Medical Operations: The First Army Special Operations Focused Joint Readiness Training Center Rotation 24-06J (25 Mar – 20 Apr 2024)

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ABSTRACT

The Joint Readiness Training Center (JRTC) at Ft. Johnson, Louisiana is a key training area for US military forces. Special Operations have been a part of many exercises at JRTC, however, between 25 March and 20 April 2024, rotation 24-06J was the first of its kind in that the rotation was completely Special Operations focused. Multiple challenges facing Special Operations Forces during Large Scale Combat Operations while setting the conditions for Joint Forcible Entry were highlighted. A key strength of Special Operations is its flexible nature, which allows it to adapt to multiple environments and operations. This exercise and these types of operations are no different. Four focus areas were determined to be key for medical operations in this environment. Set the battlespace, build the team, understand assets, and communication is key. Continued exercises of this kind will help further define the role and needs of Special Operations Forces in preparing the battlespace for this type of conflict. It is important for medical leaders to understand the medical nuances of the pre-Joint Forcible Entry environment in order to more efficiently and effectively enter the battlespace.

INTRODUCTION

The following will focus on the after-action review (AAR) from the medical operations lens for the first Army Special Operations (ARSOF) focused Joint Readiness Training Center (JRTC) rotation 24-06J which occurred between 25 March and 20 April 2024. An overview of the exercise will be presented followed by a discussion of the differences in SOF medicine and conventional health services support. This paper will focus on the medical enterprise as planned and executed by the Combined Joint Special Operations Task Force (CJSOTF) as well as lessons learned and ways ahead for future planning.

EXERCISE SUMMARY AND PRE-EXERCISE PLANNING

JRTC Rotation 24-06J Summary

"From 26 March to 20 April 2024, 7SFG(A), Regimental Special Troops Battalion (RSTB) 75th Ranger Regiment, B/3/160th Special Operations Aviation Regiment (SOAR), D/98th Civil Affairs (CA), A/1/4 Psychological Operations Group (POG), Marine Reconnaissance, and UK observers, as well as two red operational detachment alphas (ODAs) from 1st Special Forces Group (1SFG(A)) and two red psychological operations (PO) personnel from 4th POG conducted JRTC Rotation 24-06J, an O-6 level ARSOF focused combat training center (CTC) rotation at JRTC. During the rotation, these units operated across the JRTC "super box" covering Louisiana, Mississippi, and northeast Texas. In scenario, the rotational training unit (RTU) began by conducting a theater security cooperation plan (TSCP) engagement with the partner nation, Republic of South Torbian (RoST). The enemy, North Torbian forces, began massing along the host nation's northern border for invasion. As the threat situation escalated from competition through crisis into conflict, the ARSOF Team's mission evolved with it, resulting in a multi-domain irregular warfare campaign against a peer adversary to set conditions for a Joint Forcible Entry Operation."[1] *"24-06J was a historic rotation that broke new ground for the Army's Combat Training Centers through the interdiction of ARSOF and Multidomain Operations at a previously unprecedented scale. For ARSOF, the rotation was an important opportunity to test and develop concepts for how we will fight in future high-end conflict at every echelon from the detachment to the joint special operations task force (JSOTF)."*[1]

Understanding of Conventional vs SOF Health Services Support

The Army Medical Department (AMEDD) defines the Army Health System (AHS) as "a complex system of systems" comprised of ten medical functions and grouped under the protection (Force Health Protection) and sustainment (Health Services Support) warfighting functions. The Army Medical Department (AMEDD) ten functional areas of medical treatment were kept in mind and discussed throughout the lead up training and the exercise itself (Figure 1).[2] These same functions are expanded within Joint Publication 4-02 – Health Service Support (Figure 2).[3] It is important to note that SOF

Fig 1. System of systems.

