UNITED STATES MARINE CORPS

FIELD MEDICAL TRAINING BATTALION EAST
BOX 20042
CAMP LEJEUNE, NC 28542

IDENTIFY THE COMPONENTS OF A HEALTH SERVICE SUPPORT PLAN

FMSO 205

a. **TERMINAL LEARNING OBJECTIVE**

(1) Given a mission, pertinent information and acceptable risk, develop a Health Service Support Plan for the Annex Q in support of the Op Order (FMSO-ADMN-2001)

b. **ENABLING LEARNING OBJECTIVES**

(1) Without the aid of references, given a scenario, identify needs of the mission, without omission, in accordance with the student handout (FMSO-ADMN-2001a)

(2) Without the aid of references, given a scenario, identify health service support needs for detainee operations and displaced civilian personnel, within 80%, in accordance with the student handout. (FMSO-ADMN-2001b)

(3) Without the aid of references, given a scenario, plan for combat personnel replacements, without omission, in accordance with the student handout (FMSO-ADMN-2001c)

a. **Health Service Support Planning.** Within the Marine Corps, it isn't possible to have a class on planning without making reference back to some dead German (or Corsican). The point here is that Health Service Support planning begins with the Marine Corps Planning Process, something that you will become more familiar with at your future Marine Corps commands.

b. **The Marine Corps Planning Process (MCPP).** The MCPP supports the Marine Corps war fighting philosophy of maneuver warfare. Since planning is an essential and significant part of command and control (C2), the MCPP recognizes the Commander's central role as the decision maker. It helps organize the thought processes of a Commander and his staff throughout the planning and execution of military operations. The MCPP focuses on the mission and the threat. It capitalizes on the principle of unity of effort and supports the establishment and maintenance of tempo. The MCPP is applicable across the range of military operations (ROMO) and is designed for use at any echelon of command. The process can be as detailed or as abbreviated as time, staff resources, experience, and the situation permit. Planning is the act of envisioning and determining effective ways of achieving a desired end state. It supports the commander in making decisions in a time-constrained and uncertain environment.

"Planning is the art of envisioning a desired end state and determining effective ways of achieving that goal."

—MCWP 5-1, Marine Corps Planning Process

c. **Key Functions of the Planning Process.** Whether planning is performed at the strategic, operational, or tactical level, the key functions of ***Planning*** are to:

(1) Direct and coordinate actions

(2) Develop a shared situational awareness

(3) Generate common expectations about how actions will evolve and how they will affect the desired outcome

(4) Support the exercise of initiative
Shape the thinking of planners

> "Start planning as early as possible and include ***everyone*** in the planning process."
>
> —General A.C. Zinni, USMC

d. **The Six steps of the process**. The MCPP establishes procedures for analyzing a mission, developing and war gaming courses of action (COAs) against the threat, comparing friendly COAs against the Commander's criteria and each other, selecting a COA, preparing an operation order (OPORD) or operation plan (OPLAN) for execution, and transitioning the order or plan to those tasked with its execution. The MCPP organizes these procedures into six manageable, logical steps (see figure 1). These steps provide the Commander and his staff, at all levels, a means to organize their planning activities, to transmit plans to subordinates and subordinate commands, and to share a common understanding of the mission and Commander's intent.

