

UNITED STATES MARINE CORPS
FIELD MEDICAL TRAINING BATTALION EAST
BOX 20042
CAMP LEJEUNE, NC 28542

MANAGE FIELD MEDICAL SERVICE TRAINING PROGRAM

FMSO 206

a. **TERMINAL LEARNING OBJECTIVE**

(1) Given subordinate field medical personnel, manage field services training program to provide unit personnel adequate sustainment and progression training, to ensure mission success (FMSO-ADMIN-2003)

b. **ENABLING LEARNING OBJECTIVES**

(1) Without the aid of reference, define the requirements for command CGI inspection, within 80%, per MCRP 3-0A Unit Training Management Guide (FMSO-ADMIN-2003a)

(2) Given a unit training requirement, utilize the T&R Manual to identify appropriate training tasks, within 80%, per NAVMC 3500.84 Unit Training and Readiness Manual (FMSO-ADMIN-2003b)

1. **Purpose**

a. **Purpose.** The purpose of this class is to provide you the knowledge and skills to develop and implement the required training programs in accordance with appropriate directives. The bottom line is that “Saving Lives on the Battlefield”, our mantra for FMTB-East, is something that you can take to your units and continue to make a difference.

2. **Systems Approach to Training**

a. **Background.** The Instructional Systems Design process has been used since World War II, with the Marine Corps accepting the systems approach to training that includes 5 phases – analyze, design, develop, implement, and evaluate. The goal of Marine Corps instruction is to develop performance-based, criterion referenced instruction that promotes student transfer of learning from the instructional setting to the job. The Systems Approach to Training (SAT) is a comprehensive yet flexible process that identifies what is performed on the job, what should be instructed, and how this instruction should be developed, implemented and evaluated. The SAT serves as a blueprint for organizing or structuring the instructional process. While originally intended to be used in the formal learning centers, code for the schoolhouse, the SAT process has been determined to be useful for the development of training programs in the operating forces. As stated earlier, it is implemented in 5 phases.

b. **5 Phases.** As stated earlier, the five phases of the SAT are Analyze, Design, Develop, Implement, and Evaluate. Let's take a look at each of these phases.

(1) Analyze. In the analyze phase, we need to look at three elements.

(a) We must assess the unit strengths and weakness in support of the mission and take a look at any training guidance that the Commander has already developed. How do we determine strengths and weaknesses? You can observe training and exercises, look at previous IG reports, hotwashes from training evolutions, question leaders or bring in external observers. This should give you a sense of where you are with your training and skills.

(b) Next, take a look at training opportunities available within higher headquarters (HHQ) Training Plan. HHQ might have available slots at various skill training courses to better prepare your personnel. This might include the TCCC/CLS-Trainer course at the FMTB's or possibly a Combat Trauma Training course offered by civilian contractors.

(c) Finally, try and identify any obstacles that might impact training, such as extended deployments for training (DFT), higher priority tasks, lack of qualified trainers, and so on.

(2) Design. In the Design phase,

(a) We need to identify the Training and Readiness (T&R) Manual events based on HHQ Training Guidance/training plan and identify and prioritize the T&R events based on the assessment of your unit that you conducted in the Analyze Phase. But, before we can do any of these things, you need to know what is this "Training and Readiness Manual", and the mysterious T&R event that has been mentioned.

(b) The T&R Manual established training standards, regulations and policies regarding the training of Marines and Sailors throughout a wide-range of Military Occupational Specialties (MOS) and Navy Enlisted Classifications (NEC). Initially developed in the aviation world, the T&R program has expanded to include the entire Marine Corps and for our purposes today, we will focus on the Health Service Support (HSS) T&R Manual and the Marine Corps Common Skills (MCCS). For the HSS T&R, it identifies the training requirements for Hospital Corpsmen with NECs of 8404, 8427, and 8403

(c) Each T&R event identified will include:

1. Task. The actual event that must be accomplished.

2. Sustainment interval. How often the event must be trained.

3. Training setting. Formal school or managed on- the-job training.

4. Condition. The condition refers to the constraints that may affect event in a real-world setting.

5. Standard. The standard indicates the basis for judging the effectiveness of the performance.

6. Performance steps. A description of the actions that the event must include.

7. References. The references shall be utilized to determine performance steps, and assist the evaluator in determining the effectiveness of task completion, or helps the trainee in satisfying the performance standards.

8. Support requirements. Any external or internal support that is necessary to complete the event.

9. Admin instructions. Anything that helps in the completion of the training event.

(d) The T&R Manual is separated by individual and collective tasks, ranging from 1000-8000 as identifiers. The individual tasks are 1000 and 2000 level tasks, with 1000 level tasks typically taught at Marine Corps Formal Schools like FMTB and the 2000-level tasks taught at either schools or through on-the-job training. The 3000-8000 level tasks, collective tasks, are taught at a variety of levels, and are identified as team tasks through HQ level. Some examples in the HSS arena might be “Conduct casualty evacuation” (3000) to “Establish a resuscitative/surgical capabilities” (6000). This next slide shows an example of the levels of tasks within a Marine Corps Regiment.

