEDLOG 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 an HN as well as unnecessary risk to US personnel.

5. Information Management

a. The theater medical information program provides the suite of DOD standard applications that support theater medical operations. These include medical C2, health care delivery, patient tracking, and MEDLOG. The theater medical information program applications are fielded and maintained by each Service.

b. The Defense Health Services Systems office in conjunction with Theater Medical Information Program-Joint provides the DOD standard applications for MEDLOG in

both institutional and operational environments, respectively, integrating national and operational-level business processes, medical information management, and medical information technology. The Defense Medical Logistics Proponent Committee, under the direction of ASD(HA), is the functional proponent for the Defense Medical Logistics Standard Support Automated Information Systems as well as business process innovations that increase the efficiency and effectiveness of MEDLOG support of health support across the full range of military operations. The Defense Medical Logistics Standard Support applications enable end-to-end management of MEDLOG processes. These include:

(1) The Defense Medical Logistics Standard Support provides medical supply, medical equipment management and maintenance, assembly management, facility management, and customer support functions.

(2) The Defense Medical Logistics Standard Support Customer Assistance Module provides a simple, laptop-based tool for customer order management for tactical medical units. The Defense MEDLOG Standard Support Customer Assistance Module provides tactical customers with a ‘store and forward’ capability when communications are not available.

(3) The Theater Enterprise Wide Logistics System provides an enterprise-level solution for the total life cycle management of medical assemblages and Class VIII supply chain management.

(4) **The Joint Medical Asset Repository.** Joint Medical Asset Repository is a web-based data repository that provides worldwide asset visibility for medical materiel.

c. **Communications.** MEDLOG is highly dependent upon reliable and timely data and voice communications to exchange information among customers, MEDLOG units, commercial suppliers, and transportations systems. Theater MEDLOG 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. MEDLOG planning must address the need for reliable data connectivity for MEDLOG customers and organizations, especially during the earliest stages of theater operations before theater communications capabilities are fully mature. MEDLOG planners must coordinate closely with their J-6 and understand the communications plan for the operation. MEDLOG issues that should be considered include:

(1) Medical units’ ability to communicate requirements and receive status.

(2) Medical units’ ability to communicate with customers as well as supporting theater and national-level organizations.

(3) MEDLOG 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 medical/MEDLOG support.

(6) Training, fielding, and in-theater support for hardware and applications.

6. Medical War Reserve Materiel

a. **War Reserve Materiel Requirements.** The DOD programs and maintains war reserve materiel 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. War reserve materiel requirements are programmed and met through five basic strategies:

(1) Pre-positioned equipment 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 war reserve materiel stocks pre-positioned in or near a theater of operations to last until resupply is established.

(3) Swing stocks are war reserve materiel 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 War Reserve Materiel Programs.** Each Service computes, programs, funds, and manages Service-specific programs to meet planned operational requirements for medical materiel. Service programming includes pre-positioned equipment sets and war reserve materiel stocks to provide initial operating capability for their operational forces.

(1) **United States Army.** The USA pre-positioned stock program is comprised of 3 major components: pre-positioned brigade and equipment sets; pre-positioned operational project stock; and pre-positioned sustainment stock. The USA Pre-positioned

Stock Program is stored at strategic land based locations and aboard pre-positioned ships. Packages of potency-dated supplies are also provided through vendor managed inventory programs to provide full unit operational capability and initial sustainment upon activation.

(2) **United States Navy.** The EMF Program provides pre-positioned unit sets stored at strategic locations, and provides packages of potency-dated supplies through contractor programs to provide full operational capability and initial sustainment upon activation.

(3) **United States Air Force.** Starter and resupply stocks are maintained at US and overseas MTFs and other strategic locations. Vendor managed inventory programs for selected materiel provides full operational capability upon activation. Deployed USAF medical units use expeditionary MEDLOG, a “reachback” system of support, for sustainment of early-deployed USAF platforms until the TLAMM becomes fully operational.

(4) **United States Marine Corps.** The USMC units are supported by the maritime pre-positioning ships squadrons.

c. **Commercially Based Contingency Programs.** To the extent possible, the DLA manages commercially based contingency programs with numerous manufacturers and distributors to meet medical war reserve materiel requirements. The DLA commercial contingency programs include prime vendor “surge” capabilities, stock rotation contracts, corporate exigency contracts, and vendor managed inventories. These programs are especially useful in reducing the need to maintain potency-dated materiel in war reserve materiel 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 MEDLOG Planning.** The availability of medical materiel is critical to the success of the MEDLOG mission. MEDLOG planners must understand the CCDR’s operational requirements and how war reserve materiel 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. Planning considerations must include:

(1) Adequate pre-positioned equipment sets and standing war reserve materiel stocks to meet operational requirements.

(2) TPFDD plans to support the execution of the medical plan.

(3) TPFDD plans to provide sufficient MEDLOG capability to receive, store, and begin distribution operations in support of the medical 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 Medical Maintenance.** Medical equipment maintenance and repair is a core function of MEDLOG and critical to medical operations. Health care delivery at every role of the medical system is highly reliant upon specialized equipment requiring service and repair that can only be provided by appropriately trained medical equipment technicians. 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 medical equipment technician training have increased medical capabilities for joint interoperability and support and provided technicians that are exceptionally versatile in supporting the technology demands of health support. 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. **Medical 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 medical units in the theater make simple exchange of unserviceable equipment an unrealistic basis for maintaining equipment operational availability. MEDLOG planners must understand the organic medical equipment technician capabilities of medical units and ensure that medical equipment maintenance capabilities at the theater level are appropriately scaled to adequately support the medical plan and CONOPS.

(1) At forward locations, medical equipment repair technician capabilities are limited to first response diagnosis, component exchange, and relatively simple repair.

(2) Theater hospitalization capabilities normally have a medical 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 medical maintenance capabilities are provided by the TLAMM and/or operational MEDLOG units employed as part of the theater medical system. These organizations have personnel and expertise to provide support to medical 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 medical 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 medical maintenance capabilities are provided by the Services' MEDLOG agencies and by DLA Troop Support, 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 and third party maintenance vendors, and provision of national contracts and/or one-time contracts for maintenance and repair services. The MEDLOG agencies also are able to project medical equipment maintenance assistance teams into the theater at the request of the CCDR.

c. Under the single integrated MEDLOG manager, the CCDR may direct one Service to provide theater medical equipment support to all supported Service components, and direct other Services to provide medical equipment technician augmentation necessary to accomplish this mission if required. This provides the medical commander with a single support organization for all theater MEDLOG as well as a single POC for national-level support agencies. While medical equipment maintenance is not a responsibility of DLA, the theater-level medical organization that is designated as TLAMM normally provides all core MEDLOG functions, to include medical equipment maintenance. Therefore, organizations designated as TLAMM will normally provide theater-level medical equipment maintenance as well as medical supply chain management and other MEDLOG functions directed by the CCDR.

d. **Other Considerations for Medical Equipment Maintenance.** The concept of support for theater medical equipment maintenance should be scaled to meet medical requirements with the smallest possible theater footprint. The single integrated MEDLOG manager may be employed to reduce theater redundancy and more efficiently synchronize the use of MEDLOG 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 single integrated MEDLOG manager mission, the TLAMM would provide all medical components with on-site contact repair 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) DLA Troop Support provides national contracts with the original equipment manufacturers and third-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 CCDR requirements for predeployment processing and individual protection are met.

8. Threat of Chemical, Biological, Radiological, or Nuclear Weapons

a. **Medical Logistics Considerations.** The threat of CBRN weapons against US military personnel constitutes a tremendous medical 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 response to a CBRN incident will depend upon the CCDR's assessment of the threat and directives for planning and materiel readiness. MEDLOG considerations may include:

- (1) Management of medical biological chemical defense materiel.
- (2) CBRN response sets.
- (3) Disruption of distribution channels.
- (4) Threats to medical units.
- (5) Reconstitution of MEDLOG capabilities.
- (6) Partnership with other USG departments and agencies.

b. **Medical Biological, Chemical Defense Materiel.** The MEDLOG plan may have to provide theater storage for individual medical biological chemical defense materiel 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. CCDR 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 medical biological chemical defense materiel to contractors, embedded reporters, and other non-DOD personnel.

c. **CBRN Response Sets.** The medical plan may require theater storage and plans for distribution of preconfigured packages of medical materiel developed for CBRN response. Information on the composition of CBRN response sets and their availability should be coordinated through the TLAMM and the Service MEDLOG agencies.

d. **Disruption of Distribution Channels.** CBRN incidents may make targeted distribution nodes unusable and destroy medical materiel in storage or in-transit. MEDLOG managers must work closely with 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 Medical Units.** The deliberate or accidental introduction of chemical or biological agents into water sources, foodstuffs, or other supplies used by theater hospitals may occur. Medical 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 MEDLOG Capabilities.** CBRN incidents may require the reconstitution of medical capabilities. This could involve the release of medical equipment items being held by the TLAMM or other MEDLOG units, or the fielding of new equipment sets from war reserve materiel or national sources.

g. **Collective Protection.** In the event of a CBRN incident, medical personnel must be ready to conduct medical operations in a safe and protected environment. Adequate collective protection capabilities, able to withstand all types of expected hazards, must be available and prepared to operate.

h. **Partnership With Other USG Departments and Agencies.** DLA, as the DOD executive agent, coordinates with Federal agencies that maintain strategic capabilities for a CBRN response. These include the Department of Veterans Affairs, the Department of Health and Human Services, and the Centers for Disease Control and Prevention. 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 vendor managed inventory 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. MEDLOG 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 Medical Logistics Planning Considerations

a. **Foreign Sources of Materiel.** The JFS and MEDLOG 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 Class VIII supplies and equipment are commercial, nonstandard products obtained by Service MEDLOG 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 identification and

packaging that, in many cases, do not meet all Defense Transportation System requirements for the labeling of packages destined for DOD customers. When such packages are routed through Defense Transportation System distribution hubs, they frequently become frustrated.

(1) MEDLOG managers should monitor distribution hubs for backlogs of frustrated Class VIII shipments and consider assigning a MEDLOG liaison to critical hubs to serve as medical freight expeditors, if the situation warrants.

(2) MEDLOG planners should coordinate with the TLAMM to route shipments from commercial vendors in the US through designated commercial activities serving as a “medical air bridge.” These are prime vendors under contract with DLA acting as 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. Medical logistic 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 from the CCDR in coordination with 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 FHA 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 medical plan must include command policy for reporting, handling, and disposition of excess or unserviceable medical 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 MEDLOG units.

(2) Serviceable and unserviceable pharmaceuticals may be able to be returned through the TLAMM to commercial companies under contract with DLA Troop Support that in many cases return funds to DOD as credit.

(3) Serviceable excess materiel may be made available to HN or NGOs for FHA consistent with CCDR policy and direction.

(4) The local destruction of excess or unserviceable materiel must comply with HN laws and DOD policy. The MEDLOG planner should coordinate with the command environmental science officer as well as supporting engineer and contracting officer.

e. **Medical Logistics Support to Contractors.** Medical and MEDLOG planners must understand the GCC'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 MEDLOG support include the provision of prescription refills for chronic conditions and the provision of prescription eyewear.

APPENDIX E BLOOD MANAGEMENT

1. The Armed Services Blood Program

a. Established by the ASD(HA), the Armed Services Blood Program (ASBP) provides transfusion products when required to US forces worldwide. The Secretary of the Army, through the Surgeon General, serves as the DOD Executive Agent for the Armed Forces Blood Program Office (ASBPO) in accordance with DODD 6000.12, *Health Services Support*. Tri-Service cooperative efforts between the USA, USN, and USAF 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 the US to the battlefield. The various aspects of this coordination are depicted in Figure E-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 as established in *Standards for Blood Banks and Transfusion Services* (and found in Technical Manual 4-02.70, Navy Medical Publication P-5150, Air Force Manual [Instruction] [AFMAN{I}]41-111). The 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) Coordinate the day-to-day activities of the ASBP, in accordance with the policies established by the ASD(HA) and the plans, programs, standards, and procedures established by DOD, the CJCS, the CCMDs, and the Services. As required, serve as the DOD direct liaison for coordination and policy recommendations.

Armed Services Blood Distribution System

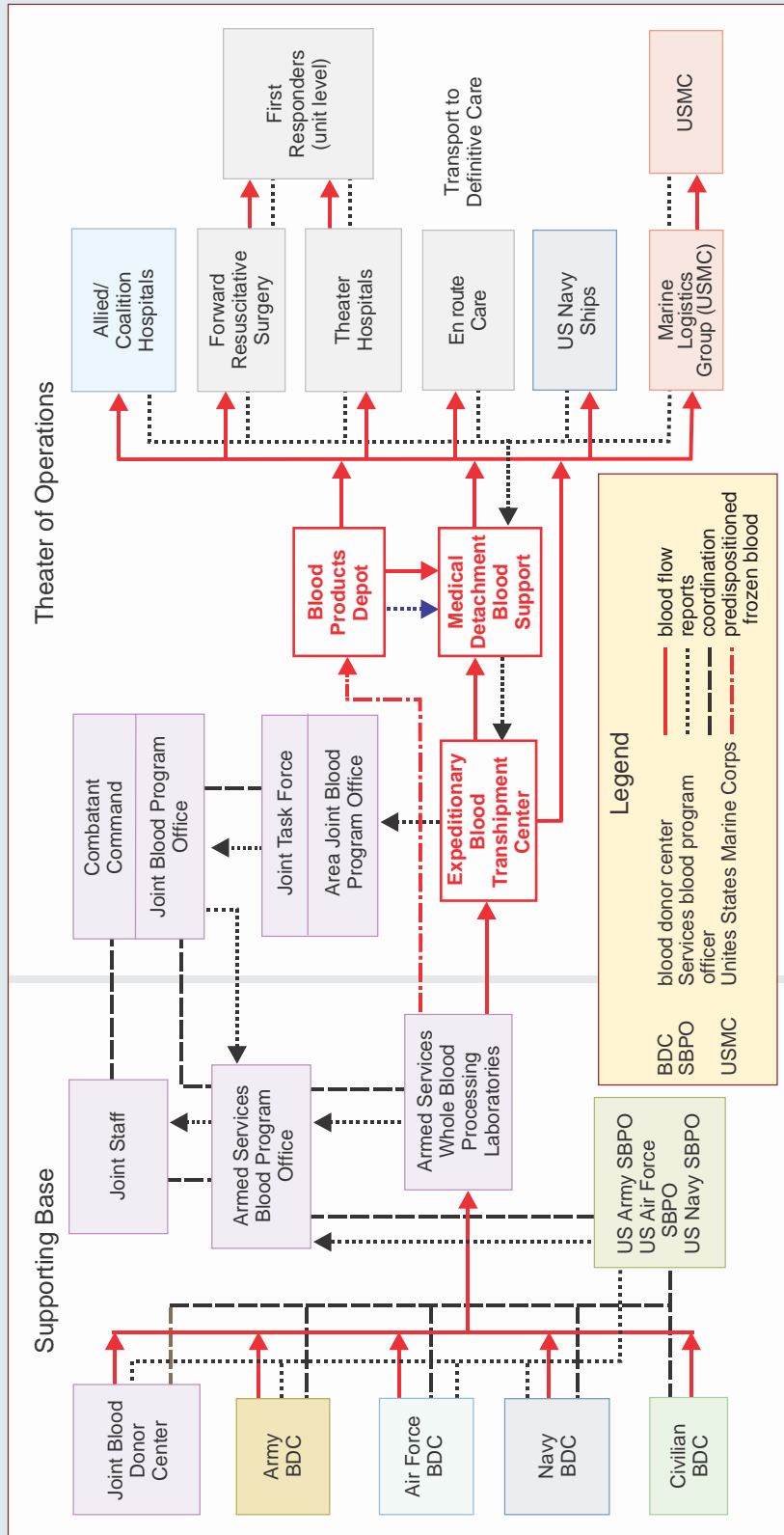


Figure E-1. Armed Services Blood Distribution System

(b) Serves as a military POC for blood bank matters for other USG and civilian agencies having an interest in blood products and related items. That includes, but is not limited to, the CCMDs and the following federal agencies:

1. The FDA, Center for Biologics and Research.

2. The Department of Health and Human Services Office of Emergency Preparedness and/or NDMS and the Blood Safety Committee.