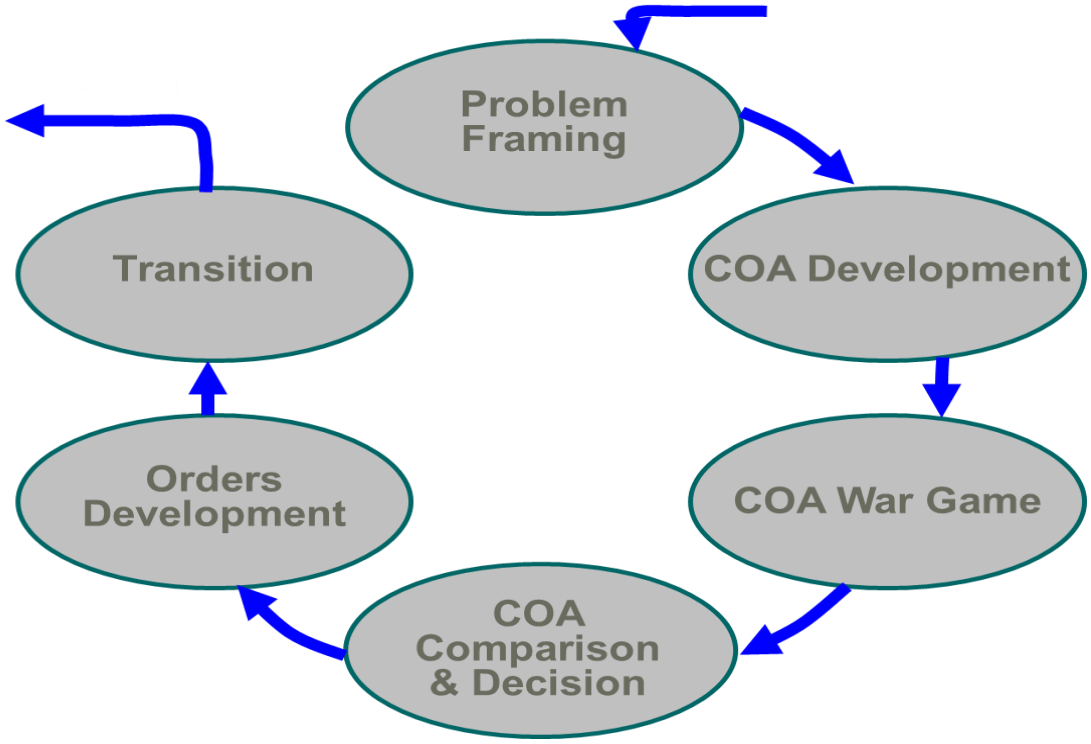

Figure 1. Marine Corps Planning Process

(1) **Problem Framing.** Problem framing is the first step in planning and drives the MCPP. Its purpose is to review and analyze orders, guidance, and other information provided by higher headquarters and to produce a unit mission statement.

(2) **Course of Action Development.** During COA development, planners use the mission statement (which includes the higher headquarters Commander's tasking and intent), Commander's intent, and Commander's planning guidance to develop COAs. Each prospective COA is examined to ensure that it is suitable, feasible, acceptable, distinguishable, and complete with respect to the current and anticipated situation, the mission, and the Commander's intent.

(3) **Course of Action War Gaming**. COA wargaming involves a detailed assessment of each COA as it pertains to the enemy and the battle space. Each friendly COA is war gamed against selected threat COAs. COA wargaming assists planners in identifying strengths and weaknesses, associated risks, and asset shortfalls

for each friendly COA. COA wargaming also identifies branches and potential sequels that may require additional planning. Short of actually executing the COA, COA wargaming provides the most reliable basis for understanding and improving each COA.

(4) **Course of Action Comparison and Decision**. In COA comparison and decision, the Commander evaluates all friendly COAs against established criteria, and then evaluates them against each other. The Commander then selects the COA that will best accomplish the mission.

(5) **Orders Development**. During orders development, the staff uses the Commander's COA decision, mission statement, and Commander's intent and guidance to develop orders that direct unit actions. Orders serve as the principal means by which the Commander expresses his decision, intent, and guidance. We will spend time later in the class on order development.

(6) **Transition**. Transition is an orderly handover of a plan or order as it is passed to those tasked with execution of the operation. It provides those who will execute the plan or order with the situational awareness and rationale for key decisions necessary to ensure there is a coherent shift from planning to execution.

2. **Principles of Health Service Support**

a. **Health Service Support principles**. HSS principles are guides for planning, organizing, managing, and executing HSS. Seldom will all principles exert equal influence; usually, one or two dominate a given situation. Effective HSS identifies which principle(s) have priority. The HSS principles are as follows:

(1) **Conformity** - Conformity with the tactical plan is the most fundamental element for effectively providing Health Service Support (HSS). Only by participating in the development of the Operating Plan (OPLAN) can the HSS planner ensure adequate HSS on the battlefield at the right time and place.

