

APPENDIX B

COMBAT HEALTH SUPPORT PLANNING**Section I. COMBAT HEALTH SUPPORT ESTIMATE****B-1. General**

a. The staff prepares estimates on their areas of expertise to assist the commander in the decision-making process. The staff estimate consists of significant facts, events, and conclusions based on current or anticipated situations and recommendations on how available resources can best be used. These recommendations are used by the commander to—

- Identify and eliminate from consideration the courses of action (COAs) that are not feasible.

- Select the best COAs for further analysis.

b. Adequate plans hinge on early and continuing estimates by staff officers. Failure to make these estimates may lead to errors and omissions in the development of a COA.

c. Regardless of the level of command, the military planning process remains unchanged; however, the level of detail and the means of communicating (verbal or written) will differ. At the medical company level many procedures are already set forth in TSOPs, thereby effectively limiting the level of detailed input required for preparation of the estimate. Although the level of detailed information contained in this appendix is considerable, it is provided for illustrative and educational purposes. In the medical company situation, for example, the CHS estimate for medical company operations may be verbal since TSOPs cover routine activities; however, the FSMC commander may be required to provide a formal written estimate to the FSB support operations for inclusion in the FSB estimate. Additionally, the FSMC commander is dual-hatted as the brigade surgeon and may be required to provide formal written input for inclusion in the brigade estimate.

d. For additional information on the CHS estimate, refer to FM 8-42 and FM 8-55.

B-2. Responsibilities

After the commander provides his planning guidance, the surgeon should prepare estimates of requirements and descriptions of projects to be undertaken for establishing adequate CHS to support the mission. The surgeon makes a CHS estimate that may stand alone or that may be incorporated into the personnel estimate. The estimate forms the basis for the subsequent CHS plan. The estimate is a logical and orderly examination of all the factors affecting the accomplishment of the mission to determine the most suitable COA. All of the significant CHS possibilities that can affect the accomplishment of the tactical commander's mission must be considered. The CHS estimate, along with estimates of the other individual staff members, is used by the commander in preparing his own estimate. It provides him with information on which to base his selection of the best COA. This decision is then included in the operational and logistics support plans.

B-3. Format for the Estimate

a. A sample format for a CHS estimate is presented in paragraph B-4. This format is applicable to any echelon of command and can be used under any operational condition. It is lengthy and includes many more details than may be needed in some situations. Depending on the situation and the unit for which the estimate is being completed, organic capability of certain functional areas may not exist. The estimate, however, must include these areas, as support or augmentation from corps assets may be required, such as CSC and veterinary services. Each CHS planner must tailor the estimate to meet his needs. The estimate is a continuous process; as the battle continues, new factors and COAs are developed and impact on the estimate.

b. Staff estimates may be presented orally or in writing. Often only the staff officer's conclusions or recommendations are presented to the commander.

c. Depending on the level of command, separate estimates may also be made for the dental, PVNTMED, veterinary, and CSC functional areas. For information on these estimates, refer to FM 8-55. For additional information on the unique aspects of planning for medical operations in peacetime and conflict, refer to FM 8-42.

d. The format for the estimate should be considered more as stool to assist the planner than as a rigid format that might complicate the task. Examples of information which may be required or considered are provided for the different subheadings. They are not to be considered as an all-inclusive listing, but rather as a starting point for consideration.

B-4. Sample Format for the Combat Health Support Estimate

(Classification)

*Headquarters
Location
Date, time, and zone*

COMBAT HEALTH SUPPORT ESTIMATE OF THE SITUATION

References: *Maps, overlays, charts, or other documents required to understand the estimate. Reference to a map includes the map series number and country or geographic area, if required; sheet number and name, if required; and edition and scale.*

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1. MISSION *(Statement of the overall CHS mission.)*
2. SITUATION AND CONSIDERATIONS *(Consists of facts, assumptions, and deductions that can affect the successful support of an operation.)*

a. Enemy Situation. *(Includes such issues as the enemy's ability to interfere with the delivery of CHS, his attitude toward the Geneva Conventions, his ability to inflict casualties [both combat and disease], types of weapons available, and the health status of potential EPW.)*