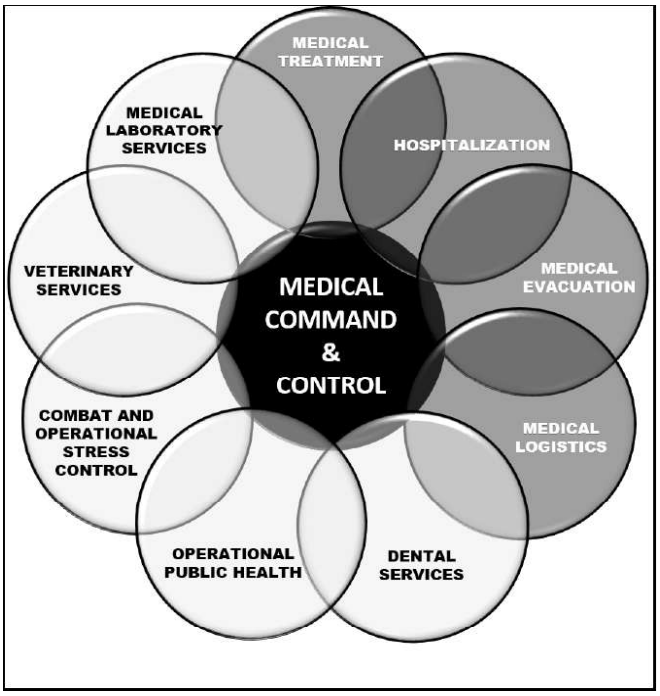
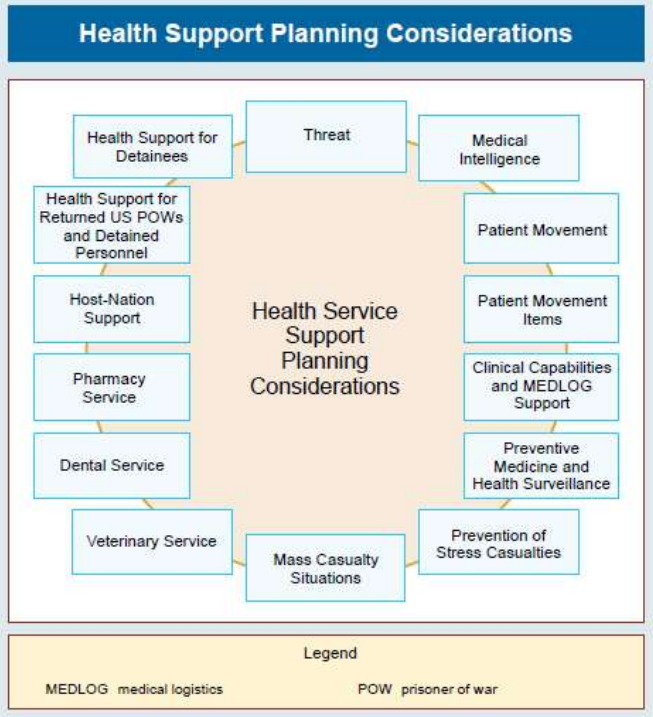


Fig 2. Health Support Planning Considerations



units do not have the assets or manpower to heavily impact each functional area. Army Special Operations units provide role 1 care at the team (SFOD-A) and battalion (SOTF) levels but there is no organic role 2 asset or dedicated medical evacuation platforms. Having an understanding of where SOF casualties can enter the AHS support operational framework is a key planning consideration and will continuously change as the battlespace matures.[4]

Preparation

In preparation for JRTC 24-06J the medical section participated in several training events. These training events were a combination of staff exercises, which exercised communication methods with a SOTF, as well as a Leader Training Program (LTP) exercise at JRTC. The medical staff focused on understanding communication methods as well as products needed for casualty and supply tracking throughout the battlespace. The Military Decision-Making Process (MDMP) repetitions, particularly during LTP, were imperative for the medical staff's conversation and understanding when it comes to the differences between conventional planning and the planning for SOF medical support. Doctrine on Operations, the Army Health System, and Joint Health Service Support was reviewed internally. Through the multiple preparatory repetitions, it became abundantly clear that medical sections presence in multiple warfighting functions was essential for overall mission planning as well as sustained operations. Making the appropriate connections within the CJSOTF staff was essential for ensuring shared understanding.

MEDICAL OPERATIONS

Medical Operations during JRTC 24-06J

We will use medical operations as an all-encompassing term for the unit's medical enterprise. The following will address the key components of medical operations during the exercise.