(2) **Continuity** - HSS must be continuous since the interruption of treatment may cause an increase in morbidity and mortality. Procedures are standardized at each organizational level to ensure that all required medical treatment at that echelon is accomplished. ***No patient is evacuated any farther to the rear than his physical condition or the operational situation requires.***

(3) **Coordination** – The medical plan must ensure that HSS resources in short supply are efficiently employed and used effectively to support the planned operations.

(4) **Proximity** - The location of HSS assets in support of combat operations is dictated by the tactical situation (mission, enemy, terrain, troops, time available and civilian considerations) factors, the time and distance factor, and the availability of evacuation resources. The speed with which medical treatment is initiated is extremely important in reducing morbidity and mortality. Medical evacuation time must be minimized by the efficient allocation of resources and the judicious location of a Medical Treatment Facility (MTF). The MTF cannot be located so far forward that it interferes with the conduct of combat operations or

is subjected to enemy interference. Conversely, it must not be located so far to the rear that medical treatment is delayed due to the lengthened evacuation time.

(5) **Flexibility** - Since a change in tactical plans or operations may require redistribution or relocation of medical resources, the HSS plan must be flexible. The Medical Commander must be able to shift HSS resources to meet the changing requirements. No more medical resources should be committed nor MTFs established than are required to support expected patient densities. When the patient load exceeds the means available for treatment, it may be necessary to give priority to those patients who can return to duty (RTD) the soonest rather than those who are more seriously injured. This ensures the manning of the tactical Commander's weapons systems.

(6) **Mobility** - Since contact with supported units must be maintained, HSS elements must have mobility comparable to that of the units they support. Mobility is measured by the extent to which a unit can move its personnel and equipment with organic transportation. When totally committed to patient care, a HSS unit can regain its mobility only by immediate patient evacuation. When the mobility of the unit is jeopardized by the accumulation of patients, it may be necessary to leave a small holding element with the patient.

3. HEALTH SERVICE SUPPORT PLANNING CONSIDERATIONS

Timely, effective planning and coordination are essential to ensure adequate and sustainable health support in the Area of Operations (AO). Proper planning permits a systematic examination of all factors in a projected operation and ensures interoperability with the OPLAN. Some considerations include, but are not limited to:

a. **Threat** – The threat is a composite of ongoing or potential adversary actions; it should include environmental, geographical, and meteorological conditions, endemic diseases and the threat of employment of weapons of mass destruction (WMD).

b. **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.

c. **Patient Movement** – 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 platforms, and movement control.

d. **Patient Movement Items** – Specific medical equipment and durable supplies that must be available to support patient movement. Don't let it all leave your location!

e. **Clinical Capabilities and MEDLOG Support** – Assets and personnel to provide a specified level of care. This includes the long-term logistic support to continue providing care.

f. **Preventive Medicine and Health Surveillance** – Risk assessment and analysis as well as preventive medicine measures to counter the threats in an AO.

g. **Prevention of Stress Casualties** – Responsibility of commanders and leaders. A coordinated program must be planned that considers prevention, treatment, and return to duty of combat stress reaction personnel.

h. **Mass Casualty Situations** – Procedures and capability to manage a mass casualty incident must be developed to successfully manage this situation.

i. **Veterinary Services** – This includes the capability to provide animal health care for government-owned animals (Think military working dogs), veterinary prevmed, and food safety and security. Can be considered a force multiplier in stability operations.

j. **Dental Service** – Dental resources and capabilities must be planned for and include treatment, restoration, and maintenance of oral health. Includes dental readiness, operational care and comprehensive care.

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

l. **Host Nation Support (HNS)** – HNS can be a significant force multiplier. HNS must be equivalent to US standards for services provided to US forces.

m. **Health Support for Returned US POWs and Detained Personnel** – Must provide care for former US POWs and detained personnel.

n. **Health Support for EPWs and Detainees** – Plans and policies must be developed for the legal and ethical treatment of EPWs and detainees.