(1) Strength and disposition. *(Includes information on the numbers and types of enemy forces which will be encountered and on their distribution throughout the battle area. This entry may indicate where weak areas exist in the enemy's defenses.)*

(2) Combat efficiency. *(Includes information on training received by enemy forces, previous battles, degree of fatigue and nutrition, and other factors which may indicate how effective the enemy force may be.)*

(3) Capabilities. *(Includes the conventional warfare capabilities and the potential for use of NBC and DE weapons/devices.)*

(4) Logistics situation. *(The logistics situation provides insight on the enemy's ability to fight a sustained battle and indicates weak areas which may be exploited by friendly forces.)*

(5) State of health. *(This is an important issue as it may effect the enemy's will, desire, and ability to continue fighting. It may also provide some insight into the numbers of anticipated EPW and the CHS requirements for this subpopulation. NOTE: Historically, the number of EPW has been underestimated.)*

(6) Weapons and weapons systems. *(Includes the weapons systems which are available and those that could be used to deliver NBC and DE weapons/devices. The types of weapons used may dictate the type and distribution of wounds throughout the battlefield.)*

b. Friendly Situation. *(Includes the tactical plan of the commander, anticipated areas of patient densities, best placement of supporting CHS elements, health of the command, rear operations, and base clusters.)*

(1) Strength and disposition. *(Includes not only US Army troops but sister Services, allies, coalition, and HN forces which must be supported. The disposition throughout the battlefield may indicate the areas of the heaviest patient densities, lines of patient drift, and potential evacuation routes [both ground and air]).*

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(2) Combat efficiency. *(Includes training, experience, morale, and recent campaigns.)*

(3) Present and projected operations. *(Includes the current mission and all follow-on missions. This subparagraph can provide information on the potential for augmentation, reinforcement, and/or regeneration. It may also indicate requirements for CSC support after particularly heavy fighting.)*

(4) Logistics situation. *(Includes information on supply/resupply operations [both general and medical], location and hours of establishment/disestablishment of the facility, stockage levels, distribution points, and US and HN medical/nonmedical transportation support availability for patient evacuation.)*

(5) Rear battle plan. *(Includes information on responsibilities and procedures for mass casualty situations and rear area protection operations.)*

(6) Weapons. *(Medical units only have defensive weapons; however, the types of weapons systems being used may dictate the types of wounds, potential injuries, and security.)*

c. Characteristics of the Area of Operations. *(The CHS planner should obtain medical intelligence regarding the AO. This information should be included in the planning process as the medical threat will influence the numbers and types of casualties.)*

(1) Terrain. *(Includes any special equipment requirements needed to conduct the CHS mission, such as mountain climbing equipment; effect on medical evacuation [to include potential landing sites and ambulance turnaround]; and effect on layout of unit resources.)*

(2) Weather. *(Includes its effect on aeromedical and ground evacuation of casualties; care of the wounded in adverse weather conditions, such as extreme cold weather operations; effect on supplies and equipment, such as storage requirements [hot or extreme cold], maintenance requirements, and repair parts usage.)*

(3) Civilian population. *(Includes potential requirements for providing CHS assistance [to include Geneva Conventions requirements or civic action programs]; endemic and epidemic diseases in the population; any rules, regulations, or laws affecting interaction between military and civilian populations; and pertinent information on cultural aspects of the country [to include social, political, religious, and economic considerations]).*

(4) Flora and fauna. *(Includes poisonous reptiles, dangerous animals, disease vectors [such as arthropods], poisonous plants, or other medically significant information [such as medicinal herbs and plants] in the AO.)*

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(5) Local resources. *(Includes information on any significant assets which are available to the military force such as buildings, food sources, water sources, potential repair and maintenance facilities and capabilities, POL, hospitals, and clinics.)*

(6) Other. *(Any significant information not covered previously, such as language requirements.)*

d. Strengths to be Supported. *(Includes the different categories of personnel described below. Emphasis should be placed on accurately forecasting the numbers of refugees, displaced persons, and EPW that will require support. Large numbers of these personnel can severely strain the CHS capabilities [in particular the PVNTMED and treatment arenas]).*

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Allied forces.