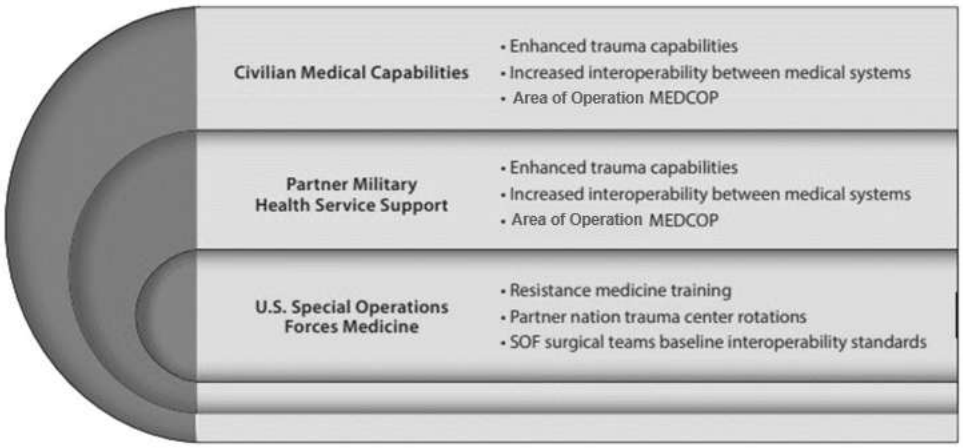
SOF Medical Concept of Support Overview

Army SOF organic medical resources differ greatly from traditional Brigade Combat Team's (BCT) Army Health System (AHS) support. Patient evacuation does not have a linear flow from point of injury (POI), through Role 1, Role 2, Role 3, and intertheater movement to Role 4 care. SOF medical operations are dependent on joint area, partner force, and resistance network assets. This creates periods where prolonged casualty care is necessary while waiting for windows of evacuation opportunity and nonstandard assets to become available. There is also the need for rapid and discreet treatment in order to maintain operational security within a hostile or denied territory. All of these factors created a unique set of challenges throughout JRTC rotation 24-06J.

Evacuation

A critical component in the future success of SOF medical operations will be the preparation of the battlefield prior to crisis and conflict phases of the operation. The establishment of local and resistance networks was vital for patient evacuation. While SFOD-As were conducting operations in the deep and extended deep areas, the teams had little to no evacuation assets and were solely reliant on partner force and resistance assets for any patient movement back towards friendly medical capabilities. The distance and difficulty

Figure 3. Approach to enhanced treatment.[5]



increase the time it takes to evacuate wounded personnel, reducing the window for definitive medical intervention and increasing the risk of mortality or permanent injury.

Traditional evacuation operations, such as air Medevac and the use of Field Litter Ambulances (FLA), were susceptible to detection or attack. This necessitates the use of unconventional means of transportation or establishing clandestine medical facilities closer to the point of injury. The unconventional means of patient evacuation also negated the standard use of a 9-line Medevac request. The CJSOTF received 9-line Medevac requests throughout rotation 24-06J, but the evacuation assets were not available, and the 9-line ended up being used as a means of tracking casualty information. In this environment a MIST report or medical SITREP would have provided better understanding at the CJSOTF level. A SITREP would have also been more applicable due to the SFOD-As not requesting evacuation but instead tying into partner force or resistance evacuation platforms while not possessing the ability to utilize organic U.S. medical assets.

Casualty evacuation for SOF in a contested battlespace requires a high level of planning, coordination, resourcefulness to overcome the numerous obstacles posed by hostile environments as well as an understanding of enemy activity and logistical constraints.

Treatment

Another critical component of preparing the battlefield is establishing treatment assets. The use of local treatment facilities, partner military support, and safe sites are vital when an urgent patient occurs in the deep areas. Special Forces Medical Sergeants (18Ds) and SFOD-As can provide prolonged casualty care, however limited availability of medical supplies and equipment severely hinders their ability to conduct this treatment. SFOD-As must carry essential medical gear to minimize weight and maximize mobility, which may mean sacrificing certain advanced medical interventions normally available in more conventional settings. Tying into local assets provides the ability to move into a hard stand structure with potentially additional medical supplies and treat the casualty until an evacuation opportunity is presented (Figure 3).

The distribution of medical providers in the battle space should be considered while developing plans in depth, advisement to commanders, and coordination with conventional forces. Splitting SOTF providers with one provider forward at the AOBs and one provider at SOTF may decrease the evacuation chain between point of injury and the patient being treated by either a doctor or physician assistant. The role and location of an Austere Resuscitative and Surgical Team (ARST) will be discussed in following section. Phase of operation, enemy location, and evacuation routes are all key considerations when planning medical asset distribution in the battle space.