3. The DLA for activation of the contingency blood contracts, blood equipment, and supply procurement contracts.

4. The Defense Medical Material Program Office on the development of essential characteristics of equipment, supplies, policies, and procedures associated with military blood banks.

(c) Direct the ASBPO, which shall be staffed by a minimum of three officers (Medical Service Corps [Army, Navy] and Biomedical Sciences Corps [Air Force]) in the grade of O-4, or above. One of the officers shall serve as the director and the others as deputy directors. All ASBPO members carry out their ASBPO assignments as their primary duty.

(d) Receive and take appropriate action on military requirements for blood products that exceed Service resources.

(e) Coordinate the preparation of written guidelines for blood bank policies to be used as minimum standards by the Services.

(f) Coordinate the development of technical aspects of blood research programs, conveying requirements through the ASD(HA) to the office for Armed Services Biomedical Research Evaluation and Management.

(g) Collate DOD emergency and mobilization blood product requirements, and ensure that plans are in place to meet those requirements.

(h) Establish contingency blood product quotas to be maintained at the Armed Services Whole Blood Processing Laboratories and assign requirements to the military Services to meet those quotas.

(i) In coordination with the CJCS, oversee the operations of the ASBP during contingencies.

(j) Coordinate theater blood program issues with the CCMDs through the CJCS. That includes the following:

1. OPLAN and contingency plan blood support review, to include sourcing of blood requirements.

2. Pre-positioning of frozen blood products, to meet contingency theater blood product requirements.

3. Direct liaison with partner nation programs.

c. **Service Blood Programs.** The USA, USN, and USAF operate separate blood programs to meet normal peacetime requirements. Services maintain their respective FDA licenses for blood establishments. Each Service blood program office has ultimate responsibility for ensuring that its blood facilities meet or exceed federal regulations and national standards for the blood industry. To meet ASBP contingency requirements, the Services direct expansion of their blood donor centers rapidly increase their blood collecting capabilities. Additional responsibilities of the Services with regard to the ASBP are described in DODD 6000.12, *Health Services Support*, and DODI 6480.4, *Armed Services Blood Program Operational Procedures*.

d. **Combatant Commands.** Each CCMD's JBPO serves as the Class VIIIIB 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 CCMD surgeon. This office is responsible for the joint blood program management in the JOA. 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.

(2) **Area Joint Blood Program Office.** The CCMD surgeon may direct the establishment of one or more AJBPOs 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 medical detachments, blood support, and MTFs in the AJBPO area regardless of Service component. This includes defining the distribution system for blood and blood products at all roles from the supporting expeditionary BTC or blood support medical detachment (MDBS)/blood supply detachment down to the MTF.

(b) Evaluates in-theater emergency blood collecting activities, blood products depot, expeditionary BTC, MDBS, and MTF transfusion services within the operational area to ensure the requirements of the JBPO are supported or addressed in the CCMD and/or JTF OPLAN.

2. Blood Support Care Capabilities

a. **Blood Distribution System.** Blood and blood products (Class VIII B) 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 JOA 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 MDBS, MEDLOG company, 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, multinational military and indigenous civilian medical facilities.

(4) Theater blood support may consist of a combination of shipped liquid, frozen blood components, or emergency collected whole blood or platelets. The actual amount of liquid and frozen blood components is determined by the urgency of need and availability of resources within the JOA. (Emergency collection of fresh whole blood in theater is a procedure that should only be used as a last resort when no fully tested blood products are available.)

(5) Blood services in a JOA 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 and apheresis platelets in the JOA. (This procedure should be used only as a last resort when no fully tested blood products are available.)

(e) Tracking/maintaining pertinent information for donor/unit testing and follow-up requirements and patient transfusion information to include non-FDA transfused products.

(6) The Armed Services Blood Distribution System from the supporting base to the MTF is depicted in Figure E-1. The JBPO or AJBPO will be responsible for the joint blood distribution system within their geographic area. The JBPO works for the CCMD 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. CCMD, subunified command, and JTF OPLANs will include projected blood requirements developed by the JMPT. These requirements are documented in appendix 2 (Joint Blood Program) to annex Q, (Medical Services) of OPLANs as prescribed in CJCSM 3122.03C, *Joint Operation Planning and Execution System, Volume II, Planning Formats*.

(7) **Theater MTFs**

(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 and apheresis platelets in emergencies. These emergency collections result in blood products that are considered non-FDA compliant. Non-FDA compliant blood products should only be used as a last resort. When non-FDA compliant blood must be transfused, it carries the risk of transmitting infectious diseases. To adequately mitigate this risk, proper controls must be applied to ensure every emergently collected blood product is retrospectively tested and proper follow-up of the blood recipient is accomplished. Patient follow-up also applies to US patients transfused in HN healthcare facilities.

1. When emergency blood collections are required, donors will be selected from among the following groups, in order:

a. Donors who have been pre-screened within the last 90 days by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory using all the current FDA-required blood donor infectious disease screening tests.

b. Donors who report being repeat blood donors in the past and have not been deferred for a transfusion transmitted disease. (Donation cards may serve as evidence of this.)

c. Donors who have not been pre-screened with FDA licensed tests, nor have been a blood donor in the past.

2. To the maximum extent possible, MTFs and US Navy vessels will establish and maintain rosters of pre-screened donors, and repeat the screening at regular intervals (not to exceed 90 days). Retrospective testing following an emergency blood donation may serve as a pre-screen for a subsequent donation.

a. All blood donors must be US personnel—military, DOD civilians, DOD contractors, or beneficiaries (non theater donation).

b. All prospective donors will be screened for eligibility on the day of donation using ASBP approved donor history screening protocols and ASBPO/CCDR approved infectious disease rapid screening test kits. NOTE: Use of infectious disease rapid screening test kits is not equivalent to testing with an FDA licensed screening test for donor eligibility.

c. Specimen sample tubes will be collected and labeled with a unique International Society of Blood Transfusion donor identification number at the time of blood donation, and sent to a designated CLIA certified donor testing laboratory for retrospective testing. Results of all pre-screening and retrospective testing will be provided to the theater JBPO.

d. Donor collection information will be submitted to the theater JBPO within 48 hours of collection. The required information will be determined by the theater JBPO but should at minimum include: donor's full name, unique identifier/Social Security number, unique donation identification number, organizational unit assigned, date of donation, location of donation, unit disposition (transfused, destroyed), unit disposition date, and any testing results (rapid or retrospective) available.

e. All records of emergency blood donation must be maintained in accordance with ASBP, Service, and/or GCC policies.

f. Follow up notification and counseling will be provided to any donor who tests positive on either the pre-screen, rapid, or retrospective test panels as follows:

(1) Document, track, and follow-up blood donors with positive infectious disease testing results, regardless of whether the unit was transfused.

(2) The donor will be deferred from subsequent blood donations, notified of the test results, and offered counseling.

(3) A PVNTMED or infectious disease agency will be utilized for ensuring all donors have been notified of their retrospective test results and the appropriate follow-up is completed (i.e., notification, counseling and treatment referrals).

(b) Submit required blood reports to their supporting blood distribution unit, as designated by the JBPO or AJBPO. This blood distribution unit 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 service blood program office should be notified to coordinate the provision of the necessary blood products prior to the unit's deployment.

(8) The MDBS is a modular unit that can usually support several MTFs depending on the operation, and may include supporting forces afloat. The JBPO determines the number of MTFs that an MDBS supports. The mission of the MDBS is to receive, store, process, and distribute blood products to its supported MTFs, collect whole blood and apheresis platelets on an emergency basis, and perform limited testing. An MDBS:

(a) To the maximum extent possible, maintain a 100 percent resupply of the blood products based on its supported MTF requirements or as designated by the JBPO. Maximum storage capacity is 4,080 RBCs.

(b) Is deployable with blood products when the operation involves immediate conflict.

(c) Is modularly tailored to force packages for contingency operations.

(d) Can be tasked by the JBPO to manage a blood products depot or expeditionary BTC.

(e) Can provide a consolidated blood report (from its supported MTFs) to the AJBPO or JBPO, as required. The commander, MDBS, can serve as the area joint blood program officer.

(9) The blood products depots have been built into some CCMDs to provide frozen blood products such as frozen RBCs, FFP, and cryoprecipitate.

(a) Are pre-positioned to offset strategic shortages of blood products during the initial stages of an operation until the liquid RBCs 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 frozen RBCs.

(d) Issue blood and blood products to MDBS, as directed by the JBPO.

(e) Act as an MDBS and distribute blood and blood products to MTFs.

(f) Provide required blood report to their respective AJBPO or JBPO.

(g) The blood product depot ensures proper maintenance of the frozen inventory, rotating products back to the US, as necessary for utilization within medical treatment facilities. This helps keep inventories current and helps minimize outdate rates.

(10) CCDRs are responsible for ensuring that blood products depots are maintained, manned, equipped, and supplied during peacetime operation.

(11) The expeditionary BTCs are managed by the USAF at various airfields. They receive blood products from the Armed Services whole blood processing laboratories, or other expeditionary BTCs, store, re-ice, and distribute the products to other expeditionary BTC, MDBSs, or MTFs when required. They provide required blood reports to their respective AJBPO or JBPO. The expeditionary BTC 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 expeditionary BTC provides a maximum storage of 7,200 RBCs.

(b) The goal of the expeditionary BTC is to maintain 50 percent of the established inventories of its supported blood support medical detachments.

b. Available Blood Products. Figure E-2 provides a summary of the blood products now available to the theater. *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 degrees Celsius. During transport from one facility to another, the shipping temperature of liquid RBCs is 1 to 10 degrees Celsius.

(2) FFP is stored at -18 degrees Celsius 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 degrees Celsius temperature or colder. FFP can be maintained for up to 5 days as thawed plasma. FFP outdating can be modified/extended by in-theater policy (if converted to thawed plasma). FFP stored at -65 degrees Celsius has a seven-year expiration.

(3) Platelets are stored at 20-24 degrees Celsius with continuous agitation. The temperature during shipment must remain as close to 20-24 degrees Celsius as possible. The maximum time that platelets can be stored without agitation is 24 hours.

(4) Cryoprecipitate is stored at -18 degrees Celsius or colder. It has a 12-month frozen shelf life, 4 hours post thaw open pooled product, or 6 hours single unit. During transport, cryoprecipitate should maintain a frozen state.

(5) Frozen RBCs have a 10-year shelf life when stored frozen at -65 degrees Celsius. Once thawed and deglycerolized, shelf life is 14 days when stored refrigerated at 1-6 degrees Celsius.

Blood Bank Products and Procedures by Treatment Role

Treatment Role	Available Blood Products	ABO Group & Rh Type	Transfusion Service Procedures	Maximum Storage Capacity	Blood Supplier
Forward resuscitative surgery	Red blood cells	O Rh+/-	None	50 Units RBCs per medical field refrigerator	MDBS, EBTC, or MTF
Theater Hospitals					
Combat support hospital (CSH)	Red blood cells	O, A, B Rh+/-	ABO group/Rh type on patient and donor RBCs* Immediate spin crossmatches	480 Units: CSH/FH 90 Units: EMEDS+25 500 Units: LHD/LHA 2000 Units: hospital ships	MDBS, EBTC
Fleet hospital (FH)	Frozen/deglycerolized red blood cells	O Rh+/-	N/A	950 Units: LHA/LHD 2850 Units: hospital ships	MDBS, EBTC
Expeditionary medical support (EMEDS)+25	Fresh frozen plasma	O, A, B Rh+/-	N/A	20 Units	MDBS, EBTC
Ships	Cryoprecipitate	O, A, B Rh+-	N/A	30 Units minimum	MDBS, EBTC

NOTE:

* Not necessary if Armed Services whole blood processing laboratories have verified the ABO group.

Legend

ABO	actual blood type	MDBS	medical detachment blood support
EBTC	expeditionary blood transshipment center	MTF	medical treatment facility
LHA	amphibious assault ship	RBC	red blood cell
LHD	amphibious assault ship (multipurpose)	Rh	Rhesus

Figure E-2. Blood Bank Products and Procedures by Treatment Role

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. OPLANs 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 JOA with the initial medical units?
- (c) Will there be multinational operations and will the JBPO be responsible for blood requirements of multinational forces?
- (d) Do the storage capabilities of the expeditionary BTCs, blood support medical detachments, and blood products depots support the blood product requirements?
- (e) Will blood products depot 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?
- (i) Where are local sources of wet ice for refrigerated shipments and dry ice for frozen shipments of blood?
- (j) What are the logistical shortfalls that will affect blood operations (reagents, test kits, consumable supplies, blood boxes)?
- (k) Are theater wide policies and procedures in place for blood support, emergency collection SOPs, policies on who can donate blood (US military, NGOs, civilians, government contractors)?
- (l) What cultural barriers exist or must be overcome to provide blood support in the area of responsibility?
- (m) How will emergency blood collections occur in the theater of operations (who are potential donors, how will they be prescreened, are blood types known, are staff trained in proper procedures, are collections being reported)?

(2) The locations of the expeditionary BTCs are dependent upon the location of the air terminals and operational necessity. Depending upon the requirements within the CCMD, the expeditionary BTC needs to be able to appropriately manage a varied throughput of blood products. Current capacity is 7,200 RBCs per day. The JBPO and/or AJBPO must provide the expeditionary BTC personnel with their supported blood program elements, types, DOD activity address codes, and location of MTFs within the operational area 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 RBCs.** Subject to availability, RBCs shipped from the US are packed with the unit group and type distributions as determined by the JBPO and AJPBO.

(3) **Blood Planning Factors.** Blood planning factors are programmed in the JMPT to help the JBPO and the CCMD determine the estimated requirements and subsequently used by the respective CCMD medical planners to generate daily blood product requirements for the JOA.