(6) Coalition forces.

(7) Enemy prisoners of war. *(Every effort must be made to arrive at a realistic forecast of the EPW population. Traditionally, the US Forces have underestimated the number of enemy soldiers who will be captured or who will surrender. By underestimating the EPW population, adequate medical supplies and equipment have not been available when needed and have, therefore, adversely affected the delivery of health care.)*

(8) Indigenous civilians.

(9) Detainees *(Enemy medical personnel are not considered EPW and should be identified as soon as possible to assist in providing medical care for the EPW patients.)*

(10) Internees.

(11) Others. *(Includes refugees from battle areas.)*

e. Health of the Command. *(Consists of the following factors which indicate command and medical measures that should be taken into consideration prior to each operation.)*

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(1) Acclimatization of troops. *(Includes requirements for acclimatization of newly arriving troops or for forecasted operations, such as mountain operations.)*

(2) Presence of disease. *(Includes the endemic diseases which are not at a clinically significant level in the native population. Deploying forces may not be immune and the incidence of endemic disease cases may increase with a disruption of services [such as sanitation and garbage disposal].)*

(3) Status of immunizations. *(US Forces should receive all appropriate immunizations prior to deployment.)*

(4) Status of nutrition.

(5) Clothing and equipment. *(Includes consideration for specialized clothing and equipment [such as jungle fatigues, bed netting, parkas, and mountain climbing equipment]. When deploying to desert environments, both hot and cold weather clothing should be brought.)*

(6) Fatigue. *(The fatigue factor must be monitored since fatigue can contribute to lowering an individual's resistance to disease and may lead to combat stress reactions.)*

(7) Morale. *(It is important to the morale of a soldier that he know that medical attention is readily available if he is wounded.)*

(8) Status of training. *(Includes soldier training first-aid training, and MOS- and mission-specific training.)*

(9) Other, as appropriate. *(This can include water discipline programs or other PVNTMED measures and programs.)*

f. Assumptions. *(Assumptions may be required as a basis for initiating planning or preparing the estimate. Assumptions are modified as factual data and specific planning guidance becomes available.)*

g. Special Factors. *(Mention items of special importance in the particular operation to be supported such as the unique conditions to be encountered in NBC warfare, or the impact that patients suffering from combat stress will have on the CHS system.)*

3. COMBAT HEALTH SUPPORT ANALYSIS

a. Patient Estimates. *(Indicate rates and numbers by types of units or divisions.)*

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(1) Number of patients anticipated. *(Includes all categories of patients from the supported population.)*

(2) Distribution within the AO (space). *(The dispersion of troops throughout the battle-field will affect patient densities, areas requiring augmentation or reinforcement, and the projected patient work loads.)*

(3) Distribution in time during the operation (evacuation time). *(Includes the establishment of patient collecting points, AXPs, BASs, and division clearing stations based on the crossing of phase lines or other predetermined events.)*

(4) Areas of patient density. *(Heaviest areas of patient density will normally be in the MBA.)*

(5) Possible mass casualty situation. *(Includes establishing a triage point, coordinating for the use and augmentation of nonmedical vehicles to assist in transporting casualties, and establishing a decontamination station [augmented with nonmedical personnel to perform patient decontamination], if required.)*

(6) Lines of patient drift and evacuation. *(Includes those areas where terrain features canalize ambulatory casualties.)*

b. Support Requirements.

(1) Medical evacuation and regulating. *(Includes resources available, limitations, and requirements for using nonmedical transportation assets; procedures for requesting a mission; procedures for conducting medical evacuation missions during radio silence conditions; and preparation of overlays or strip maps.)*

(2) Hospitalization. *(Includes requirements for a MASH in the division rear and for CSHs or specialized teams.)*

(3) Health service logistics. *(Includes blood management; supply, equipment, optical fabrication, maintenance, and medical repair parts requirements; location of supply facility; and emergency resupply requirements, procedures, and delivery.)*

(4) Medical laboratory services. *(Includes information on organic capabilities of Echelons III and IV hospital laboratory support and supporting area medical laboratory, and how to obtain these services, if required.)*