The prolonged duration of missions and casualty treatment means that patients may endure extended periods without definitive medical care, increasing the risk of complications. SOF units must ensure proper medical training for all team members to provide additional medical assistance during prolonged casualty care situations.

Medical Logistics

Due to the nature of SOF operations, teams are limited on the amount of CLVIII and medical equipment that can be infilled. During the conflict stage, conventional resupply methods such as ground resupply from the Forward Support Companies (FSCs) or aerial resupply were not feasible with the SFOD-As being in hostile or denied territory. This limitation can be mitigated through the use of cache sites, pre-set supplies and equipment at safe sites, and the procurement of supplies off the local economy. All of these require close sensitive activity coordination to build local networks.

The CLVIII Approved Supply List (ASL) prior to JRTC rotation 24-06J did not reflect the needs that were encountered within a LSCO fight and needed to carry more prolonged casualty care supplies and medications. There also needed to be more supplies at the AOB level upon establishment with the SOTF being the primary node to resupply its subordinate units and the CJSOTF facilitating the procurement for the theater.

Preventive Medicine

The preventive medicine section plays a key role as the Force Health Protection arm in the protection warfighting function. The preventive medicine team, functioning as medical intelligence, can identify public health threats as well as assist in the understanding of health threats due to ongoing and potential enemy activities. This includes threats due to environment occupation, geography, endemic disease, and chemical, biological, radiological, and nuclear (CBRN). As the MEDCOP is build out in terms of treatment in evacuation, the preventive medicine team can further develop the picture by identify the above-mentioned threats.

MEDCOP

The CJSOTF had a vital role in the development of the MEDCOP (Medical Common Operating Picture). This required information from top down as well as bottom-up feedback. The SOJTF and MOI provided information on theater level assets, partner forces, and host nation capabilities. The SOTF provided bottom-up information as well as validating the ground truth of medical asset. This information flow allowed the CJSOTF to build shared understanding through all echelons.

LESSONS LEARNED

Austere Resuscitative and Surgical Team (ARST)

The ARST was utilized in multiple locations during the exercise. During the crisis and early conflict phase of the operation the ARST was placed far forward with an AOB. However, there was concern about the security and utility of the ARST at the AOB once there was a definitive forward line of enemy troops (FLET). As the AOBs displaced to friendly areas there was discussion that the ARST was no longer in a location to receive patients in a timely manner. Additionally, the AOBs were not in an area that facilitated patient or resupply efforts making the utilization of the ARST at that location less effective. There was discussion of infilling the ARST to an SFOD-A. This was not done for multiple reasons. With infill being the incredibly dangerous, it was felt that it was not worth risking a limited theater level asset. If they were to infill or if they stayed with SFOD-As during the transition to crisis to conflict phases there was concern that they would have too much of a signature or that they would not be effective given their on-hand supply and unlikely resupply. The ARST was moved to the CJSOTF given that it was a theater asset. However, the CJSOTF possessed no mobility platform making the ARST non-usable. The ARST was then moved to the SOTF that was the main effort in shaping the battle space for the JFE. This was more effective; however, it was more effective because this SOTF was co-located with a mobility platform. The mobility platform allowed for potential patient evacuation to the ARST, but more importantly allowed the ARST to be mobile in the battle space to support special missions and areas of interest.

Manning

Manning was limited during the rotation for various reasons. This put a lot of stress on the limited medical staff to be able to embed with multiple warfighting functions while also maintaining communication with higher and lower echelons as well as keeping the MEDCOP up to date. In order for the medical section to effectively be employed in this type of operation pre-exercise planning must determine appropriate minimal manning. For this type of operation, it will be important to have MEDLOG embedded with sustainment and preventive medicine embedded with protection. The Surgeon, Senior Enlisted Medical Advisor, and Medical Operations officer will then be free to concentrate on advising command, patient movement, outside communication, and operations. Preventive medicine should take lead on medical intelligence and building the MEDCOP while MEDLOG should stay operationally relevant by pre-forecasting needs based off of plans and areas of likely conflict or need.

Phases

The JRTC rotation highlighted multiple challenges. Several of these challenges were phase specific. The following will discuss challenges and lessons learned through the phases: competition, crisis, conflict, pre-JFE.