4. TAXONOMY OF CARE.

a. Formerly known as "echelons" of care, the seven capabilities of care are the fundamental levels a casualty will flow through as they move through the health care system. Notice how the enroute care capability extends throughout all the different capabilities. The bottom two levels in figure 2 are not capabilities a patient would flow through but outcomes and goals of each capability. Please note how they increase in skill and capability, starting at the Individual Marine, Combat Lifesaver (CLS), Corpsman, and BAS to Shock Trauma Platoons (STP) and Forward Resuscitative Surgical System (FRSS) to the Surgical Company and on to Regional Hospitals like Landstuhl in Germany to Bethesda and Brooke Army Medical Center.

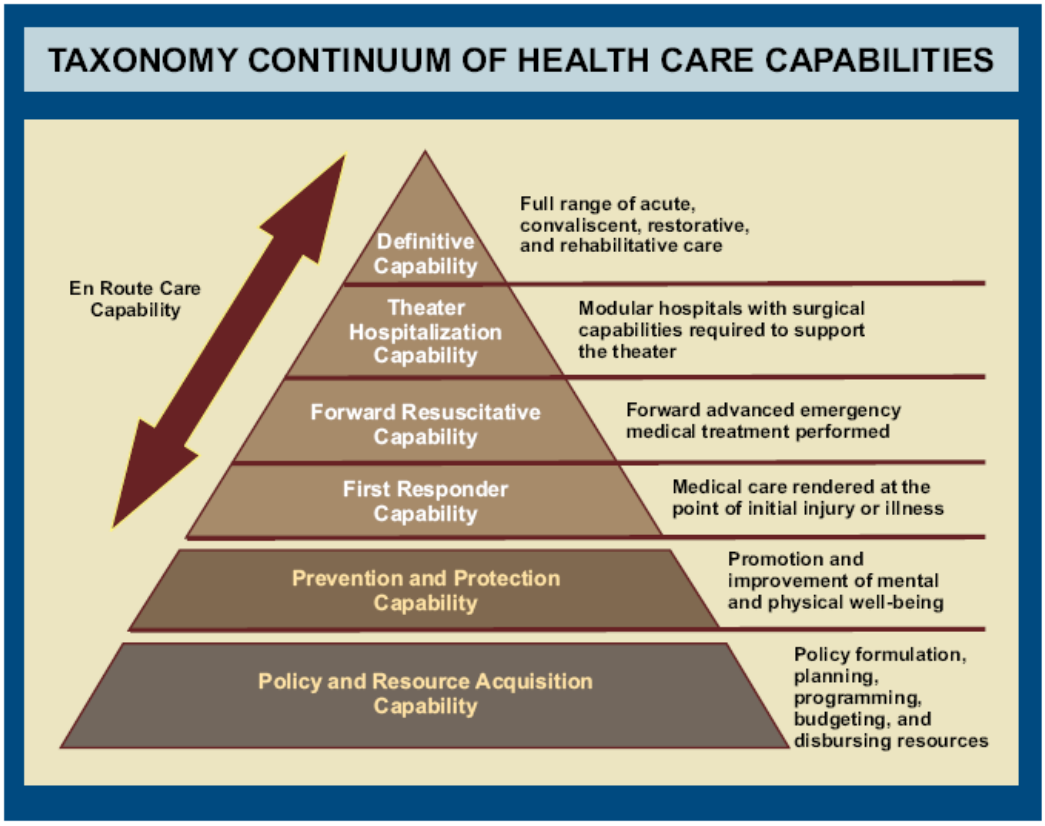

Figure 2. Taxonomy of Care

5. **OPERATION PLAN:** The orders development step in the Marine Corps Planning Process communicates the commander's intent, guidance, and decisions in a clear, useful form that is easily understood by those executing the operation. An operation order or the more comprehensive operation plan is a written or oral communication that directs actions and focuses a subordinate's tasks and activities toward accomplishing the mission. The traditional method of portraying an operations plan (OPLAN) or operation order (OPORD) is through the acronym SMEAC.