NOTE: Assets to meet anticipated EPW, civilian, and valid partner nation personnel workload must be included in the TPFDD as documented in accordance with CJCSM 3122.03C, *Joint Operation Planning and Execution System Volume II, Planning Format*. Additionally, a 5 day safety factor will normally be added to blood requirements in the combat zone to take into account line of communication disruption, damage, and in-transit spoilage.

(4) **Blood Support to Rhesus (Rh) Factor Negative Patients.** 80 to 90 percent of all blood supplied to all roles of care will be Rh factor positive. 10 to 20 percent will be Rh factor negative. This is in keeping with the levels as found in the donor population within the US. Rh factor negative RBCs will be provided to both Rh factor negative female and male patients. In the event that there is not enough Rh factor negative blood to meet all of the needs, transfusing Rh factor positive RBCs to Rh factor negative patients becomes an emergency requirement in saving the patient's life and should be thoroughly documented in the patient's medical record. Rh immune globulin should be available and administered to those Rh negative patients that receive Rh positive blood.

(5) **Pre-Positioned Frozen Blood Products.** Frozen RBCs are pre-positioned at various locations within the CCMDs. These pre-positioned products are intended as a stop gap to ensure blood products are available at the onset of hostilities until the US

blood system is fully activated and shipping products into theater. To ensure rotation of frozen RBC inventory stocks, the use of frozen deglycerolized RBCs must be incorporated routinely into available MTF blood inventories. Deglycerolized frozen RBCs have a 14-day expiration.

(6) **ASBP Office Reaction Time.** The reaction time of the AJPBO 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 CCMDs, blood products depots with pre-positioned frozen blood products have been constructed to provide blood products in anticipation to receiving liquid blood products from the US. There are also limited blood donor operations outside the US, which will be able to provide products prior to receiving them from the US. 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. To the maximum extent possible, MDBS should have a 100 percent replacement goal. Realistically, a planner may expect a 4 to 5 day resupply response time from outside the theater dependent upon at least 2 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- to 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 the US. This will be based upon the current requirements with the JOA. Blood collected in CPDA-1 (a citrate, phosphate, dextrose, and adenine-formula 1; an anticoagulant preservative solution) and stored at 1 degrees to 6 degrees Celsius expires 35 days after collection. Blood collected in additive solutions 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-3 can provide insight to future operations that will require blood planning. The J-2 can facilitate the best current intelligence be provided to assist the JBPO. Once located in the JOA, 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 JOA as a whole, or he may reallocate resources within the JOA 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?

(d) How can the blood be cross leveled?

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 AJPBO 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 wet and dry 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 for 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 JOA. Prior planning must be accomplished with the joint movement center 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 activity address codes of the 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 USA is the dominant user, a MEDLOG company could be augmented to perform Class VIIIA management functions and if tasked, could assume the role of the SIMLM for the JOA. A cell from a USA blood support detachment may be colocated with a MEDLOG company to provide blood products to supported medical units. Medical treatment facility coordination with the SIMLM is imperative. The SIMLM will have liaison officers from supported Services to assist in coordinating logistic support requirements during joint or multinational operations. Examples of required supplies include:

- (a) Whole blood collection sets.
- (b) Rapid diagnostic viral screening test kits.
- (c) Blood typing system grouping and Rh factor typing antiserum/gel cards.
- (d) Test tubes.
- (e) Blood shipping boxes and labels.

(f) Plastic bags.

(g) Adequate supply of wet and dry ice for maintenance of required blood temperature during transit.

4. Blood Report

a. **Purpose of Standardized Blood Reporting.** The purpose of the standardized blood report 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 JOA. The JBPO will establish the report format and reporting frequencies based upon operational factors. Examples of blood reports are shown in Figure E-3 and Figure E-4.

b. Blood Reporting

(1) Each facility with blood products will submit required blood reports to the next higher organization as follows:

(a) MTF (lowest level with blood) to blood support medical detachment/blood products depot. For first responder care capability and forward resuscitative care capability units, the JBPO may direct that the report be sent to the supporting theater hospitalization capability MTF.

(b) MDDBS (to include roll up of all MTF's), blood products depot, and expeditionary BTC to AJBPO, if established, or directly to the JBPO if no AJBPO.

(c) AJBPO (to include roll up of all lower reporting facilities) to joint program office.

(d) Joint blood program office to ASPBO.

(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 blood report:

(a) Number of blood components by the blood typing system and Rh factor.

(b) Number of RBCs due to expire within next 7 days by the blood typing system and Rh factor.

(c) Number and type of components transfused since last report by blood typing system and Rh factor. Medical treatment facilities should also include patient transfusion data.

(d) Immediate requirements with required delivery date.