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(5) Dental services. *(Includes procedures for obtaining dental support above the organic capability.)*

(6) Veterinary services. *(Includes information on obtaining veterinary support for food inspection and animal care.)*

(7) Preventive medicine and sanitation. *(Includes PVNTMED measures and programs, support requirements for EPW, civilian, and other nonmilitary populations, unit field sanitation teams, and dining facility inspections.)*

(8) Combat stress control. *(Includes support requirements and augmentation, if required.)*

(9) Command, control, communications, computers, and intelligence. *(Includes information on attachments, OPCON, or other control means for augmentation or reinforcement; SOIs; and all other CI activities.)*

(10) Others, as appropriate. *(Includes topics such as medical regulating procedures or requirements, general supply procedures and support requirements; and nonmedical personnel required to establish a patient decontamination station.)*

c. Resources Available. *(Consider all sources available within the AO.)*

(1) Organic medical units and personnel. *(Includes US, ally, coalition, and HN forces.)*

(2) Attached medical units and personnel.

(3) Supporting medical units.

(4) Civilian public health capabilities and resources. *(Civil affairs personnel are responsible for obtaining HN support.)*

(5) Enemy prisoners of war medical personnel.

(6) Medical supplies and equipment. *(Includes other services, allies, coalition forces, or HN capabilities.)*

(7) Medical troop ceiling.

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d. Courses of Action. *(As a result of the above considerations and analysis, determine and list all logical COAs which will support the tactical commander's OPLAN and accomplish the CHS mission. Consider all TSOPs, policies, and procedures in effect. Courses of action are expressed in terms of **what, when, where, how, and why.**)*

4. EVALUATION AND COMPARISON OF COURSES OF ACTION

a. Compare the probable outcome of each COA to determine which one offers the best chance of success. This may be done in two steps:

(1) Determine and state those anticipated difficulties or difficulty patterns which will have a different effect on the COAs listed.

(2) Evaluate each COA against each significant difficulty or difficulty pattern to determine the strengths and weaknesses inherent in each.

b. Compare all COAs listed in terms of significant advantages and disadvantages, or in terms of the major considerations that emerged during the above evaluation.

5. CONCLUSIONS

a. Indicate whether the mission set forth in paragraph 1 can (cannot) be supported.

b. Indicate which COA can best be supported from the CHS standpoint.

c. List the limitations and deficiencies in the preferred COA that must be brought to the commander's attention.

d. List factors adversely affecting the health of the command.

/s/ _____
Command Surgeon

Annexes (as required)

Distribution:

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Section II. COMBAT HEALTH SUPPORT PLAN

B-5. General

Before the CHS estimate is completed, the commander (or surgeon) starts to prepare the CHS plan. As each problem is recognized and solved, a part of the plan is automatically defined. Once the estimate is completed, it defines requirements, identifies sources, and determines policies and procedures.

B-6. Format for the Combat Health Support Plan

(Classification)

Copies _____ of _____ copies
Headquarters
Location
Date, time, and zone

References: *Maps, overlays, charts, or other documents required to understand the plan. Reference to a map includes the map series number and country or geographic area, if required; sheet number and name, if required; and edition and scale.*

Time Zone Used Throughout the Plan: _____ *(Included only if used as the initial plan, or if a major organization is to be affected.)*

Task Organization: Annex A (Task Organization) *(Task organization may appear here, in paragraph 3, or in an annex.)*

1. SITUATION *(Provide information essential to understanding the plan.)*
 - a. Enemy Forces. *(Emphasis on capabilities bearing on the plan.)*
 - b. Friendly Forces. *(Emphasis on CHS functions and responsibilities for higher headquarters and adjacent units.)*
 - c. Attachments and Detachments. *(May be published as an annex.)*
 - d. Assumptions. *(Minimum required for planning purposes.)*
2. MISSION *(Statement of overall CHS.)*