a. **SMEAC**: Situation, Mission, Execution, Administration and Logistics, and finally Command and Signal. Various portions of the operations order, such as the mission statement, have been prepared during previous steps of the Marine Corps Planning Process. The chief of staff or executive officer, as appropriate, directs operations orders development. The operation order contains only critical or new information — not routine matters normally found in standing operating procedures. A good operation order is judged on its usefulness — not its weight.

b. **Annexes**: In more complex operation orders and plans, the more detailed information is normally placed into annexes, appendices, tabs, and enclosures, with each level getting into more detailed and finite information

Each annex is identified by a letter for each functional area. As seen in the following slides, Annex A is for the command's task organization, Annex B is for Intelligence, Annex C is for operations and so on.

6. **ANNEX Q**

a. **Operations Order**. The Annex Q is part of the overall operations order. The HSS Concept of Operations must include the following functions into the medical plans; health maintenance, casualty collection, casualty treatment, temporary casualty holding, and casualty evacuation. Let's take a closer look at each of these functions.

(1) *Health maintenance* - routine sick call, physical examination, preventive medicine, dental maintenance, record maintenance, and reports submission.

(2) *Casualty collection* - selection of and manning of locations where casualties are assembled, triaged, treated, protected from further injury, and evacuated.

(3) *Casualty treatment* - triage and treatment (self-aid, buddy aid, and initial resuscitative care).

(4) *Temporary casualty holding* - facilities and services to hold sick, wounded, and injured personnel for a limited time, usually not to exceed 72 hours. The Medical Battalion, Marine Logistics Group, is the only HSS unit staffed and equipped to provide temporary casualty holding.

(5) *Casualty evacuation* - movement and ongoing treatment of the sick, wounded, or injured while in transit to MTFs. All Marine units have an evacuation capability by ground, air, or sea.

b. **Annex Q structure**. Now that we have addressed the OPORD, let's take a look at the structure of the Annex Q, Medical Services.

(1) Situation. Similar to the OPORD, the Annex Q will begin with the Situation.

(a) The operational area must be addressed to include any aspects that may affect medical services such as prevalence of disease, remote locations or refugee populations.

(b) Enemy Forces/Medical Threats. The second area of concern within the Situation is Enemy Forces/medical Threats.

1. We need to identify threats most likely to affect military personnel, such as diseases associated with geography and climate throughout the projected deployed period.

2. Environmental health should be addressed by considering the environmental characteristics of the AO. Concerns such as water supply, sewage treatment systems, industrial pollutants, poisonous plants and animals need to be addressed.

3. Civilian medical infrastructure such as location and capabilities major health treatment facilities should be noted.

4. Additionally, military medical facilities should be noted, along with location, capabilities, and supply status.

5. Biological agents associated with known or suspected biological warfare programs should be noted.

6. Finally, we should be aware of any likelihood of enemy targeting of medical facilities.

(c) Friendly medical capabilities must be identified and addressed.

(d) Key assumptions affecting medical planning need to be identified.

(e) Any key limiting factors affecting medical capabilities. Limitations include both constraints (options to which I am limited) and restraints (what cannot be done) and must be taken into consideration.

(2) Mission. Paragraph 2 of the Annex Q is the Mission. The mission must be clearly and succinctly stated. Think "who, what, when, where, and why" and is a product of the first step in the MCPP.

(3) Execution. Paragraph 3 is a key part of the Annex Q, identifying the Execution of Medical Services.

(a) Concept of Operations. The first section is the Concept of Operations. The concept of operations identifies the "big picture", the "HOW" necessary to accomplish the mission.

1. First off, we need to discuss the transition from peacetime (garrison) to wartime posture.

2. Responsibility for medical services between allies and sister services should be addressed, and what the command relationships will be.

3. The concept of operations for hospitalization to include a brief assessment of initial in-theater medical treatment capabilities, including host-nation and allied support if available.

4. Patient movement needs to be addressed, to include land, sea, and air.

5. Host Nation Support (HNS) availability and capability should be assessed.

6. Other health readiness needs to be considered, such as for EPW, formerly captured US personnel, NEO, and civil affairs.

