

MC4 Challenges at the National Training Center

Soldiers have been using the Medical Communications for Combat Casualty Care system to manage medical information for more than a decade, but training on the system is still being provided by field support representatives.

By Sgt. 1st Class Shawn D. Hardiek

The Medical Communications for Combat Casualty Care (MC4) system has served as the premier comprehensive medical information management system on the battlefield for more than 10 years. However, MC4 continues to require significant focus, direction, and training by medical observer-coach/trainers and MC4 field service representatives (FSRs) at the National Training Center (NTC) at Fort Irwin, Calif.

During my 13 rotations as a brigade surgeon section trainer and brigade support medical company treatment platoon trainer, it has become clear that many brigade combat teams (BCTs) lack the skill sets within their formations to establish MC4 systems at the role I and role II medical treatment facilities. This task has been completed primarily through significant FSR support.

If this trend continues as we move into decisive action operations, the use of MC4 systems on our battlefields will be significantly degraded. This could result in the loss of the single comprehensive electronic health record and the ability to automate the maintenance and ordering of medical supplies.

Overreliance on FSRs

MC4 use was always highly encouraged at the NTC, but it was mandated in August 2010 that the rotational training units (RTUs) use MC4 throughout the continuum of care. Thanks to the support of MC4 FSRs, great strides have been made in the use of MC4 at every level of care at the NTC.

However, units continue to lack the skill sets needed to set up and configure MC4 systems without significant FSR support. When issues arise with MC4 systems, the BCTs often return to the comfort of paper-based systems like Standard Form 600, Chronological Record of Medical Care, for patient documentation or Department of the Army Form 3161, Request for Issue or Turn-in, to order class VIII (medical materiel).

The FSRs are more than willing to help the unit get to the usage phase of its training at the NTC, but they often

spend much of their time fixing issues that should have been addressed before the BCT arrived. This is especially true if the unit has not used MC4 in garrison. The FSRs often go above and beyond to ensure the RTU can use the Armed Forces Health Longitudinal Technology Application–Theater (AHLTA–T), which is an MC4 application that enables the RTU to electronically document medical care provided to a Soldier anytime and anywhere.

In addition, the FSRs provide detailed support on the Defense Medical Logistics Standard Support Customer Assistance Module (DCAM), which automates maintenance requests and medical supply ordering. Furthermore, FSRs continue to be the only subject matter experts in the medical or sustainment automation support management office (SASMO) sections of the BCTs. An FSR’s time is often limited at the NTC, and it takes an average of five training days to get the BCT within 75 to 85 percent of MC4 proficiency, which can result in training gaps.

The BCTs’ lack of proficiency in using MC4 has been easily masked by the current forward operating base (FOB)-centric fight. FSRs have been for the most part unhindered in their movements across the battlefields of Operations Iraqi Freedom, Enduring Freedom, and New Dawn. Their efforts have taken medical regulating to levels never before seen during conflict.

But the concern still remains that if the unit cannot establish its MC4 systems without complete or significant reliance on MC4 FSRs, it has completely missed the mark on “train as you fight.” If MC4 is truly a “foxhole-to-treatment-facility” comprehensive medical information system, then the BCTs must be able to use this system by relying on their own skill sets within their organizations.

The Problem

The reliance on FSRs to support MC4 systems has created a gap in knowledge and expertise that has yet to be filled by anyone in uniform. One solution was to fix

the problem by officially placing a military occupational specialty (MOS) 68G (patient administration specialist) in the SASMO to be the MC4 subject matter expert.

However, in my experience, that MC4 subject matter expert has never had the training required, such as the SASMO Course. After a Soldier completes that course, additional skill identifier (ASI) N8 is awarded, indicating that the Soldier has many of the skills needed to support medical communication systems.

Also, MC4 provides unit-level administrator (ULA) training, known as tier 1 training, but often either no one in the BCT has had the training or the unit has only one ULA-trained individual and that person does not participate in training at the NTC.

Furthermore, tier 1 ULAs are not trained to deal with connectivity issues related to the Combat Service Support Automated Information Systems Interface (CAISI), very small aperture terminals (VSATs), or joint network node/command post nodes. Often the S-6 or SASMO is busy with competing requirements throughout the BCT, leaving connectivity issues related to role I and II medical treatment facilities on the back burner.

This gap in support is partly due to the lack of command emphasis on MC4. Often MC4, unlike the Standard Army Retail Supply System (SARSS) and the Standard Army Maintenance System (SAMS), is not viewed as an integral part of the Standard Army Management Information System (STAMIS) suite.

Without technical expertise and designated support within the BCT, the progress made in medical communication and class VIII management will be all but lost if BCT treatment facilities revert to an inefficient paper-based system.

Solutions

Many issues helped to create the problem, and there are just as many potential solutions. Some RTUs have already benefitted from a few of the following methods.

STAMIS gunnery. MC4 gunnery at the NTC has been very helpful to units. This gunnery now includes all MC4 systems within the BCT. This is usually a joint effort between the S-6 or SASMO and medical leaders. The key is to require the RTU to set up each MC4 using its assigned CAISI and VSAT. This will reveal issues with faulty or missing equipment or connectivity problems. The concept is that each system should be plug and play once it reaches its area of operations.

The ULA, or someone who is identified as the ULA during the rotation, is required to attend the gunnery. The ULA is given limited administrative privileges to set up accounts and reset passwords. The FSRs are usually present and can help identify problems with systems. The FSRs will also identify systems that will be used for AHLTA-T and DCAM. Units that have taken full advantage of this were much better prepared to use their systems once training began. This helps the FSRs focus

their support as the RTUs move into the training area.

Garrison use. BCTs that have used MC4 in garrison arrive at the NTC much better prepared. Although this does not solve their connectivity issues when they arrive, they are able to quickly implement their systems once connectivity is established. However, if the units would place MC4 on their tactical network at home station, this would be a true train-as-you-fight implementation of MC4, much like SARSS and SAMS.

MC4 training. BCTs that have taken full advantage of tier I training for medics and tier II training for the SASMO are well ahead of other units in many areas concerning MC4. These BCTs, although few and far between, have clear command emphasis from the BCT commander, understand the system and its relevance, and are able to quickly implement it. This enables the FSRs to move to a technical support role instead of a full system implementation role.

Committed technical support. The Army should develop a dedicated MOS to be the subject matter expert for medical communications throughout the BCT. This would not be an additional duty but an actual MOS. Individuals with this MOS would have the skill sets needed to deal with not only the use of the MC4 suite but also connectivity issues related to CAISIs and VSATs.

Currently, the ASI N8 is available only to MOS 68G Soldiers. This ASI should be open to other medical MOSs, such as 68W (health care specialist) and 68A (biomedical equipment specialist). This would greatly increase the BCT's internal support of medical communications systems.

BCTs rely heavily on FSR support in order to set up and use their MC4 systems effectively. BCTs currently do not take ownership of the system, nor do they have the skill sets within their formations to accomplish the mission on their own. This issue has not surfaced to a point of great concern because of the overwhelming support that FSRs have provided in OEF and OIF.

However, as we transition away from the FOB-centric fight, FSRs could be limited in their support of the BCT. Units must be self-sufficient in setting up and using MC4, or they will continue to struggle with timely implementation of what is meant to be a foxhole-to-treatment-facility comprehensive medical information system.

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