Example Blood Report Message Format

```

*** UNCLASSIFIED ***
PRIORITY
TO RUEAUSA/ASBPO WASHINGTON DC
INFO RUEOLIA/ASWBPL MCGUIRE AFB NJ
RULYOGB/RHEVAZZ/CJTF ONE EIGHT ZERO//J4/SURG MAIN/FT BRAGG//
UNCLAS
OPER/UPHOLD DEMOCRACY//
MSGID/BLDREP/CJTF-180 JBPO/BLD/OCT/A//
ASOFDTG/150001OCT94//
REPUNIT/32NDMED BN (LOG) BLDPLT/G/CAMP DEMOCRACY HAITI//
BLDINVT/32NDMED BN (LOG) BLDPLT/G/115JS/31JT/3JU//
BLDREQ/30JQ//
BLDEXP/32NDMED BN (LOG) BLDPLT/G/49JS/24JT//
BLDEST/32NDMED BN (LOG) BLDPLT/G/45JS//
CLOSTEXT/REQUEST 30JQ FOR DELIVERY ON 20OCTOBER AND
2NOVEMBER. CHANGE
STANDING ORDER TO 45JQ FOR DELIVERY ON 14TH OF EACH MONTH//
*** UNCLASSIFIED ***

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Figure E-4. Example Blood Report Message Format

- (e) Seventy-two hours projected estimated need.
- (f) Calculated days of supply as determined by the JBPO.

(4) The JBPO will establish the blood report format. One method is spreadsheet sent via e-mail (see Figure E-3). Another method is message text format sent through current military message programs such as the Global Command and Control System (see Figure E-4). Secure voice messages may also be used. Additional reporting tools utilizing Internet database type programs that may reside on unsecure or secure channels.

(5) The JBPO may assign brevity codes and designate specific lines to be utilized in the required reporting.

(6) 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 forward resuscitative care 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 blood report transmission will be by means designated by the JBPO. The method should be outlined in the appendix 2 (Joint Blood Program) to annex Q (Medical Services).

(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 appendix 2 (Joint Blood Program) to annex Q (Medical Services).

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) Blood shipment reports are used within the ASBP to report blood shipments.

APPENDIX F INTELLIGENCE SUPPORT TO JOINT HEALTH SUPPORT

1. Aspects of Medical Intelligence

a. Medical planners and providers must consider the entire scope of the threat to effective medical support. Intelligence support to health support must address all aspects of the threat. Considerations range from the potential impact of enemy combat operations on medical personnel, lines of communications, 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 medical 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 NCMI 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. Medical intelligence data is critical in enabling health support to provide the JTF commander with early warning of biological warfare attacks, as well as prompt detection and identification of biological attacks or naturally-occurring disease outbreaks. Bio-intelligence is closely related to but not a true subset of health surveillance. It is the regular or repeated collection, analysis, and interpretation of data specifically related to extremely virulent biological organisms or toxins that have the potential either naturally or after modification to produce mass casualties either as a local area contamination hazard or through highly contagious spread of disease. The data includes but is not limited to the identification and characterization of select agents, the identification and monitoring of facilities capable of handling select agents, the identification and monitoring of personnel capable of researching and/or modifying select agents. The purpose of bio-intelligence is to provide assurance that select agents are not accidentally released into the environment or transferred to unlicensed facilities or actors in order to prevent select agents from being used as a weapon of mass destruction. Bio-intelligence therefore utilizes both open source health surveillance data and closed source intelligence data, the combination of which is useful to both health professionals and law enforcement officials. The health surveillance aspect of bio-intelligence is sufficient to detect an event of human cases of disease being caused by select agents.

c. 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 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. Health support 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) MEDLOG, to include blood products, MTFs, and the number of trained MEDLOG 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) Health 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) The JOA (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 medical operations.

(11) The 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 identification of threats.

(12) The use of informatics. All source/open source data mining, correlation, and nodal analyses to identify and tie together events of medical 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.

Medical personnel engaged in the collection of medical intelligence as opposed to medical information or similar tasks relating to enemy forces should be made aware that this would constitute a combatant role that jeopardizes their protected status under the law of war.

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 medical strategies that:

- (1) Detect and/or identify the health threat.
- (2) Counter the health 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 CCMD surgeon with geographic responsibility for the area into which the JTF is being deployed. The CCMD surgeon's PVNTMED officer should be intimately familiar with the region's health threats. If the PVNTMED officer does not have specific information right at his/her fingertips, he or she probably has access to a library of applicable health threat data, in addition to what is available from NCMI.

b. NCMI produces a wide range of publications that can assist in developing a military intelligence preparation of the operational environment. NCMI publications available on the country's page within the NCMI Web site include:

- (1) Environmental Health Risk Assessment.
- (2) Industrial Facility Health Risk Assessment.
- (3) Health Service Assessment.
- (4) Infectious Disease Risk Assessment.
- (5) Infectious Disease Alerts.

c. Additionally, NCMI has made available much of its unclassified information through the Medical Environmental Disease Intelligence and Countermeasures which can be downloaded from the NCMI Web site. The Navy and Marine Corps Public Health Center, AFHSC, USA Medical Research and Materiel Command, USAF School of Aerospace Medicine, and others can be of tremendous assistance in identifying and

analyzing threats in a JOA. This information is also available at the NMCI Web site: <https://www.intelink.gov/ncmi/index.php>.

d. 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, mode of transmission, geographic and seasonal incidence, and prevention and control recommendations. Some of its other publications are also available online. A compact disc of operational entomology references is also available.

e. A third publication of value is the quarterly *Communicable Disease Report* published by the Walter Reed Army Institute of Research. It identifies disease outbreaks worldwide. Additionally, Walter Reed Army Institute of Research quickly responds to ad hoc queries and provides timely regional medical assessments.

f. Another military source is the USA Research Institute of Environmental Medicine. The USA Research Institute of Environmental Medicine 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. The Department of State publishes *Background Notes*, a series of publications on selected countries and regions.

h. The Centers for Disease Control and Prevention 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.nc.cdc.gov/travel/>.

i. The World Health Organization publishes *Vaccination Certificate Requirements and Health Advice for International Travel*, a document that is similar to the “Yellow Handbook.” The World Health Organization also publishes the Weekly Epidemiological Record.

APPENDIX G CASUALTY PREVENTION

1. Introduction

a. FHP provides the conceptual framework for optimizing health readiness and protecting military personnel from all health threats associated with military service. Casualty prevention 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 behavioral rigors associated with combat and other military operations. The ability to remain healthy and fit in a 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 force. The adversary threat produces most combat-related casualties commonly called BIs, while the total environmental threat produces DNBI casualties. Disease and nonbattle injuries 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 to ensure mission success. Success is dependent on all facets of casualty prevention, 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. Prevention of casualties is a continuous process conducted during predeployment, 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 military personnel 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 activities are critical to FHP. These activities which include identifying the population at risk; 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 for recording individual daily deployment location or when the potential health risks indicate actions necessary beyond the scope of normal shipboard occupational health programs. During all deployments, a process will be in place to record the once-daily individual Service member locations and location records will be electronically reported to the Defense Manpower Data Center at least weekly. DODI 6490.03, *Deployment Health*, and DODD 6490.02, *Comprehensive Health Surveillance*, list the mandatory requirements for pre-, during, 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 the US response. The AFHSC is the central resource for the US Armed Forces to provide health surveillance information and epidemiological analysis that impact medical readiness. Analytical reports are provided to policy makers, medical planners, and researchers to help recognize medical and public health threats in DOD. The AFHSC, through the Defense Medical Surveillance System provides DOD with a centralized DOD epidemiological capability. No single surveillance system fits every situation. For instance, many biological agents also cause disease in animal populations. Depending on the route of exposure and degree of susceptibility, illness or death within animal populations may precede illness in humans. Depending on the specific scenario, other types of surveillance may provide an early indication of potential problems. Examples of complementary DOD health surveillance systems, and their parent organizations, include medical intelligence (NCMI); sentinel mortality surveillance (Armed Forces Medical Examiners System); and laboratory-based surveillance to identify emerging, re-emerging, or changing pathogens, such as the DOD Global Influenza Surveillance program (part of the Global Emerging Infections Surveillance and Response System within the Armed Forces Health Surveillance Center). For additional information about health surveillance in the DOD, both in garrison and deployed settings, the reader is referred to DODD 6490.02, *Comprehensive Health Surveillance*, DODI 6490.03, *Deployment Health*, and MCM [Memorandum issued in the name of the CJCS] 0028-07, *Procedures for Deployment Health Surveillance*.

3. Identifying Preventable Threats and Implementing Countermeasures

a. PVNTMED competencies and training must elicit continuous command interest to ensure support for deployment operations. CCDRs should ensure PVNTMED 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 PVNTMED

expertise. DD 6055.05-M, *Occupational Medical Examinations and Surveillance Manual*, provides health professionals information and references for use in developing, performing, interpreting, and conducting occupational medical examinations and surveillance for Service members as well as DOD civilians.

b. PVNTMED training should become an integral part of predeployment preparations. Wide dissemination of any PVNTMED 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. PVNTMED 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. PVNTMED 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 PVNTMED 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 PVNTMED operations during deployment.

e. All required medical equipment and supplies (mosquito bed netting and poles, permethrin treated-uniforms, and so on) to support FHP must be issued or made available in theater for all deploying personnel.

f. All required individually issued medical defense materiel 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 predeployment. The NCMI can provide medical environmental disease intelligence and countermeasures, health services assessments, infectious disease risk assessments, and other medical intelligence products during predeployment to assist in planning for proper medical countermeasures and health care support (including personnel). 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 identification 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. Communicable diseases particularly those that cause epidemics or pandemics can present disease management difficulties. Often theater commanders are focused on diseases within a theater when diseases introduced from outside the theater may pose a threat to the health of the force. Experience with the influenza H1N1 outbreak in 2009 indicated that reception, staging, onward movement, and integration facilities were unaware of the precautions taken by stateside units to ensure personnel traveling into theater were free from infection. Theater PVNTMED personnel must coordinate with public health emergency officers (PHEO) at ports of embarkation to prevent further spread of disease within theater. Training facilities should confer with installation PHEOs and theater PVNTMED personnel to ensure infection is not transmitted from the training facility to theater units.

b. During deployment, vigilant monitoring of medical diagnoses, and of DNBI reporting categories and rates (such as, 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 management and disposal.
- (3) Advanced surveillance of endemic zoonotic and foreign animal disease.
- (4) Control of disease carrying vectors, including feral animals.

(5) Personal protection measures (such as, 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 military personnel 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 reassessment survey. The post-deployment surveys serve as a tool to evaluate the member for any infectious diseases, injuries, and other medical conditions obtained during deployment.

(6) Contagious diseases can be a threat to forces. As an FHP measure, isolation and quarantine may be useful in preventing disease from being directly introduced into theater or to delay the spread of disease within a theater. Isolation is for ill persons and lasts the duration of communicability of the disease. Quarantine is generally applied to individuals who have been exposed to a disease but are not symptomatic. Quarantine lasts as long as necessary to ensure the individuals are not infectious to others. Restriction of movement can be used to protect a group of unexposed people from interacting with contagious or potentially contagious individuals. Restriction of movement may be useful in ensuring key capabilities are maintained during outbreaks. Isolation and quarantine are legal actions. Legal advice should be sought when considering isolation and quarantine measures. Further guidance can be found in DODI 6200.03, *Public Health Emergency Management within Department of Defense*, which implements the federal human quarantine regulations.

d. When directed, all military personnel 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. Behavioral Health Casualty Prevention

a. Behavioral health problems and appropriate medical intervention throughout all phases of deployment are critical to mission success. Individuals identified at high risk for developing behavioral health problems are often associated with dual-military personnel 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 behavioral health problem. Four key indicators are increased use of health services, use of medication, disciplinary problems, and increased absences.

b. Behavioral 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 policies and schedules.

(6) Critical incident stress debriefings.

c. Historically, post-deployment behavioral health interventions for personnel returning from theater have remained a low priority. To change this, the stigma of behavioral health interventions must be minimized. Educational briefings aimed at mitigating the stress and anxieties that often follow a unit's return from theater are suggested. Those briefings may address personal finances, combat stress prevention, repatriation issues, general behavioral health issues (such as, stress indicators and stress reduction), rest and recuperation suggestions, and positive information regarding the accomplishment of mission objectives.

6. Health Risk Communication

Effective health risk communication is essential to casualty prevention including threat identification, predeployment health debriefings, and any medical follow-up indicated. All significant risks must be clearly and accurately communicated to deploying military personnel 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 PVNTMED and veterinary 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. Medical 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 DNBI's resulting from a deployment should be provided to all appropriate individuals.

For additional guidance, see DODI 6200.03, Public Health Emergency Management within the DOD.

APPENDIX H PATIENT AREA RECEPTION

1. Purpose

The purpose of this appendix is to provide guidance for military health forces in homeland defense/defense support to civil authorities missions for the assistance to the Federal Coordinating Center in developing patient reception SOPs and maintaining the support of hospitals and area agencies for the assigned patient reception areas plan.

2. Responsibilities

The Federal Coordinating Center Director is responsible for ensuring the development, exercise, and evaluation of local patient reception area plans. The Federal Coordinating Center Area Coordinator assists the Federal Coordinating Center Director, ensuring that a patient reception team is developed for each patient reception area and that each patient reception team remains viable through training and exercises. The Federal Coordinating Center Coordinator maintains contact with appropriate authorities in each patient reception area, and includes contact information in each patient reception area plan. The Federal Coordinating Center Coordinator notifies all agencies involved as soon as activation of the Federal Coordinating Center geographical area of responsibility is anticipated.

3. Plan Development

The development of local plans is critical if the 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 patient reception area plan will vary among communities. Each patient reception area 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 patient reception area plan. In fact, it is advisable that the patient reception area plan be based on existing plans where possible. In few circumstances is it envisioned that a patient reception area 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 patient reception area plan. Each patient reception area plan should address the following areas:

a. CONOPS

- (1) Provide a concise mission statement.
- (2) Define the geographic patient reception operational area.

(3) Briefly define the roles and responsibilities of principle agencies, teams, and individuals.

(4) Identify any applicable references, including the National Response Framework 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. Patient Reception Plan Activation

(1) Define the processes for NDMS activation of the local patient reception area.

(2) Define the local processes for alerting and augmenting the Federal Coordinating Center staff.

(3) Define the processing and provide a checklist for notifying local agencies of activation.

c. Federal Coordinating Center Operations

(1) Define Federal Coordinating Center staff roles, responsibilities, and shift schedules.

(2) Define Federal Coordinating Center internal communications, logs, reports, and so on.

(3) Define control of access to the Federal Coordinating Center.

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 Patient Reception Area

(1) Define the role of the DOD GPMRC.

(2) Define the processes and procedures for coordinating patient missions between GPMRC and the Federal Coordinating Center area of operations.

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 patient reception area (such as 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 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 patient reception team. The patient reception team 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 (Department of Veterans Administration or DOD) or comprised of volunteers from community organizations. Disaster medical assistance team staffs make exceptional patient reception team members if they are available to the Federal Coordinating Center. Local emergency medical services 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 emergency medical services.

(b) Military, Department of Veterans Affairs, 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 (such as airport limousines or buses).

(e) Military and other governmental general use trucks, vans, school buses, and so on.

(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 Federal Coordinating Center Area Coordinator. The Federal Coordinating Center 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 Military 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 National Defense Medical System hospital.

(4) Define the roles and responsibilities of each participating National Defense Medical System 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 internal procedures and forms. The National Defense Medical System member hospitals should provide information to the Federal Coordinating Center 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 patient reception area. Ensure that the following information is included in the tracking system adopted by the Federal Coordinating Center:

(a) Patient name.

(b) Social security or other identification number.

(c) Medical regulating/diagnostic category.

(d) Type of patient (such as, 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 (such as hotel or shelter), address, POC, and telephone number for outpatients.