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3. EXECUTION

a. Surgeon's Concept of Support. *(First lettered subparagraph provides a concise overview of planned CHS operations.)*

b. *(The second lettered paragraph identifies the major CHS control headquarters and lists the tasks /missions assigned.)*

c. *(The third and subsequent lettered paragraphs identify the remaining medical units in turn and list their respective tasks/missions.)*

d. *(The next to the last lettered subparagraph discusses the evacuation/holding policy by phases of the operation.)*

e. Coordinating Instructions. *(The final lettered subparagraph contains any coordinating instructions that may be appropriate to ensure continuity in CHS.)*

4. SERVICE SUPPORT

a. Supply. *(Refer to the TSOP or another annex if they provide sufficient information.)*

(1) General supply. *(Provide special instructions applicable to medical units, such as additional requirements for potable water for patient care.)*

(2) Medical supply. *(Provide special procedures applicable to this operation.)*

(a) Requirements. *(To sustain supported forces; this includes blood management.)*

(b) Procurement. *(Provide detailed information on resupply and stockage levels.)*

(c) Storage. *(Provide any specific equipment requirements, such as refrigerators.)*

(d) Distribution. *(Include method of distribution and any limitations and restrictions, as well as transportation requirements.)*

(3) Medical supply installations. *(Give the locations, mission, hours of opening and closing, and troops supported for each health service logistics installation. [In the division AOC, this includes the DMSO.] An overlay may also be used for clarity.)*

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(4) Salvage of medical equipment and supplies. *(Note that medical equipment and supplies are afforded protection under the provisions of the Geneva Conventions and cannot be intentionally destroyed. If they cannot be taken with the force, they must be abandoned [refer to FM 8-10].)*

(5) Captured enemy medical supplies and equipment. *(Note that the disposition of these supplies and equipment is also governed by the provisions of the Geneva Conventions. They can be used to treat EPW patients.)*

(6) Civilian medical supplies and equipment. *(Include availability, compatibility, and maintenance support requirements.)*

(7) Other health service logistics matters.

b. Transportation and Movements. *(Include medical use of various transportation means.)*

(1) Ground.

(2) Air (Army air).

(3) Air (USAF).

(4) Rail.

(5) Water (inland and/or sea).

(6) Movement control and traffic regulation. *(Include designation of medical evacuation routes and air corridors.)*

c. Services.

(1) Services to medical units and facilities. *(Include information on the following services: laundry, bath, mortuary affairs [MA], utilities, fire fighting, construction, and real estate.)*

(2) Medical equipment maintenance. *(Include in separate subparagraphs the location, mission, and hours of operation for medical maintenance and/or optical repair teams, unless included as attachments to health service logistics units.)*

(3) Labor. *(Include policies on the use of civilian or other personnel for labor. Comply with existing agreements, arrangements, or policies.)*

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(4) General maintenance. *(Include priority of maintenance, location of facilities, and collecting points.)*

5. MEDICAL EVACUATION, TREATMENT, AND OTHER HEALTH SERVICES

a. Medical Evacuation.

(1) Evacuation requirements for Army, Navy, USAF, allied and coalition forces, civilians, and refugees, detainees, and EPW. *(Note that guards for EPW are nonmedical personnel selected by the echelon commander.)*

(2) Requirements. *(List requirements, including percentage to be evacuated by air or sea transportation means.)*

(3) Units. *(Give location, mission, and attachment of evacuation elements, such as forward-sited corps ground ambulances or forward-sited air ambulances.)*

b. Treatment.

(1) Policies. *(State treatment policies to include civilians, refugees, and EPW.)*

(2) Units. *(Give the location and the establishing and disestablishing date and time [opening and closing] at new or old location for all MTFs. Each MTF, such as division clearing station or ACR medical company, should be listed in a separate paragraph.)*

c. Other Health Services. *(Include the provision of the remaining CHS functions: laboratory services, dental services, PVNTMED and sanitation, CSC, veterinary services, and required C⁴I)*

6. MISCELLANEOUS. *(Address areas of support not previously mentioned which may be required or needed for the execution of the CHS mission, such as CP locations, SOI, medical intelligence, and international or HN support agreements affecting the delivery of CHS.)*

/s/ _____
(Commander/Command Surgeon)

Appendixes
Distribution:

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