(e) Getting back to the design phase, the next step is to design unit level training guidance, e.g. what are the priorities, points of emphasis, identification of individual and mandatory training, resource allocation, along with any guidance from the CO. Next, a short range training plan is designed that will coordinate and finalize specific training events, activities, and resource actions. Typically, the short-range plan might be a 1-3 month projection. Upon the design of the CO’s training guidance and the development of the short-range plan, they are published for subordinate commands and sections to execute.

(3) Develop. In the Develop Phase, we need to be concerned with the following concepts.

(a) We need to develop a letter of Instruction (LOI) that will tell everyone what needs to be accomplished, to include specific tasks to be performed. The format can be the same as the 5-paragraph order we discussed in a previous class. Remember SMEAC?

(b) Logistical and support preparations for an event need to be coordinated. Think of this as the saline lock kits, fluids, Chux pads, PPE, etc for an IV Fluid Resuscitation class.

(c) A detailed training schedule needs to be developed, whether it is a one-hour class on hemorrhage control or a week-long Combat Lifesaver (CLS) course. It should include time/date, topic, location, and any gear needed.

(d) Similar to above, once I have coordinated my logistic and support preparations, I have to develop or acquire my training materials, and secure the necessary support.

(e) In order to be able to evaluate the training that is being conducted, I need to make sure that we have Performance Evaluation Checklists (PECL). A good source to start looking for these might be the Committee on Tactical Combat Casualty Care (CoTCCC) website that provides some very detailed checklists for medical training evolutions.

(f) You need to have appropriately trained trainers and support personnel. This might range from personnel who have the requisite medical skills to drivers for an emergency vehicle if you are conducting this training in the field, as well as evaluators, assistant instructors and position safety officers if the evolution has a safety component to it.

(g) It is critical that rehearsals be conducted. This ensures that all assigned personnel know their roles, but it might also identify shortfalls in the training.

(h) Most Commanders will insist on a confirmation brief. This is nothing more than a recitation of the tasks and timeline and making sure that all bases are covered. If gaps or shortfalls are identified, they must be addressed in an updated LOI.

(i) Operational Risk Management (ORM) is a process of dealing with risks associated with military operations. It includes risk assessment, risk decision-making, and the implementation of risk controls to assist in executing a safe evolution.

The Operational Risk Assessment Worksheet (ORAW) is the tool that we use to identify and mitigate any risks associated with our training. I would like you to think of the risks with IV training or simulated needle thoracentesis.

(4) Implement. During the Implement Phase, we need to be concerned with the following items.

(a) Conduct any time-critical ORM. Time critical is different than deliberate ORM because it is the situation as we see it now. What has changed? Weather? New personnel? Location?

(b) Next, we need to stage our resources and personnel so that they are all ready to start the training event.

(c) Again, make sure all personnel know and understand the plan. You will be surprised at how often people change due to conflicting requirements.

(d) Conduct a safety brief for all hands. It might be a simple fire safety brief, or it might get into the technical details of the event you are training, e.g. IV, or cricothyroidotomy.

(e) The point we have all been focused on is upon us, the training itself. All the planning that has gone into this day is finally upon us and we need to conduct the training in accordance with our plan.

(f) After the training is concluded, a debrief with all participants should be conducted. This can be used to reinforce the learning objectives, identify any trends that were noticed and can help the overall learning process for the audience.

(g) As hard as it might seem, some of the students might need to be remediated. Since the goal is for all to master the training, you may have to hold some of the students after training to make sure they “get it”.

(h) Last, but certainly not least, the training results need to be entered into the appropriate record keeping system, whether it is training jackets for the individuals or into the MCTIMS database.

(5) Evaluate. The final phase in the development of training is the Evaluation Phase. The following bullets will expand on this phase.

(a) The first point that needs to be emphasized is that evaluation is continuous through all phases of the SAT. As we work through our planning effort, we might find a better way to conduct our training and it should be incorporated through an evaluation process.

(b) After Action Reviews (AARs) should be conducted within the staff executing the preparation and conduct of the training. Sometimes referred as a “hotwash”, it is an opportunity to identify any problems encountered and solutions, or a better way to conduct our training. This is an opportunity to capture any feedback from the implement phase and potentially improve future training.

(c) Our PECL should be reviewed, and evaluator feedback should be considered in order to develop a better training opportunity.

(d) Finally, any trends or training deficiencies of units or individuals need to be identified so that training might be modified in the future, or determine areas that need to be emphasized in the next evolution.