(6) Define policies and procedures for disposition of records. The Federal Coordinating Center 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 Federal Director Center 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 Federal Coordinating Center Coordinator and National Defense Medical System 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 patient reception area 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 Federal Coordinating Center.

(b) Appropriate HQ elements or agencies.

(c) GPMRC.

(d) Local authorities and agencies.

(e) Patient reception site authorities.

(f) Patient reception teams.

(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 J MEDICAL ASPECTS OF REINTEGRATION

1. General

The purpose of this appendix is to describe medical processing of recovered isolated United States 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 medical objective within 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: report, locate, support, recover, and reintegrate.

a. Reintegration is a critical, straightforward task that allows DOD to gather necessary tactical and survival, evasion, resistance, and escape (SERE) information while protecting the health and well-being of returned isolated personnel. Qualified SERE and intelligence debriefers that 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 that care for the physical well being of returned isolated personnel are key to the successful accomplishment this task.

b. The CCDRs personnel recovery directive, the OPLAN/OPORD, and personnel recovery CONOPS should specify the required personnel recovery debriefing and reintegration teams and their composition and responsibilities. The joint force commander's reintegration team chief will be responsible for the promulgation, execution, and oversight of the reintegration plan. The scope and complexity of the process will vary depending on the isolating circumstances of the recovered isolated personnel (e.g., survivors and evaders may require less debriefing and psychological attention than captives, detainees, and POWs) and their physical and behavioral condition. Medical stability and gathering time-sensitive information are top priorities of the reintegration process. 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. The Reintegration Process

Reintegration 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 reintegration 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 examination and any medical treatment necessary to stabilize the returnee should be conducted.

b. **Tactical Intelligence 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. **SERE Debriefing.** The SERE debriefings 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 the 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 debriefing and reintegration 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 all aspects of and helps coordinate the debriefing and reintegration 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 reintegration team leader who makes the recommendation on disposition (such as, return to duty or continue to next phase) to the component commander.

3. Debriefing and Reintegration Phases

a. **Phases.** Reintegration is normally conducted in three phases, the first two are directed by the CCDR in coordination with the Services, and the final phase is conducted by the Services in the US. 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 processing 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 personnel recovery coordination cell. All isolated personnel must undergo Phase I. Based on the debrief and reintegration team chief's recommendation and theater guidance, the component commander should have the authority to return 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 debriefing and integration team and must be accomplished as soon as possible. The reintegration team chief will determine the most appropriate place and means to accomplish Phase I. Based on the CCDR'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 identification 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 reintegration 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 MTF) 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 and executed by the CCDR's designated reintegration team. The reintegration team should have Service component representation to keep component commanders informed on the status of their recovered isolated personnel.

(a) The reintegration team chief will ensure coordination with other members of the CCDR'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 reintegration team chief will be charged with prioritizing and monitoring, in coordination with the SERE psychologist and medical authorities, all debrief and reintegration processes to prevent confusing the recovered isolated personnel or damaging their behavioral 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 isolating 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 the 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 reintegration team chief determines the completion of Phase II and recommends the disposition of the recovered isolated personnel to the respective component commander or CCDR. The decision is made to either return the recovered isolated personnel to their DOD duties or transfer them into Phase III where they will come under the control of their respective Service in the US.

(3) **Phase III.** Phase III begins with the transition of the recovered isolated personnel to a Service-designated US location. A designated personal escort, physician, chaplain, DOD public affairs officer, and SERE psychologist normally will accompany the recovered isolated personnel. Phase III does not have a prescribed time limit and depends on the 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 reintegration within the context of ongoing military operations.

For more information on debriefing and reintegration see JP 3-50, Personnel Recovery.

4. Challenges During Reintegration

The greatest challenge during reintegration 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 examples of common mistakes that have negatively impacted the reintegration process:

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 reintegration. These types of activities serve to increase the state of shock 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 these intense emotional reactions complicate the reintegration process and in many cases isolate/alienate them from unit members.

c. **VIP and Command Presentations/Visits.** Attempts to honor recovered isolated personnel with high level visits serve necessary political purposes but are not in their best interest if conducted during the early stages of reintegration. They will remember these events as positive if they are conducted at the proper time and in accordance with the wishes of the recovered isolated personnel. Brief telephone calls may be appropriate during Phase II if coordinated with the reintegration 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 often 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. Family reunions are more appropriate when the reintegration process is nearing completion or when recovered isolated personnel return to the US.

5. Follow-Up

SERE psychologists should follow-up with recovered isolated personnel, as needed, for at least one year. All former isolated personnel are eligible for follow-up medical and psychological services at the Robert Mitchell Center for Repatriated Prisoner of War 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 reintegration of returned isolated personnel. The SERE psychologist's duties are well defined, require specialized training, and are described in detail in other publications such as DODI 2310.4, *Repatriation of Prisoners of War, 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 reintegration.

a. **Medical Triage and Evaluation.** In addition to their isolating incident, 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 reintegration process if possible, including MEDEVAC transportation. It is essential that all recovered isolated personnel are initially evacuated 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 Phase I care will take place at the forward location. The lead medical person is responsible to consult with the reintegration team chief and the SERE psychologist in making return to duty recommendations.

APPENDIX K IMPACTS OF THE LAW OF WAR AND MEDICAL ETHICS

1. General

a. The conduct of armed hostilities is regulated by the law of armed conflict. This law is derived from two principal sources:

(1) Treaties or conventions (such as The Hague and Geneva Conventions).

(2) Customary international law (resulting from a general and consistent practice of states following them from a sense of legal obligation).

b. Under the US Constitution, treaties ratified by the Senate constitute part of the supreme law of the land, and thus must be observed by both military and civilian personnel. The unwritten or customary law of armed conflict is part of international law as recognized by the US. As such, it is binding upon the US, citizens of the US, and other persons serving the United States.

c. Conflicts within the joint operating environment now and in the future pose additional issues because adversaries within non-state organizations are neither signatories nor adherent to the Geneva Conventions. Some irregular tactics of adversaries include purposeful attacks against military and civilian health and humanitarian personnel and assets. Even within this environment the US military adheres to and honors the law of armed conflict at all times.

d. Additional ethical issues arise in the treatment of HN civilians as part of health support operations. Delivery of direct health care and western/US standard health care and health services may exceed the law of armed conflict mandate due to humanitarian ideas, counterinsurgency, or inertia. When evaluated deeper and with a long-view exceeding local standards of care by too much may actually result in negative health sector effects. HN resources may never be able to support western programs in the long run or the services may competitively damage local health system components. Careful thought and analysis of the HN in regards to mission goals and objectives should guide all significant health sector engagement.

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 medical 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 medical 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) Medical evacuation assets subjected to attack and destruction by the adversary.

(2) Medical capability degraded.

(3) Captured medical personnel becoming POWs rather than retained personnel. They may not be permitted to treat fellow prisoners and would not be repatriated before the end of hostilities even if surplus to the POW population's needs.

(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 on the battlefield who has been wounded or who is sick, and for that reason is out of the combat in a disabled condition, known as hors de combat, 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 *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 adversary combatant who has ceased to fight and laid down his arms as a result of his injuries. At the same

time, these words impose an obligation to come to the enemy person's aid and give him such care as his 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 that 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 medical 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 an operational area. 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 *specially 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 Red Crescent, or Red Crystal 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 identification card authorized in Article 40, GWS (in the United States Armed Services, DD Form 1934 [Geneva Conventions Identity Card for Medical and Religious Personnel Who Serve in or Accompany the Armed Forces]). 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 identification card or wear the distinctive emblem armband. Such personnel carry a common access card 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 an operational 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 concurrently 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 shall be applied equally to all Parties to 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. However, such systems must not be used for military purposes in any way harmful to a potential adversary.

(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 must 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 may become 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 identification 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. 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 and Additional Protocol III authorize the use of the following distinctive emblems on a white background: Red Cross; Red Crescent; Red Crystal; and Red Lion and Sun, which was once employed by Iran but is no longer used. In operations conducted in countries using an emblem other than the Red Cross on a white background, United States personnel must be made aware of the different official emblems. United States forces are authorized to 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. Medical treatment facilities 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, it [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 for ceasing 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:

(1) That the 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) That in the absence of armed orderlies, the unit or establishment is protected by a picket or by sentries or by an escort.

(3) That 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) That personnel and material of the veterinary service are found in the unit or establishment, without forming an integral part thereof.

(5) That the 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, create some doubt.

(1) **Defense of Medical Units and Self-Defense by Medical Personnel.** A medical unit is granted a privileged status under the law of armed conflict. 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 actions 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 law of armed conflict 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 that use their arms in circumstances not justified by the law of land warfare expose themselves to penalties for violation of the law of armed conflict 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, pistols, squad automatic weapons (USA), 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) **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

a. Definitions

(1) The term detainee refers to any person captured or otherwise detained by an armed force.

(2) 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.”

b. Medical personnel exclusively engaged in the:

(1) Search for, collection, transport, or treatment of the wounded or sick.

(2) Prevention of disease.

(3) Staff administration of medical units and establishments exclusively.

(a) Chaplains attached to enemy armed forces.

(b) 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 L PLANNING CHECKLISTS

SECTION A. MEDICAL 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 defense support of civil authorities?

(a) Is the defense support of civil authorities' mission for disaster response non-CBRN, or domestic CBRN response?

(b) Is the defense support of civil authorities' 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 USG agency employees, government contractors, NGO personnel (American Red Cross workers/volunteers), and/or civilian personnel (victims and rescuers)?

(3) Will medical units provide health support 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 medical capability of participating agencies?

(4) Will civilian or interagency MTFs be utilized (clinics, health centers, or hospitals)?

(a) What capabilities do they possess?

(b) Will they require augmentation by military medical personnel?

(c) Can medical 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 health support?

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 health 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 OEH 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 identification 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. Medical Treatment Facilities and Hospitalization Considerations

a. What MTFs and medical 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 medical resources document the furnished medical/dental care?

c. What medical resources are already in the JOA? And what are their capabilities?

(1) What are the total number of military, Department of Veterans Affairs, and NDMS MTFs in the JOA?

(a) What are 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 federal coordinating centers in the JOA?

(3) What are the total numbers and capabilities of non-National Disaster Medical System participating civilian MTFs 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 behavioral health support will be available for victims, caregivers, and rescuers?

(1) Will the JTF be required to provide behavioral health support to other agencies and individuals supporting the operation?

(2) Will civilian behavioral 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 behavioral 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 the National Disaster Medical System within/outside the JOA?

d. How will patients be regulated within and if necessary, outside the JOA?

(1) Will casualties go to the same MTF 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? Who will be responsible for AE support?

f. How will MEDEVAC support be requested? How will AE 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 patient movement 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. Medical Logistics Considerations

a. What is the source of Class VIII materiel?

(1) Will Class VIII be obtained through conventional military channels?

(2) What is the funding source for use of military Class VIII materiel?

(3) Will they be provided by other USG departments and agencies or non-DOD entities?

(4) Will donated medical items be used in disaster relief operations?

(5) 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 USG department or agency? Or will the joint force 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 joint force is tasked/authorized to provide blood products to the operation, will the International Committee of the Red Cross be responsible for blood product distribution in the JOA?

c. Will the GCC's designated TLAMM provide MEDLOG support for the operation?

d. How will medical equipment maintenance and repair be accomplished?

(1) What medical 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 military working dogs, other government-owned animals, or civilian working dogs be used during the operation?

(1) What is the military working dog 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 working 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 military working dogs during evacuations?

(3) If animals are unable to accompany handlers, can they be sedated before evacuation?

d. What are the zoonotic disease threats to military working dogs and government-owned animals in the JOA?

e. What are the immunization requirements for military working dogs 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 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, civil support, FHA, or peace operations?

(a) If a noncombatant evacuation operation is anticipated, has a contact list to include phone numbers of embassy health officials been established?

(b) Is the noncombatant operation permissive or nonpermissive, and how best can it be supported?

(c) What are the numbers and demographics of noncombatants and civilians, and how many are known to require medical care? Are there high-risk individuals?

(d) What is the physical location of the civilians and noncombatants, and is there a published plan addressing their collection prior to evacuation?

(e) Are there any civilian casualty projections for the noncombatant operation?

(f) What is the MEDEVAC policy for noncombatant operation 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 Department of State authorized pets to accompany noncombatant operation evacuees? And, will the US Department of Agriculture or other department or 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, FHA or peace enforcement operation, will action be unilateral or multinational? What are potential countries? And, what type of health support will they provide?

(k) If mission is a disaster relief, FHA, or peace enforcement operation, what type of military personnel may be used to resolve the crisis or conflict, and how might they best be supported medically?

(l) If it is a noncombatant operation, disaster relief, FHA, or peace enforcement operation, what other resources are available (civil affairs, International Committee of the Red Cross, interagency community, and so on) to share additional medical information about the threat, crisis, conflict, or region?

(2) Will the supported population for the operation comprise of USG agency employees, government contractors, NGO and international organization personnel (American Red Cross workers/volunteers, US Agency for International Development workers), allied military personnel, and/or civilian personnel (foreign nationals, victims and rescuers)?

(3) Will JTF medical 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 patient movement for nonmilitary or multinational military personnel been established?

(5) Are there specific cultural, religious, or social considerations, which may impact health support?

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 medical capability of participating agencies?

(5) Will civilian or interagency MTFs be utilized (clinics, health centers, or hospitals)?

(a) What capabilities do they possess?

(b) Will they require augmentation by military medical personnel?

(c) Can medical 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 medical resources document the furnished medical care?

9. Preventive Medicine Considerations

a. Where will military personnel be billeted?

(1) Will military personnel be billeted in military facilities, housed in makeshift facilities or in a field environment? Are there sufficient sanitary facilities?

(2) Have site surveys been conducted for areas to be occupied by JTF military personnel?

(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 military personnel 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 multinational force 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?

(e) How will wastewater be managed and disposed?

(6) What personal protective equipment and supplies are required for the operation?

(7) Have multinational force 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 who are they indicated?

(10) Have the required deployment health surveillance programs been established for pre-, during, and post-operations?