Competition to Crisis

As previously mentioned, caches were an important method of unconventional resupply during the conflict phase of operations. These caches require forward planning and should be thought of as pre-positioned stock. SFOD-As and SFOD-Gs should be developing locations and stock during the competition and crisis phase. It is important that the SOTF medical staff, to include their MEDLOG component, stay aware of operations and participate in planning in order to build out these plans. Additionally, during the competition and then crisis phases, it is important that the ground truth of partner force military medical capability be understood and that resistance medical resources be developed. Teams operating within a given AOR must start developing a detailed MEDCOP. SFOD-As already perform medical planning during normal operational rotations. The medical picture of these plans must be shared and continually improved upon. The medical intelligence, or preventive medicine, section should be responsible for compiling this information at the Battalion level. The information should be shared with

and compiled at the Group and Theater Special Operations Command (TSOC) level to build a theater level MEDCOP. The integrated and updated MEDCOP must be built during these early phases as it is much more difficult to build and understand with the pace of escalation.

Crisis to Conflict

18Ds at the AOB and SOTF levels need to consider medical capabilities and evacuation. This includes when helping to advise on potential displacement locations, if they are needed, during crisis/conflict. AOB locations that are not in vicinity of evacuations or supply routes play little role in casualty treatment or evacuation and are a poor location for provider or ARST placement. Additionally, the CJOSTF must integrate and communicate with Geographic Combatant Command assets to quickly establish communication with partner force and host nation Ministry of Defense (MoD), Ministry of State (MoS), and US Department of State (DoS) liaison officers (LNOs).

Conflict to Pre-Joint Forcible Entry

During early conflict and the pre-JFE phases there will likely be no US medical treatment facilities besides the care provided by 18Ds and SOTF surgeons and physician assistants. Casualties are very likely to end up moving through resistance, partner force, and host nation medical resources. Given difficulty with communication in a LSCO scenario it is unlikely that casualty notification will be instantaneous. Tie-ins with residence forces will need to come from those in or closer to the fight. It is very likely that there will be gaps in casualty tracking. The partnerships and lines of communication built during the pre-conflict phases will be imperative to locating casualties as they move through different evacuation and medical systems.

Pre-Joint Forcible Entry to Joint Forcible Entry

Communication and LNOs with units performing the JFE will also be key to understanding the change to MEDCOP as conventional US forces enter the battle space. Understanding the operational picture in terms of setting conditions for the JFE will provide information on possible lines of evacuation and CLVIII resupply as the fight develops. In much the same way as the MEDCOP is built from bottom up and top down in pre to early conflict, the MEDCOP is now built from the feeding of information to and receiving information from the JFE unit of action.

CONCLUSION

JRTC 24-06J rotation, occurring between 25 March and 20 April 2024, was the first of its kind and brought to light multiple challenges that will be faced by SOF during LSCO while setting the conditions for Joint Forcible Entry. A key strength of special operations is its flexible nature which allows it to adapt to multiple environments and operations. This exercise and these types of operations are no different. Continued exercises of this kind will help further define the role and needs of SOF in the execution of preparing the battle space for this type of conflict.

There were several key take aways during this exercise from the medical operations point of view. The most pertinent include:

Set the battlespace. Now is the time when we need to prepare the battlespace in terms of pre-supply areas, building resistance networks, and developing a theater MEDCOP through better understanding of partner force and host nation medical capabilities.

Build the team. Medical operations will encompass the entirety of the medical enterprise. Medical sections should be looking ahead at how to utilize their subsections operationally to better integrate them for LSCO. Preventive medicine sections should be utilized as medical intelligence arms and embedding with protection during all exercises. Additionally, MEDLOG should ensure an operational thought process and be involved in current mission planning in order to better understand SFOD-A/AOB/SOTF needs. This will be beneficial when they are embedded with sustainment during exercises.

Understand Assets. Ensure the understanding of assets in the battlespace. The MEDCOP, driven from below and above, will help drive sustainment and evacuation lines. Additionally, assets such as the ARST, must be thought of as a theater asset and kept mobile. Placing the ARST with a mobility asset allows it to flex to units of action with the most need while also freeing the ARST to play a role in special missions that set the conditions for JFE.

Communication is key. Communication above and below echelon is something that is easily understood. However, in this type of operation the CJSOTF must also have medical tie-ins to host nation Defense and State departments/ministries as well as the US Department of State. This communication is key to understanding the full theater MEDCOP and to be able to track casualty movement throughout multiple medical systems.

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