3. **Directives**

a. **IGMC**. The Inspector General of the Marine Corps (IGMC) has developed a number of inspection checklists that run the gamut of personnel issues to installation security and safety. One checklist that is of particular importance to you as medical personnel is the Automated Inspection Reporting System (AIRS) 500 checklist. The AIRS 500 is a 13-page checklist that addresses Administration, Individual Medical Readiness, Medical Leadership, Provision of Care, Medication Management, Health Records, Information Management, Patient Rights, Environment of Care, Infection Control, Human Resources, Independent Duty Corpsman (IDC), and finally Training. Training is our emphasis today and the AIRS 500 checklist directs the support for Tactical Combat Casualty Care (TCCC) training and the support of the CLS Program. It is imperative that the TCCC and CLS Programs be active and current. They are your combat multipliers. Marine Corps Administrative (MARADMIN) message 209/12 directs the conduct of this training.

b. **Marine Corps Common Skills.** While the emphasis today has been on the requirements for training of your Corpsmen, NAVMC 3500.18B, Marine Corps Common Skills (MCCS) directs the annual training of Marines from close-order drill to history, customs, and traditions. A key portion of the MCCS is the medical section that drives the annual training requirement for Marines in medical topics. While this training is normally coordinated by the Company Commanders, it should be your Corpsmen who are doing the actual instruction and practical application efforts. They are the duty experts and need to be doing this training.

c. **Draft Order.** Finally, an effort has been underway by CG, Training and Education Command (TECOM) and The Medical Officer (TMO) of the Marine Corps to develop a comprehensive order that addresses TCCC and CLS training throughout the Marine Corps. It is in a draft form and is being worked by the TMO staff.

4. **Lessons Learned**

a. The battlefield statistics show that we have made great strides in improving the survival rate for our combat wounded. All the courses of instruction here at FMTB are focused on increasing the skills of our students so that they can continue to “save lives on the battlefield”. From the days when I was a new 2dLt and was told to treat a sucking chest wound with the cellophane from a cigarette package, to the inclusion of a Chest Wound Seal Kit in our Individual First Aid Kit (IFAK), it is obvious that we have made progress. The process has improved, medicine has gotten better. Can we save more lives? Can we do better?

b. In 2001, the tri-service CoTCCC was established to be a clearinghouse of emerging technology and information, along with lessons learned from the battlefield, all combined to ensure the update of the TCCC guidelines on an ongoing basis, all leading to better medical treatment for our combat wounded. This committee, chaired by CAPT Frank Butler MC USN (Ret), has been the driving force in improving the techniques, the gear, and the overall system for saving lives in modern combat. As a Department of Defense (DOD) Committee, they recently collaborated with the Defense Health Board who released an 82-page report titled “Combat Trauma Lessons Learned from Military Operations 2001-2013” this past March. In this report, the increased survival rate is attributed to four factors; tactics, body armor, faster medevac times along with the deployed trauma system, and Tactical Combat Casualty Care (TCCC). The DHB report had 15 lessons learned with a recommended way ahead for each lesson, but only eight of the lessons are pertinent to our level.

(1) We need a standardized, comprehensive training system for military health care providers in order to bridge the gap that affects our unit-level training, as well as effective utilization of the military system to reduce combat mortality.

(2) Effective TCCC training has a demonstrable effect on reducing potentially preventable causes of death on the battlefield.

(3) TCCC and combat trauma training, aimed at achieving core competencies in combat casualty care, must be provided in a tiered fashion to all personnel operating in the battle space.

(4) TCCC training must be multi-modal in order to achieve effective knowledge acquisition and retention and must include classroom, practical application, scenario-based learning, distance learning, live tissue training (LTT), human role models, clinical experience, and high-fidelity simulations. This will help reinforce the newly gained information for all learners.

(5) Medical and trauma training must be integrated into operational and tactical training. I suggest that medical training get integrated into all aspects of life as a Marine – during hikes, in the field, on the rifle range, during the time we wait for MV-22 Ospreys to show up!

(6) Live Tissue Training (LTT) has an important, tailored role in trauma training for life saving interventions on the battlefield. Make sure your units comply with USMC policy and use only approved vendors, and check on their programs to make sure they aren't doing something illegal, unethical, or immoral, or just plain wrong!

(7) Leaders (line leaders) and first responders must understand TCCC and support/incorporate training into unit battle drills. **Medical training is NOT a once a year, check in the box drill.** It must be constant, making it a muscle memory issue for the Marines and Sailors.

(8) Amazing advances in care have been made during OIF and OEF but more research is needed to fill critical gaps. If you see a need, push it up the chain of command. The CoTCCC welcomes new ideas and will pursue them.

REFERENCES:

NAVMC 3500.84 HSS T&R Manual

NAVMC 1553.1, SAT

MCO 1553.3B, Unit Training Management Program

MCRP 3-0A

MCRP 3-0B

Defense Health Board Report dated 9 March 2015