(11) What PVNTMED support will US military personnel provide to other members of the multinational force?

b. 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 diagnose disease?

c. How will medical waste be collected and disposed?

d. Are refugee and displaced civilians anticipated?

(1) Are sufficient sanitation facilities planned and available to support refugees and supported civilian populations?

(2) Are sufficient PVNTMED resources planned and available to support refugees and displaced civilians?

(3) How will coordination with international organizations be handled (such as, United Nations High Commissioner for Refugees, International Organization for Migration)?

(4) Has coordination with civil affairs 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?

e. What is the health 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 OEH 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 multinational force members' health screening processes meet the multinational force requirements?

(8) Have any of the participating nations conducted previous operations in the proposed JOA and documented the health threat?

(9) Are immunizations or chemoprophylaxis available to counter the disease threat? And, have participating nations of the multinational force been immunized and/or provided chemoprophylaxis? Also, do members of the multinational force plan to immunize their personnel to US standards?

10. Health Support Facilities and Hospitalization Considerations

a. What medications 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 MTFs 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 MTFs? And can they be utilized as a shared resource?

(5) Are organic dental resources deployed with the medical resource?

b. Will non-US physicians and nonmilitary physicians be permitted to treat patients in a US MTF in the JOA?

c. If non-US physicians and nonmilitary physicians are permitted to treat patients in a US MTF, who will provide credentialing?

d. 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 FHA 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 FHA been considered (such as, World Health Organization emergency health kits)?

e. During disaster relief operations, what behavioral health support will be available for victims, caregivers, and rescuers?

(1) Will the joint force be required to provide behavioral health support to other agencies and individuals supporting the operation?

(2) Will civilian and/or NGO behavioral health become available to provide support to victims, caregivers, and rescuers?

f. What behavioral health intervention support will be available should a terrorist incident occur?

g. What JTF MTFs will be designated for the care of detainees?

11. Medical Regulating and Evacuation Considerations

a. What is the theater patient movement 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 MTF 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 AE team and AE crew 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 patient movement 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 AE requests so that the correct PMI can be replaced when the patient is transferred through the AE system?

i. Will an MASF be established for staging patients awaiting AE 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 remains with the patient?

(4) What medical capability will be established at the aerial point of debarkation or airfield to receive incoming patients and prepare them for further evacuation to the next role of care?

(5) If patients are to be moved to a casualty receiving and treatment ship, are AE personnel qualified for deck landing?

j. Are high capacity air ambulance operations anticipated for MEDEVACs? What will be the requirements for commencing these operations?

12. Medical Logistics Considerations

a. What is the source of Class VIII materiel?

(1) Will Class VIII materiel and resupply be obtained through conventional military channels?

(2) What is the funding source for use of military Class VIII materiel?

(3) Will they be provided by other USG agencies or non-DOD entities?

(4) Will donated medical items be used in disaster relief and FHA operations?

(5) 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 USG department or agency or NGO? Or will the 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 multinational force members?

(2) Will the US be required to provide blood and blood products support to multinational force members?

c. Will the GCC's designated TLAMM provide MEDLOG support for the operation?

d. Will MEDLOG forward distribution teams be considered for seaport of debarkation, aerial port of debarkation, forward operating bases, intermediate staging bases, forward logistic sites, advanced logistic support sites, bases, and forward staging bases?

e. How will medical equipment maintenance and repair be accomplished?

(1) What medical 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 military working dogs, other government-owned animals, or civilian working dogs be used during the operation?

(1) What is the military working dog 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 working dogs such as search and rescue dogs?

b. Will animal husbandry programs be established and/or supported during the operation?

c. How are animals requiring evacuation managed?

(1) Will transportation assets (ground/air) be designated for animal evacuations?

(2) Will dog handlers accompany military working dogs during evacuations?

(3) If animals are unable to accompany handlers, can they be sedated before evacuation?

d. What are the zoonotic disease threats to military working dogs 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?

e. What are the immunization requirements for military working dogs and government-owned animals deploying in the JOA?

f. Will there be a requirement for food processing and distribution site assistance?

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 safety and defense?

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 civil-military operations?

(2) What is the political-military desired end state?

(3) How will medical civil-military operations the commander's intent and the desired political-military end state?

(4) Who has the JFC designated as the lead for medical civil-military operations? Civil affairs? JFS? How will civil affairs and JFS efforts be coordinated?

(5) What medical resources do civil affairs have?

(6) Do medical civil-military operations interfere with the traditional medical mission?

(7) Has the JFC been advised of the capabilities/limitations and major issues involved in the medical civil-military operations?

(8) How will the JTF best support the HN, if the HN does not have a clear long-term strategy?

(9) What other USG departments or 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, USC, and related DODDs and DODIs been fulfilled?

(14) Has the independence/impartiality/neutrality of the NGO/IGO community been acknowledged and respected to allow for the mutual exchange of information?

b. How will medical civil-military operations/activities be coordinated?

(1) Have liaisons with civil affairs personnel been established?

(2) Has a civil-military operations been established? And, has a medical liaison officer to the civil-military operations been appointed?

(3) What other civil-military coordination mechanisms are present (United Nation’s on-site operations coordination center, humanitarian operations center, and so on)? 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 humanitarian and civil assistance, humanitarian assistance program-excess property, and FHA (other) missions been coordinated with Department of State and HN?

c. Are the JFC resources adequate to conduct medical civil-military operations?

(1) Does the medical force have the right training/resources/personnel/equipment to conduct medical civil-military operations (such as training in civil-military operations, information operations, civil-military/interagency relations, FHA, 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 civil-military operations (language/cultural skills, civil-military/interagency/humanitarian training, or experience)? And, does the JTF have the appropriate personnel to conduct medical civil-military operations (public health, pediatrics, adequate number of female providers, and so on)?

(3) Will other multinational force nations conduct or support medical civil-military support operations?

(4) Do projects detract from the multinational force'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, and so on)?

(9) Have local resources been used to the maximum extent possible?

(10) What funding sources will be used? Title 10, USC, humanitarian and civil assistance, FHA, humanitarian assistance program-excess property? Overseas humanitarian disaster and civic aid? Central Emergency Response Fund (United Nations)? Or other funding sources?

(11) What are the restraints/constraints of each funding source?

d. Has a needs assessment preceded medical civil-military operations?

(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 joint force 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 joint force 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, and so on)?

(2) Have local cultural and religious issues been considered (including traditional medicine, female providers for female patients, and so on)?

(3) How will medical civil-military operations 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 medical civil-military operations 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 operations/activities (such as, 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, United Nations, or other agencies?

(9) Who will provide follow-up and continuity of care if direct patient care activities are rendered?

(10) What are the plans to transition responsibility for public health and other medical projects back to the HN or other appropriate authority (US, multinational joint task force, and so on)?

SECTION C. HEALTH 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 health support will they provide?

(b) If mission is a disaster relief, FHA, or peace operation, what type of military personnel 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, International Committee of the Red Cross, and so on) 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, NGO and international organization personnel (American Red Cross workers/volunteers, US Agency for International Development workers), allied personnel, and/or civilian personnel (foreign nationals, victims, and rescuers)?

(e) Will JTF medical 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 patient for nonmilitary or allied 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 medical 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 MTFs be utilized (clinics, health centers, or hospitals)?

1. What capabilities do they possess?

2. Will they require augmentation by military medical personnel?

3. Can medical resources be shared?

(m) Are there specific cultural, religious, or social considerations which may impact health support during stability operations?

(2) Are major operations being considered as part of a multinational force?

(a) Will combat operations be conducted under the sponsorship of the US?

(b) Will the US serve as the lead nation of the multinational force?

(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 multinational force? Will there be a multinational medical staff to plan for multinational-based medical operations?

(f) What are the medical capabilities of the multinational force? What medical personnel, units, and equipment will other nations of the multinational force possess?

(g) Who has been designated to provide health support to the multinational force? Will each nation provide all aspects of health support for their military personnel? What support will each nation require from the JTF?

(h) Will a multinational medical unit or a single nation be designated to provide health support for all nations in the multinational force?

(i) Will medical tasks/responsibilities be distributed to individual multinational nations (such as, MEDEVAC given to nation A, blood given to nation B, ground transportation to nation C)?

(j) Will each nation provide medical liaison officers to participating nations' surgeon's offices?

(k) Will US military personnel be treated by multinational health support? 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 multinational force be eligible for care at US MTFs within the multinational operational area?

1. If members of the multinational force are treated at US MTFs, 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, and so on, be managed and exchanged?

2. Will there be costs associated with multinational force personnel that are treated at US MTFs? Or US personnel treated at multinational force MTF? How will reimbursements be managed?

(m) If there are only US MTFs within the multinational force area of responsibility, who will evacuate multinational force patients to their homeland? What coordination will be required to return a multinational force patient to his nation's MTFs?

(n) Who will ensure communications equipment compatibility, standardization of radio frequencies, reports formats, treatment protocols, and requirements for equipment with allied multinational medical units?

(o) Has a standardized operational and medical terminology reference guide been established to facilitate the synchronization of medical efforts, and minimize misinterpretation with allied multinational medical units?

(p) Will participating nations of the multinational force comply with the provisions of the Geneva Conventions?

(q) Are there specific cultural, religious, or social considerations, which may impact health support during major operations?

b. How will EPWs, detained personnel, and HN civilian care be managed?

(1) How will local nationals be transferred from JTF multinational military personnel to HN facilities?

(2) What will be the disposition of EPWs that require more care than the multinational force 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?

d. Will laboratory support provide for the identification 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?

17. Medical Treatment Facilities and Hospitalization Considerations

a. What MTFs and medical 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 medical 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 MTFs 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 MTFs? And can they be utilized as a shared resource?

(5) Are organic dental resources deployed with the medical resource?

c. What units will provide dental service for the multinational force?

(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 multinational force JOA?

(4) Will one nation provide dental support to the multinational force?

(5) Will a preventive dentistry program be implemented for US military personnel and/or multinational military personnel 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 behavioral health support will be available for multinational force operations?

(1) Will US military personnel be required to provide behavioral health support to members of the multinational force, other agencies and individuals supporting the operation?

(2) During stability operations (FHA, disaster relief), will civilian and/or NGO behavioral health be available to provide support to victims, caregivers, and rescuers?

(3) What behavioral health intervention support will be available should a terrorist incident occur?

e. What multinational JTF MTFs will be designated for the care of detainees?

f. What notification procedures are required when a multinational force member is admitted to a US MTF?

(1) Who notifies the member's national contingent?

(2) How and when will the patient be transferred to their national contingent?

SECTION D. CHECKLIST FOR HEALTH SERVICE SUPPORT PLANNING

18. General Considerations

a. Are the medical tasks, functions, and responsibilities delineated and assigned?

b. Is a comprehensive deployment health surveillance plan developed? Predeployment (such as predeployment health assessments, serum samples collected, preliminary hazard assessment conducted and PVNTMED countermeasures integrated into the plan); deployment OEH surveillance (e.g., environmental baseline surveys, OEH site assessments, 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 patient movement policy been established? If so, have requirements for hospitals and patient movement workload been identified?

f. Are all units on the TPFDD and scheduled for timely arrival, including sufficient PVNTMED 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 population at risk data from the personnel community at least once weekly for the calculation of DNBI workload?

h. Has a theater level laboratory been established/designated?

i. Have estimates of medical sustainability and anticipated resupply requirements been established?

j. Has a JTF JPMRC been established to coordinate movement of patients within and out of the assigned JOA?

k. Has a blood program system been established?

l. Has a JBPO been activated to plan and coordinate the handling, storage, and distribution of blood and blood products within the assigned JOA and consolidate and forward resupply requirements to the ASBPO?

m. 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?

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

gg. Have all other areas of joint health support been addressed such as dental health, behavioral health, and veterinary support?

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

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

SECTION E. HEALTH SUPPORT CHECKLIST FOR CRISIS ACTION PLANNING

19. Crisis Action Planning Phase I: Situation Monitoring

a. Monitor the situation and maintain situational awareness.

(1) What is the nature of the crisis? Noncombatant evacuation operation? Possible FHA operation? Foreign consequence management? Combat? Terrorism?

(2) If noncombatant evacuation operation 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 health support will they provide?

(4) What is the current situation (who, what, when, where, and why)?

(5) What military personnel are available?

(a) Who's ready?

(b) What is their actual readiness status?

(c) Do they meet deployment requirements?

(6) What type of military personnel 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 military personnel? What is the environmental assessment?

(9) What staff actions are being taken?

(10) What courses of action are being considered?

(11) What is the expected time for earliest commitment of military personnel?

(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 area of responsibility 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 medical significance.

(2) Review operational report for medical significance.

(3) Conduct review of existing OPLANs and CONPLANs for applicability to the area or situation.

(4) Review and evaluate actions of the CCMD.

(5) Evaluate disposition of assigned and available military personnel.

(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 PVNTMED procedures and countermeasures been established?

(10) If authority to coordinate with in-place and out-of-JOA MTFs 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 (civil affairs, interagency community, and so on) 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, HN support, allied assets, or contracts with civilian organizations (such as, the International Committee of the Red Cross)?

(5) Review and assess environmental conditions with medical 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.

f. Have medical units and personnel resources been identified?

20. 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 medical implications that could adversely affect operations.

d. Evaluate available medical resources.

(1) What medical military personnel 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 area of responsibility/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 patient movement policy been established?

(2) Has a JPMRC been established?

(3) What airfields are available for intratheater and intertheater AE?

f. Evaluate patient movement from point of injury to the US.

g. Act to improve force readiness and sustainability.

(1) Has medical procedures and countermeasures been established?

(2) Has the medical intelligence preparation of the operational environment information been provided to the J-2 for inclusion in the joint intelligence preparation of the operational environment?

h. If a noncombatant evacuation operation is anticipated, the JFS and joint medical planner should consider the following:

(1) How many of the noncombatants and civilians are known to require medical care?

(2) What is the current condition of the noncombatants and civilians to be evacuated? Are there existing medical conditions?

(3) Where are these noncombatants and civilians, and is there a published plan addressing their collection prior to evacuation?

(4) Is a permissive or nonpermissive noncombatant evacuation operation anticipated, and how best can it be medically supported?

(5) Are there any civilian casualty projections for the noncombatant evacuation operation?

(6) What is the MEDEVAC policy for noncombatant evacuation operation casualties?

(7) Has the Department of State authorized pets to accompany noncombatant evacuation operation evacuees? Does the US Department of Agriculture or other department or agency prohibit any animals from entry into the US?

(8) What will be done with pets brought to evacuation control points?

i. Other Medical 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 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 AE liaison team and air crews, on the time-phased force and deployment list and scheduled for timely arrival?

(2) Identify operational and sustainment military personnel and generate medical requirement estimates using the JMPT.

(3) What reception and operations support facilities are required and available? And who will provide health support 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?

(2) Have medical tasks, functions, and responsibilities been delineated and assigned to the joint force Service component medical units?

(3) Has required medical coordination with allies and the HN been conducted?

(4) Has joint force Service components identified and requested medical personnel augmentation for the medical units and MTFs?

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 medical factors affect the COA under consideration.

(2) Identify military personnel.

(3) What types and amounts of logistic support are available from friendly and allied nations?

(4) What military personnel 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 CCDR/JFC been made aware of the risks?

o. Assist creating deployment database in JOPES for each COA.