7. Joint Blood Program process needs to be addressed, to include fresh whole blood, plasma, storage times, walking donor programs and resupply of all the aforementioned.

8. Force Health Prevention, formerly known as Preventive medicine, should be discussed and is addressed in a separate class.

9. The Theater Evacuation Policy should be addressed to include assets available, timelines, follow-on facilities and the like.

10. Dental Services scope and responsibilities to support operations.

11. Although the USN does not have veterinarians, the US Army assigns vets and their technicians, critical for the care of our military working dogs, useful in local stability operations by helping local village members, and inspecting local meat products.

12. Any other areas that need additional detail might be addressed here.

(b) Tasks. Tasks are a key part of any order. This section lays out in detail what every subordinate organization is supposed to do.

(c) Coordinating Instructions. Coordinating instructions are tasks that are common to two or more subordinate organizations and save time by not duplicating.

(4) Administration and Logistics. Paragraph 4 of the Annex Q addresses Administration and Logistics.

(a) Administration. The first sub-paragraph addresses specific reports, requirements, procedures and the like.

(b) Concept of Logistics. The second sub-paragraph discusses the concept of logistics. It is important to understand that HSS logistics encompasses the procurement, initial issue, management, re-supply, and disposition of material required to support medical and dental elements organic to the MARFOR. Requisitions for Class VIIIA (consumable and equipment) material follow the same channels as other classes of supply. As with all classes of supply, careful consideration should be given to stockage levels of Class VIIIA material. Commanders should not be burdened with moving and maintaining excess material, nor should the need for support ever be delayed because of inadequate access or lack of responsiveness. When the medical planner is developing and planning for appropriate levels of Class VIIIA support, the following information is crucial to ensuring that the entire HSS system is responsive to the Commander. The concept of operations and scheme of maneuver, the intensity of combat, the duration of combat, and any casualty estimates all drive the requirement for medical logistics.

(c) Summary of Contractor Support Estimate. Finally, any contractor support required must be considered in our planning efforts.

(5) Command and Control. The final paragraph within the Annex Q is Command and Control. Just as in any other operation, command and control must be clearly identified and delineated.

(a) Command Relationships. The first sub-paragraph describes the Command Surgeon relationship with the Commander, along with his advisory responsibility. Additionally, lines of authority between the various medical assets and facilities must be stated. The transfer of USMC assets to another component commander must be discussed, along with any command and control relationships with allied forces.

(b) Communications. The second sub-paragraph discusses dedicated medical communications networks, health information and medical surveillance information dissemination, communication requirements and previously developed communication channels, to include HNS coordination.

(6) As stated earlier, annexes frequently have subordinate appendices that provide more detail for the conduct of an operation; in the case of Annex Q, MCWP 4-11.1 identifies the following appendices for the additional detail frequently needed. Of note, Chairman Joint Chiefs of Staff Manual 3130.03 (CJCSM 3130.03) shows a different set of appendices, so let's focus on what Marine Corps doctrine is today!

Appendices of the Annex Q

- Appendix 1. Joint Patient Movement System
- Appendix 2. Joint Blood Program
- Appendix 3. Hospitalization
- Appendix 4. Returns to Duty
- Appendix 5. Medical Logistics (Class VIII) System
- Appendix 6. Force Health Protection
- Appendix 7. Medical Command, Control, Communications, and Computers (C4)
- Appendix 8. Host Nation Medical Support

- Appendix 9. Medical Sustainability Assessment
- Appendix 10. Medical Intelligence Support to Military Operations
- Tab A to Appendix 10. Disease Threat by Geographic Area and Country
- Appendix 11. Medical Planning Responsibilities and Task Identification

REFERENCES:

CJCSM 3130.03, Adaptive Planning and Execution (APEX) Planning Formats
Joint Publication 4-02, Health Service Support
Marine Corps Warfighting Publication (MCWP) 5-1, Marine Corps Planning Process
MCWP 4-1, Logistics
MCWP 4-11.1, Health Service Support Operations