p. Coordinate medical sustainment calculations and movement requirements.

(1) Are all medical units-to include AE liaison team and air crews-on the time-phased force and deployment list and scheduled for timely arrival?

(2) What airports and seaports are available to friendly military personnel? What medical support will be required at these locations?

q. Review CCDR's COAs.

(1) Is available health support adequate to support planned operations? If not, what additional assets are required and how will the joint force 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 medical requirements.

t. Prepare medical deployment estimate for each COA.

u. Ensure medical input into deployment estimate to supported commander.

v. Monitor COA development. (What is the backup COA?)

w. Plan for medical sustainment.

(1) Has a TLAMM been considered?

(2) Has an AJBPO been established?

(3) Has the handling, storage, and distribution of blood and blood products been planned and coordinated with the appropriate entities?

(4) How will Class VIIIA and B (Blood) be sustained? Theater MEDLOG management center/TLAMM? Accounts established?

x. Provide medical 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 medical 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.

(1) Identify and resolve medical shortfalls and limitations.

(a) Have Class VIII responsibilities be established?

(b) Have Class VIII channels be established?

(2) Review the TPFDD.

(3) Identify early-deploying military personnel and assign tasks.

(a) Who will provide health support for joint reception, staging, onward movement, and integration?

(b) Has medical procedures and countermeasures been established?

(c) Has the medical intelligence preparation of the operational environment information been provided to components and early deploying military personnel?

(4) Identify and plan for patient movement requirements.

(a) Is the JPMRC fully functional?

- (b) Is the theater AE system planning complete?
 - (c) Is sufficient theater AE assets in-place or programmed for early arrival?
 - (d) Have primary and secondary AE airfields been identified?
 - (e) Are AE liaison officers ready to locate at key locations within each joint force Service component medical system?
 - (f) Do Service components understand that they are required to move patients to supporting AE staging facilities, and will they be able to do so?
- (5) Ensure that adequate transportation for health support is available to support approved COA.
- (6) Coordinate changes caused by conflicts and shortfalls.
- (7) Provide medical input to CCDR's draft execute order.

21. Crisis Action Planning Phase III: Execution

- a. Review CCDR's/JFC's execute order to ensure medical guidance to components.
- b. Monitor medical force deployment.
- c. Validate medical movement requirements as required.
- d. Coordinate with appropriate staff directorates and resolve reported shortfalls.
- e. Coordinate employment of medical units as required.
- f. Consider issuance of FRAGORDs to reiterate key medical themes and countermeasures, and publish medical CONOPS to joint force personnel.
- g. Report movement requirements as required.
- h. Coordinate medical sustainment for components.

SECTION F. HEALTH SUPPORT CHECKLIST FOR HUMANITARIAN ASSISTANCE SURVEY TEAM AND ADVANCED ECHELON TEAM

22. Foreign 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 medical 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 predeployment country intelligence data (joint intelligence preparation of the operational environment).
- (8) Establish local POCs to deployment country (such as 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 humanitarian assistance survey team.

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 area of responsibility 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 latitude/longitude: _____

(8) Nature of contingency: _____

(9) Summary of population affected (such as, 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) Point of contact 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. Military Personnel Strength to be Supported.

(1) US military personnel.

(a) US Army _____

(b) US Navy _____

(c) US Air Force _____

(d) US Marines _____

(2) Multinational Military Personnel (if authorized).

(a) North Atlantic Treaty Organization _____

(b) United Nations _____

(c) Other/Origin _____

(3) Number of American Citizens _____

(4) US Agency for International Development on site?

YES No

(5) International governmental organizations, NGOs, and so on on-site?

YES NO

(6) Third-country nationals of interest to Department of State?

YES NO

(7) If Yes, list:

(8) What is the general feeling towards working with American military?

(9) Any other US and North Atlantic Treaty Organization civilians?

NO YES, approx # _____

(10) Any potential EPWs? NO YES, approx # _____

(11) If mission is a FHA, 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 status-of-forces agreements?

(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) Identify regional and local endemic diseases:

(8) Problematic seasonal diseases in the region and local population:

(9) What is the occurrence of illnesses and deaths caused by temperature extremes?

(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.
 - (q) Acquired immune deficiency syndrome.
 - (r) Other _____
-

(11) Prevalence of sexually transmitted diseases.

High Average Low

(12) What are the most common sexually transmitted diseases?

(13) Are there any sexually transmitted disease 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, and so on):

(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 military personnel trained/treating people to control outbreaks:

(28) List number and capabilities of MTFs used to control outbreaks:

(29) List of common drugs 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) Human immune-deficiency virus/acquired immune deficiency syndrome.
- (q) Rabies post exposure prophylaxis and human rabies vaccine.
- (r) 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 the operational area (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, and so on):

(5) Typical and extreme climate conditions possible during operations: _____

(6) Include brief description and number of each:

(a) Military airfields _____

(b) Civilian airfields _____

(c) Helicopter-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 area of responsibility? 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, and so on): _____

(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 operational area:

(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 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 (such as, malaria/mosquitoes, leishmaniasis/flies, 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 antivenom readily available? YES NO

If YES, list closest source: _____

(31) Are animals rabies vaccine readily available? What is closest source?

(32) List all discovered and suspected common contaminants in local food and water:

(33) Describe hand-washing facilities, showers, and latrine facilities:

(34) Are septic systems used? YES NO

(35) If YES, what is the condition of the septic tanks and drain fields? _____

(36) What type of liquid waste disposal system is available?

(37) What is the condition of liquid waste drains from buildings?

(38) How is solid waste disposed of (burial, burning, and so on)?

(39) Will the deployed unit have to collect and dispose of solid waste or does the host-nation provide garbage and refuse disposal?

(40) How is regulated medical waste disposed?

(41) Is there history of accidental or intentional chemical/biological/nuclear releases in the operational area? YES NO

(42) If YES, describe (include copies of historical records if possible): _____

(43) 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): _____

(44) 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 care policy for providing to:

(a) Military members _____

(b) General public _____

(c) Nongovernmental organizations _____

(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 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

(3) Include a wire diagram/organizational chart of the military medical system.

(4) What services are provided by military medicine?

(5) What is the care policy for providing 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 the MTF layout, medical services, supplies, and bed capacity:

(8) Describe the chain of battlefield evacuation:

k. Physical condition of military personnel from host/contributing nations.

(1) Origin of military personnel:

(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 human immune-deficiency virus/acquired immune deficiency syndrome prevention programs does the contributing nation's military practice?

(10) Is human immune-deficiency virus/acquired immune deficiency syndrome screened for during recruitment and throughout military service? YES NO

(a) If YES, is human immune-deficiency virus/acquired immune deficiency syndrome a reason for discharge from the contributing nation's military (circle)?

YES NO

l. Management of disaster/humanitarian crises.

(1) Attach a list of organizations involved in disaster response and their capabilities.

(2) Attach a diagram national level C2.

(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, Federal Emergency Management Agency

(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) United Nations Resident Coordinator _____

(i) United Nations-Office for the Coordination of Humanitarian Affairs
Field Representative _____

(j) Defense Attaché/US Ambassador

(14) Has a civil-military operations 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, Global Positioning System coordinates):

(4) Primary POC Name: _____

(5) Title: _____

(6) Hospital phone/facsimile 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 imaging: _____

(c) Magnetic resonance imaging: _____

(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, and so on):

(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 (such as, 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, and so on):

(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:

DEFENSE SWITCHED NETWORK FACSIMILE DATA SECURE
COMMUNICATION

(23) Is there a medical/fire/crash radio network available? YES NO

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

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 military 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 military personnel use?
YES NO

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

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> Human immune-deficiency syndrome	virus/acquired	immune	deficiency
	YES	NO	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, intravenous transfusion bags, catheters, and tubing:

(12) Life Support and Diagnostic Equipment: (number/condition/make and model).

(a) Respirators:

(b) Intravenous equipment:

(c) Defibrillators:

(d) Dialysis equipment:

(e) X-Ray capabilities:

(f) Ultrasound:

(g) Computerized axial tomography (better known as CAT scan):

(h) Magnetic resonance imaging:

(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 helicopter-landing zones? YES NO

(a) If YES, has it been surveyed by US airfield specialist in past year?
YES NO

If YES, obtain a copy of survey to include Global Positioning System coordinates, transit time, and capabilities.

(b) Distance to beachhead: _____

(c) Distance to port: _____

(5) Are ambulances available for use? YES NO

(a) List vehicle types/litter capacity:

(b) Number of medical transport military 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
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 US military personnel were deployed?

(3) Critical open issues:

(4) Recommended medical courses of action.

(a) Course of action 1:

(b) Course of action 2:

(c) Course of action 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, and so on). Discuss problems with other team members including the site survey mission commander or advanced echelon team chief. Your report should emphasize telephone or written correspondence to answer questions and avoid misunderstandings.

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APPENDIX M REFERENCES

The development of JP 4-02 is based upon the following primary references:

1. Federal Statutory Laws

Title 10, USC, Armed Forces.

2. Multinational Documents

a. Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949.

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 4515.13-R, *Air Transportation Eligibility*.

b. DOD 7000.14-R, *Department of Defense Financial Management Regulations (FMR)*.

c. DODD 2310.01E, *The Department of Defense Detainee Program*.

d. DODD 3002.01E, *Personnel Recovery in the Department of Defense*.

e. DODD 3115.09, *DOD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning*.

f. DODD 5101.9, *DOD Executive Agent for Medical Materiel*.

g. DODD 6000.12E, *Health Services Support*.

h. DODD 6200.04, *Force Health Protection (FHP)*.

- i. DODD 6490.02E, *Comprehensive Health Surveillance*.
- j. DODI 2310.08E, *Medical Program Support for Detainee Operations*.
- k. DODI 2310.4, *Repatriation of Prisoners of War (POW), Hostages, Peacetime Government Detainees and Other Missing or Isolated Personnel*.
- l. DODI 3000.05, *Stability Operations*.
- m. DODI 3020-41, *Contractor Personnel Authorized to Accompany the US Armed Forces*.
- n. DODI 6000.11, *Patient Movement*.
- o. DODI 6000.16, *Military Health Support for Stability Operations*.
- p. DODI 6010.22, *National Disaster Medical System (NDMS)*.
- q. DODI 6055.1, *DOD Safety and Occupational Health (SOH) Program*.
- r. DODI 6420.01, *National Center for Medical Intelligence (NCMI)*.
- s. DODI 6480.04, *Armed Services Blood Program (ASBP) Operational Procedures*.
- t. DODI 6490.03, *Deployment Health*.

4. Chairman of the Joint Chiefs of Staff Directives

- a. CJCSI 3110.04B, *Nuclear Supplement to the Joint Strategic Capabilities Plan*.
- b. CJCSI 3290.01C, *Program for Detainee Operations*.
- c. CJCSI 3500.02A, *Universal Joint Task Force (UJTL) Policy and Guidance for the Armed Forces of the United States*.
- d. CJCSM 3122.03C, *Joint Operation Planning and Execution System (JOPES) Volume II, Planning Formats*.
- e. CJCSM 3500.04E, *Universal Joint Task Manual*.
- f. MCM 0028-07, *Procedures for Deployment Health Surveillance*.

5. Joint Publications

- a. JP 1, *Doctrine for the Armed Forces of the United States*.
- b. JP 1-02, *Department of Defense Dictionary of Military and Associated Terms*.
- c. JP 3-0, *Joint Operations*.

- d. JP 3-05, *Special Operations*.
- e. JP 3-11, *Operations in Chemical, Biological, Radiological, and Nuclear (CBRN) Environments*.
- f. JP 3-16, *Multinational Operations*.
- g. JP 3-18, *Joint Forcible Entry Operations*.
- h. JP 3-29, *Foreign Humanitarian Assistance*.
- i. JP 3-33, *Joint Task Force Headquarters*.
- j. JP 3-50, *Personnel Recovery*.
- k. JP 3-57, *Civil-Military Operations*.
- l. JP 4-0, *Joint Logistics*.
- m. JP 4-06, *Mortuary Affairs*.
- n. JP 4-10, *Operational Contract Support*.
- o. JP 5-0, *Joint Operation Planning*.

6. Combatant Command Publications

- a. US Central Command, CINC's Warfighting Instructions, Vol. 1, *Operations Standing Operating Procedures*.
- b. United States European Command (USEUCOM) Directive 55-11, *USEUCOM Theater Command and Control Policy*.
- c. Common Joint Task Force Headquarters Standing Operating Procedure, Version 2.0.
- d. USJFCOM, Joint Task Force Commander's Handbook for Peace Operations.
- e. United States Pacific Command, Joint Task Force Headquarters Standing Operating Procedures.

7. Multi-Service Publications

- a. Field Manual (FM) 3-11.21, AFTTP(I) 3-2.37, NTTP 3-11.24, Marine Corps Reference Publication (MCRP) 3-37.2C, *Multi-Service Tactics, Techniques, and Procedures for Chemical, Biological, Radiological, and Nuclear Consequence Management Operations*.

b. FM 3-100.12, AFTTP(I) 3-2.34, NTTP 5-03.5, MCRP 5-12.1C, *Multi-Service Tactics, Techniques, and Procedures for Risk Management*.

c. Army Regulation (AR) 40-538, Air Force Regulation 167-5, Navy Bureau of Medicine Instruction 6700.2B, *Property Management During Patient Evacuation*.

d. FM 4-02.7, NTTP 4-02.7, AFTTP (I) 3-42.3, MCRP 4-11.1F, *Multi-Service Tactics, Techniques, and Procedures for Health Service Support in a Chemical, Biological, Radiological, and Nuclear Environment*.

e. Department of the Army Pamphlet 40-11, *Preventive Medicine*.

f. AFTTP 3-42.1, *Medical Command and Control*.

g. AFTTP 3-42.72, *Emergency Medical Support*.

8. United States Army Publications

a. AR 40-1, *Composition, Mission, and Functions of the Army Medical Department*.

b. AR 40-3, *Medical, Dental, and Veterinary Care*.

c. AR 40-4, *Army Medical Department Facilities/Activities*.

d. AR 40-5, *Preventive Medicine*.

e. AR 40-7, *Use of Investigational Drugs and Devices in Humans and the Use of Scheduled I Controlled Drug Substances*.

f. AR 40-10, *Health Hazard Assessment Program in Support of the Army Acquisition Process*.

g. AR 40-12, *Quarantine Regulations of the Armed Forces*.

h. AR 40-13, *Medical Support - Nuclear/Chemical Accidents and Incidents*.

i. AR 40-35, *Dental Readiness and Community Oral Health Protection*.

j. AR 40-38, *Clinical Investigation Program*.

k. AR 40-56, *Introduction, Requirements Determination, & Publication of New Standardized Medical Items into the Department of Defense*.

l. AR 40-60, *Policies and Procedures for the Acquisition of Medical Materiel*.

m. AR 40-61, *Medical Logistics Policies*.

n. AR 40-63, *Ophthalmic Services*.

- o. AR 40-66, *Medical Record Administration and Health Care Documentation*.
- p. AR 40-68, *Clinical Quality Management*.
- q. AR 40-350, *Patient Regulating to and Within the Continental United States*.
- r. AR 40-400, *Patient Administration*.
- s. AR 40-538, *Property Management During Patient Evacuation*.
- t. AR 40-562, *Immunizations and Chemoprophylaxis*.
- u. AR 40-656, *Veterinary Surveillance Inspection of Subsistence*.
- v. AR 40-657, *Veterinary/Medical Food Inspection and Laboratory Service*.
- w. AR 190-8, *Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees*.
- x. FM 4-02, *Force Health Protection in a Global Environment*.
- y. FM 4-02.1, *Army Medical Logistics*.
- z. FM 4-02.17, *Preventive Medicine Services*.
- aa. FM 4-02.18, *Veterinary Service Tactics, Techniques, and Procedures*.
- bb. FM 4-02.19, *Dental Service Support Operations*.
- cc. FM 4-02.2, *Medical Evacuation*.
- dd. FM 4-02.55, *Planning for Health Service Support*.
- ee. United States Army Center for Health Promotion and Preventive Medicine (USACHPPM) Technical Guide 124, *Occupational Health Program Manual*.
- ff. USACHPPM Technical Guide 185, *Commander's Guide to the Health Risk Assessment Process*.
- gg. USACHPPM Technical Guide 244, *The Medical CBRN Battlebook*.
- hh. USACHPPM, Technical Guide 248, *Guide for Deployed Preventive Medicine Personnel on Health Risk Management*.
- ii. Army Medical Research Institute of Chemical Defense, *Medical Management of Chemical Casualties Handbook*.
- jj. Army Medical Research Institute of Infectious Diseases, *Medical Management of Biological Casualties Handbook*.

9. United States Air Force Publications

- a. Air Force Doctrine Document (AFDD) 4-02, *Health Services*.
- b. AFDD 3-17, *Air Mobility Operations*.
- c. Air Force Instruction (AFI) 10-2909, *Equipment Standards*.
- d. AFI 11 2AE, Vol. 3, *Flying Operations, Aeromedical Evacuation (AE) Operations Procedures*.
- e. AFI 41-106, *Unit Level Management of Medical Readiness Programs*.
- f. AFI 41-201, *Managing Clinical Engineering Programs*.
- g. AFI 41-209, *Medical Logistics Support*.
- h. AFI 41-301, *Worldwide Aeromedical Evacuation System*.
- i. AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*.
- j. Air Force Joint Instruction 41-315, *Patient Regulation to and Within the Continental United States*.
- k. AFI 44-105, *The Air Force Blood Program*.
- l. AFMAN 41-216, *Defense Medical Logistics Standard Support User Manual*.
- m. Air Force Pamphlet 90-902, *Operational Risk Management (ORM) Guidelines and Tools*.
- n. Air Force Policy Directive (AFPD) 10-29, *Worldwide Aeromedical Evacuation Operations*.
- o. AFPD 41-1, *Health Care Programs and Resources*.
- p. AFTTP 3-42.5, *Aeromedical Evacuation (AE)*.
- q. AFTTP 3-42.8, *Expeditionary Medical Logistics System*.
- r. AMC Pamphlet 11-303, *Access to the Aeromedical Evacuation System*.

10. United States Navy Publications

- a. Navy Warfare Publication (NWP) 4-02, *Naval Expeditionary Health Service Support Afloat and Ashore*.
- b. Navy Tactics Techniques and Procedures (NTTP) 4-02.6, *Hospital Ships*.

c. Navy Medical P-6530, *Technical Manual, Armed Services Blood Program, Joint Blood Program Handbook*.

11. United States Marine Corps Publications

- a. MCWP 4-1, *Logistics Operations*.
- b. MCWP 4-11, *Tactical-Level Logistics*.
- c. MCRP 4-11.1, *Health Service Support Operations*.
- d. MCRP 4-11, *Tactical-Level Logistics*.
- e. MCRP 4-12, *Operational-Level Logistics*.
- f. Marine Corps Doctrinal Publication 4, *Logistics*.
- g. MCRP 5-12D, *Organization of The Marine Corps Forces*.
- h. Navy/Marine Corps 2599, *A Guidebook for Commanders Material Management*.

12. Other References

- a. The Defense Medical Logistics Standard Support Release 3.1.
- b. 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: Joint Staff, operational plans and interoperability directorate of a joint staff (J-7), Deputy Director, Joint and Coalition Warfighting, Joint and Coalition Warfighting Center, ATTN: Joint Doctrine Support Division, 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 US Army. The Joint Staff doctrine sponsor for this publication is the Joint Staff Logistics Directorate (J-4).

3. Supersession

This publication supersedes JP 4-02, 31 October 2006, *Health Service Support*.

4. Change Recommendations

a. Recommendations for urgent changes to this publication should be submitted:

TO: JOINT STAFF WASHINGTON DC//J7-JEDD//

b. Routine changes should be submitted electronically to the Deputy Director, Joint and Coalition Warfighting, Joint and Coalition Warfighting Center, Joint Doctrine Support Division and info the lead agent and the Director for Joint Force Development, J-7/Joint Education and Doctrine Division.

c. When a Joint Staff directorate submits a proposal to the CJCS 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 Services and other organizations are requested to notify the Joint Staff J-7 when changes to source documents reflected in this publication are initiated.

5. Distribution of Publications

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6. Distribution of Electronic Publications

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GLOSSARY

PART I—ABBREVIATIONS AND ACRONYMS

AB	air base
AE	aeromedical evacuation
AELT	aeromedical evacuation liaison team
AEOT	aeromedical evacuation operations team
AESC	aeromedical evacuation support cell
AF	Air Force (form)
AFB	Air Force base
AFDD	Air Force doctrine document
AFHSC	Armed Forces Health Surveillance Center
AFI	Air Force instruction
AFMAN	Air Force manual
AFPD	Air Force policy directive
AFSOF	Air Force special operations forces
AFTTP	Air Force tactics, techniques, and procedures
AJBPO	area joint blood program office
AMC	Air Mobility Command
AMC/SGXM	Air Mobility Command/Command Surgeon's Office
AMD	air mobility division
AOC	air and space operations center (USAF)
AR	Army regulation
ASBP	Armed Services Blood Program
ASBPO	Armed Services Blood Program Office
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BI	battle injury
BMET	biomedical electronics technician
BTC	blood transshipment center
C2	command and control
CASEVAC	casualty evacuation
CASF	contingency aeromedical staging facility
CBRN	chemical, biological, radiological, and nuclear
CCDR	combatant commander
CCMD	combatant command
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
CLIA	Clinical Laboratory Improvement Amendments
COA	course of action
COMAFFOR	commander, Air Force forces
CONOPS	concept of operations
CONPLAN	concept plan
CRAF	Civil Reserve Air Fleet

DD	Department of Defense (form)
DIRMOBFOR	director of mobility forces
DLA	Defense Logistics Agency
DNBI	disease and nonbattle injury
DOD	Department of Defense
DODD	Department of Defense directive
DODI	Department of Defense instruction
DOEHRS	Defense Occupational and Environmental Health Reporting System
DSN	Defense Switched Network
EAES	expeditionary aeromedical evacuation squadron
EMF	expeditionary medical facility
EPW	enemy prisoner of war
FAX	facsimile
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FFP	fresh frozen plasma
FHA	foreign humanitarian assistance
FHP	force health protection
FM	field manual (Army)
FRAGORD	fragmentary order
GC	Geneva Convention Relative to the Protection of Civilian Persons in Time of War
GCC	geographic combatant commander
GPMJAB	Global Patient Movement Joint Advisory Board
GPMRC	Global Patient Movement Requirements Center
GPW	Geneva Convention Relative to the Treatment of Prisoners of War
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
HN	host nation
HQ	headquarters
HSS	health service support
IGO	intergovernmental organization
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
J-7	operational plans and interoperability directorate of a joint staff
JAOC	joint air operations center
JBPO	joint blood program office
JDDOC	joint deployment and distribution operations center
JFACC	joint force air component commander
JFC	joint force commander
JFS	joint force surgeon
JMOC	joint medical operations center
JMPT	Joint Medical Planning Tool
JMWG	joint medical working group
JOA	joint operations area
JOPEs	Joint Operation Planning and Execution System
JP	joint publication
JPMRC	joint patient movement requirements center
JRSOI	joint reception, staging, onward movement, and integration
JTF	joint task force
MASCAL	mass casualty
MASF	mobile aeromedical staging facility
MCRP	Marine Corps reference publication
MCWP	Marine Corps warfighting publication
MDBS	blood support medical detachment
MEDEVAC	medical evacuation
MEDLOG	medical logistics (USAF AIS)
MTF	medical treatment facility
NAVSOE	Navy special operations forces
NBI	nonbattle injury
NCMI	National Center for Medical Intelligence
NDMS	National Disaster Medical System (DHHS)
NGO	nongovernmental organization
NTTP	Navy tactics, techniques, and procedures
OEH	occupational and environmental health
OPCON	operational control
OPLAN	operation plan
OPORD	operation order
PHEO	public health emergency officer
PJ	pararescue jumper
PMI	patient movement item
PMITS	Patient Movement Item Tracking System

Glossary

PMRC	patient movement requirements center
POC	point of contact
POW	prisoner of war
PVNTMED	preventive medicine
RBC	red blood cell
Rh	Rhesus
618th TACC	618th Tanker Airlift Control Center
SecDef	Secretary of Defense
SERE	survival, evasion, resistance, and escape
SGXM	Headquarters, Air Mobility Command/Surgeon
SIMLM	single integrated medical logistics manager
SME	subject matter expert
SOCM	special operations combat medic
SOF	special operations forces
SOP	standard operating procedure
2E	Role 2 enhanced
2LM	Role 2 light maneuver
TLAMM	theater lead agent for medical materiel
TPFDD	time-phased force and deployment data
TPMRC	theater patient movement requirements center
TRAC2ES	transportation command regulating and command and control evacuation system
USA	United States Army
USACHPPM	United States Army Center for Health Promotion and Preventive Medicine
USAF	United States Air Force
USC	United States Code
USCG	United States Coast Guard
USG	United States Government
USMC	United States Marine Corps
USN	United States Navy
USTRANSCOM	United States Transportation Command
UTC	unit type code
WIA	wounded in action

PART II—TERMS AND DEFINITIONS

acute care services. None. (Approved for removal from 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. SOURCE: JP 4-02)

aeromedical evacuation coordination center. None. (Approved for removal from JP 1-02.)

aeromedical evacuation system. None. (Approved for removal from JP 1-02.)

aeromedical evacuation unit. An operational medical organization concerned primarily with the management and control of patients being transported via an aeromedical evacuation system or system echelon. (Approved for incorporation into JP 1-02 with JP 4-02 as the source JP.)

ambulance exchange point. None. (Approved for removal from JP 1-02.)

aviation medicine. The special field of medicine which is related to the biological and psychological problems of flight. (Approved for incorporation into JP 1-02 with JP 4-02 as the source JP.)

battle injury. Damage or harm sustained by personnel during or as a result of battle conditions. Also called **BI**. (JP 1-02. SOURCE: JP 4-02)

buddy-aid. Acute medical care (first aid) provided by a non-medical Service member to another person. (JP 1-02. SOURCE: JP 4-02)

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. SOURCE: JP 4-02)

casualty category. None. (Approved for removal from JP 1-02.)

casualty evacuation. The unregulated movement of casualties that can include movement both to and between medical treatment facilities. Also called **CASEVAC**. (JP 1-02. SOURCE: JP 4-02)

casualty status. None. (Approved for removal from JP 1-02.)

casualty type. None. (Approved for removal from 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 elements of cooperation activities, and medical civil-military operations. (Approved for incorporation into JP 1-02.)

combat and operational stress. The expected and predictable emotional, intellectual, physical, and/or behavioral reactions of an individual who has been exposed to stressful events in war or stability operations. (Approved for incorporation into 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. (JP 1-02. SOURCE: JP 4-02)

deceased. None. (Approved for removal from JP 1-02.)

definitive care. Care rendered to conclusively manage a patient's condition, such as full range of preventive, curative acute, convalescent, restorative, and rehabilitative medical care. (Approved for incorporation into 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, which includes occupational and environmental health surveillance and medical surveillance subcomponents. (Approved for incorporation into JP 1-02.)

died of wounds received in action. None. (Approved for removal from JP 1-02.)

disease and nonbattle injury. All illnesses and injuries not resulting from enemy or terrorist action or caused by conflict. Also called **DNBI**. (Approved for incorporation into JP 1-02.)

disease and nonbattle injury casualty. None. (Approved for removal from JP 1-02.)

duty status - whereabouts unknown. None. (Approved for removal from JP 1-02.)

end item. A final combination of end products, component parts, and/or materials that is ready for its intended use. (Approved for incorporation into JP 1-02.)

en route care. Continuation of the provision of care during movement (evacuation) between the health service support capabilities in the roles of care, without clinically compromising the patient's condition. (Approved for incorporation into JP 1-02.)

essential care. Medical treatment provided to manage the casualty throughout the roles of care, which 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. (Approved for incorporation into JP 1-02.)

evacuation. 1. Removal of a patient by any of a variety of transport means 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. (JP 4-02) 2. The clearance of personnel, animals, or materiel from a given locality. (JP 3-68) 3. The controlled process of collecting, classifying, and shipping unserviceable or abandoned materiel, United States or foreign, to appropriate reclamation, maintenance, technical intelligence, or disposal facilities. (JP 4-09) 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. (JP 3-68) (Approved for incorporation into JP 1-02.)

expendable property. None. (Approved for removal from JP 1-02.)

expendable supplies. Supplies that are consumed in use, such as ammunition, paint, fuel, cleaning and preserving materials, surgical dressings, drugs, medicines, etc., or that lose their identity, such as spare parts, etc., and may be dropped from stock record accounts when it is issued or used. (Approved for inclusion in JP 1-02.)

expendable supplies and materiel. None. (Approved for removal from JP 1-02.)

first responder. A primary health care provider who provides immediate clinical care and stabilization in preparation for evacuation to the next health service support capability in the roles of care, and treats Service members for common acute minor illnesses. (Approved for replacement of “first responders” and its definition in 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. (JP 1-02. SOURCE: JP 4-02)

fixed medical treatment facility. None. (Approved for removal from JP 1-02.)

Fleet Marine Force. A balanced force of combined arms comprising land, air, and service elements of the United States Marine Corps, which is an integral part of a United States fleet and has the status of a type command. Also called **FMF**. (Approved for incorporation into JP 1-02.)

force health protection. Measures to promote, improve, or conserve the behavioral and physical well-being of Service members to enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. Also called **FHP**. (Approved for incorporation into JP 1-02.)

forward aeromedical evacuation. None. (Approved for removal from JP 1-02.)

forward area. An area in proximity to combat. (Approved for incorporation into JP 1-02 with JP 4-02 as the source JP.)

forward resuscitative care. Care provided as close to the point of injury as possible based on current operational requirements to attain stabilization, achieve the most efficient use of life-and-limb saving medical treatment, and provide essential care so the patient can tolerate evacuation, which is known as Role 2 care in the North Atlantic Treaty Organization doctrine. Also called **FRC**. (Approved for incorporation into JP 1-02.)

friendly fire. None. (Approved for removal from JP 1-02.)

Global Patient Movement Requirements Center. A joint activity reporting directly to the Commander, United States Transportation Command, which provides medical regulating and aeromedical evacuation scheduling for the continental United States and intertheater operations, provides support to the theater patient movement requirements centers, and 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**. (Approved for incorporation into 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. Also called **DOD health care provider**. (Approved for incorporation into JP 1 02.)

health hazard assessment. None. (Approved for removal from JP 1-02.)

health service logistic support. None. (Approved for removal from 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, which 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 and operational stress control; and medical, dental, veterinary, laboratory, optometric, nutrition therapy, and medical intelligence services. Also called **HSS**. (Approved for incorporation into 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, which includes occupational and environmental health surveillance and medical surveillance subcomponents. (Approved for incorporation into 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 chemical, biological, radiological, and nuclear weapons (to include weapons of mass destruction) that have the potential to affect the short- or long-term health (including psychological impact) of personnel. (Approved for incorporation into JP 1-02.)

hospital. None. (Approved for removal from JP 1-02.)

injury. 1. A term comprising such conditions as fractures, wounds, sprains, strains, dislocations, concussions, and compressions. 2. Conditions resulting from extremes of temperature or prolonged exposure. 3. Acute poisonings (except those due to contaminated food) resulting from exposure to a toxic or poisonous substance. (Approved for incorporation into 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. (JP 1-02. SOURCE: JP 4-02)

intransit aeromedical evacuation facility. None. (Approved for removal from JP 1-02.)

intratheater patient movement. Moving patients within the theater of a combatant command or in the continental United States. (JP 1-02. SOURCE: JP 4-02)

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**. (JP 1-02. SOURCE: JP 4-02)

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. Also called **JPMRC**. (Approved for incorporation into JP 1-02.)

joint patient movement team. Teams comprised of personnel trained in medical regulating and movement procedures. Also called **JPMT**. (Approved for incorporation into JP 1-02.)

killed in action. None. (Approved for removal from JP 1-02.)

lead agent. 1. An individual Service, combatant command, or Joint Staff directorate assigned to develop and maintain a joint publication. (CJCSI 5120.02) 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**. (JP 4-02) (Approved for incorporation into JP 1-02 with CJCSI 5120.02 as the source document for Definition #1.)

life cycle. The total phases through which an item passes from the time it is initially developed until the time it is either consumed in use or disposed of as being excess to all known materiel requirements. (Approved for incorporation into JP 1-02 with JP 4-02 as the source JP.)

litter. None. (Approved for removal from JP 1-02.)

litter patient. None. (Approved for removal from JP 1-02.)

logistic support (medical). None. (Approved for removal from 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**. (Approved for incorporation into 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 United States operational objectives, and positively impact the health sector. Also called **MCMO**. (Approved for incorporation into JP 1-02.)

medical contingency file. None. (Approved for removal from JP 1-02.)

medical engagement 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 replacement of “medical protocols” in JP 1-02.)

medical evacuees. None. (Approved for removal from 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. Also called **MIPOE**. (Approved for incorporation into JP 1-02.)

medical logistics support. A functional area of logistics support for the joint force surgeon’s health service support mission and that 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 **MEDLOG support**. (Approved for inclusion in JP 1-02.)

medical regulating. The actions and coordination necessary to arrange for the movement of patients through the roles of care and to match patients with a medical treatment facility that has the necessary health service support capabilities and available bed space. (Approved for incorporation into 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. (JP 1-02. SOURCE: JP 4-02)

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. SOURCE: JP 4-02)

military health system. A health system that supports the military mission by fostering, protecting, sustaining, and restoring health and providing the direction, resources, health care providers, and other means necessary for promoting the health of the beneficiary population. (Approved for incorporation into JP 1-02.)

military van (container). Military-owned, demountable container, conforming to United States and international standards, operated in a centrally controlled fleet for movement of military cargo. Also called **MILVAN**. (Approved for incorporation into JP 1-02).

MILVAN. None. (Approved for removal from JP 1-02.)

nonbattle injury. A person who becomes a casualty due to circumstances not directly attributable to hostile action or terrorist activity. Also called **NBI**. (Approved for incorporation into JP 1-02 with JP 4-02 as the source JP.)

nonhostile casualty. None. (Approved for removal from JP 1-02.)

not seriously injured. None. (Approved for removal from 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. (JP 1-02. SOURCE: JP 4-02)

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. SOURCE: JP 4-02)

occupied territory. Territory under the authority and effective control of a belligerent armed force and not being administered pursuant to peace terms, treaty, or other agreement, express or implied, with the civil authority of the territory. (Approved for incorporation into JP 1-02.)

operational testing. A continuing process of evaluation that may be applied to either operational personnel or situations to determine their validity or reliability. (Approved for incorporation into JP 1-02 with JP 4-02 as the source JP.)

opportune lift. That portion of lift capability available for use after planned requirements have been met. (JP 1-02. SOURCE: JP 4-02)

originating medical treatment facility. A medical facility that initially transfers a patient to another medical facility. (Approved for replacement of “originating medical facility” in JP 1-02.)

patient. None. (Approved for removal from 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. SOURCE: JP 4-02)

patient movement items. The medical equipment and supplies required to support patients during aeromedical evacuation, which is part of a standardized list of approved safe-to-fly equipment. Also called **PMIs**. (Approved for incorporation into JP 1-02.)

patient movement policy. Command decision establishing the maximum number of days that patients may be held within the command for treatment. (Approved for incorporation into JP 1-02.)

patient movement requirements center. 1. A joint activity that coordinates patient movement by functionally merging of joint medical regulating processes, Services' medical regulating processes, and patient movement evacuation requirements planning (transport to bed plan). 2. Term used to represent any theater, joint or the Global Patient Movement Requirements Center function. Also called **PMRC**. (Approved for incorporation into JP 1-02.)

pool. None. (Approved for removal from 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**. (JP 1-02. SOURCE: JP 4-02)

precedence. None. (Approved for removal from JP 1-02.)

preventive maintenance. The care and servicing by personnel for the purpose of maintaining equipment and facilities in satisfactory operating condition by providing for systematic inspection, detection, and correction of incipient failures either before they occur or before they develop into major defects. (Approved for incorporation into JP 1-02 with JP 4-02 as the source JP.)

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. Also called **PVNTMED**. (Approved for incorporation into 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**. (JP 1-02. SOURCE: JP 4-02)

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. (JP 1-02. SOURCE: JP 4-02)

seriously ill or injured. None. (Approved for removal from JP 1-02.)

seriously wounded. None. (Approved for removal from JP 1-02.)

slightly wounded. None. (Approved for removal from JP 1-02.)

stabilized patient. A patient whose airway is secured, hemorrhage is controlled, shock treated, and fractures are immobilized. (JP 1-02. SOURCE: JP 4-02)

stable patient. A patient for whom no inflight medical intervention is expected but the potential for medical intervention exists. (JP 1-02. SOURCE: JP 4-02)

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. (JP 1-02. SOURCE: JP 4-02)

stretcher. None. (Approved for removal JP 1-02.)

tactical aeromedical evacuation. None. (Approved for removal from JP 1-02.)

tactical air transport operations. None. (Approved for removal from JP 1-02.)

tactical combat casualty care. A set of trauma management guidelines customized for use on the battlefield that maintains a sharp focus on the most common causes of preventable deaths on the battlefield: external hemorrhage; tension pneumothorax; and airway obstruction. (Approved for inclusion in 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. (JP 1-02. SOURCE: JP 4-02)

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, which is known as Role 3 in North American Treaty Organization doctrine. (Approved for incorporation into 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**. (JP 1-02. SOURCE: JP 4-02)

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. (JP 4-01.5) 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. (JP 1-02. SOURCE: JP 4-02)

unaccounted for. None. (Approved for removal from JP 1-02.)

unit type code. A Joint Chiefs of Staff developed and assigned code, consisting of five characters that uniquely identify a “type unit.” Also called **UTC**. (Approved for incorporation into JP 1-02.)

unstable patient. A patient whose physiological status is in fluctuation and for whom emergent, treatment, and/or surgical intervention are anticipated during treatment or evacuation; and the patient’s rapidly changing status and requirements are beyond the standard en route care capability and requires medical/surgical augmentation. (Approved for incorporation into JP 1-02.)

very seriously ill or injured. None. (Approved for removal from JP 1-02.)

walking patient. None. (Approved for removal from JP 1-02.)

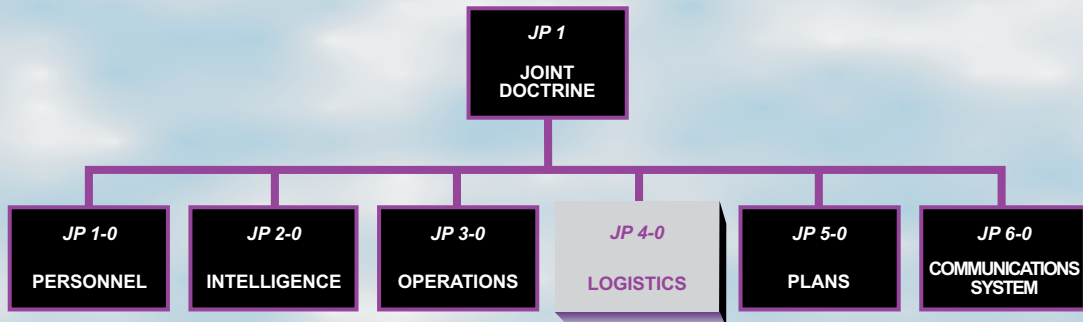
war reserve materiel requirement. That portion of the war materiel requirement required to be on hand on D-day. This level consists of the war materiel requirement less the sum of the peacetime assets assumed to be available on D-day and the war materiel procurement capability. (Approved for incorporation into JP 1-02 with JP 4-02 as the source JP.)

wellness. Force health protection program that consolidates and incorporates physical and mental fitness, health promotion, and environmental and occupational health. (JP 1-02. SOURCE: JP 4-02)

wounded. None. (Approved for removal from JP 1-02.)

wounded in action. None. (Approved for removal from JP 1-02.)

JOINT DOCTRINE PUBLICATIONS HIERARCHY



All joint publications 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:

