CHAPTER 5

HOSPITALIZATION

5-1. Hospital System

Hospitalization is part of the theater-wide system for managing sick, injured, and wounded patients.

a. The hospital system is specifically designed to provide patients with surgical and medical resuscitative, definitive, and specialty treatment. Patients with rare, unusual, or complex conditions are evacuated to hospitals that can provide them with the needed specialized treatment.

b. Within the hospital system, the scope of patient care and treatment capabilities can be adjusted. The adjustment may be to—

- Provide maximum effort for individual patients.
- Manage the extreme disparity between available medical resources and the medical work load (mass casualties). (See Chapter 14 for a discussion on mass casualties.)

5-2. Selection of Hospital Sites

a. Coordination. Selection of hospital sites in the theater of operations requires coordination at the appropriate levels of command. Within the CZ, the major consideration in selecting hospital sites is the tactical commander's plan. Within the base cluster designated by the operations officer of the unit headquarters, specific hospital sites are selected. During the process of selecting these sites, the HSS planner coordinates closely with the logistics staff officer. This officer has staff responsibility for—

- The specific allocation of real estate.
- Planning and coordinating any construction requirements.

b. Vulnerability to Enemy Actions. If possible, a hospital should be located away from a potential tactical target such as an airfield, munition and supply dump, railroad, crossroad, or bridge. A hospital could be collocated at or near a site of likely immunity such as a civilian medical, religious, or educational activity. The radius of damage of anticipated enemy weapons (conventional and NBC) should be considered. When a hospital is to be established within an existing or planned defensive perimeter, it should be located where it can be isolated from potential enemy ground or air action.

c. Accessibility. Hospital sites must be accessible, under varying weather conditions, to different means of transportation for patients and to supply and service vehicles. Consideration must also be given to locating the hospital within a reasonable distance from an airfield which can accommodate USAF aircraft performing AE missions.

d. Availability of Utilities and Com - *munications.* Adequate utilities (water, sewage, wastewater and human and medical waste disposal, electricity, and communications) are required. Where possible, existing utility systems should be used to meet hospital requirements. During the selection process, consultation and coordination are effected with all designated support units—signal, maintenance, and engineers. Engineer site preparation may include construction of semipermanent or field expedient waste disposal systems.

e. Topography. A hospital should be located on ground which is relatively high, level but slightly sloped, clear of obstructions, and which requires minimal engineer preparation. The soil should drain rapidly. Coordination is effected with the supporting engineer unit to ensure site clearance and preparation.

f. Proximity to Other Facilities. The hospital should be located away from sites likely to cause problems in maintaining good sanitation. The hospital should also be located away from areas subjected to undue noises, smoke, unpleasant odors, and any other distracting or disagreeable nuisances.

g. Space. Space should be sufficient to allow for maximum possible expansion of hospital facilities; that is, space is needed for a recreational area and spaces for storage of supplies, equipment, vehicle parking, motor pool, laundry and bath unit, receiving, shipping, waste collection, and waste disposal. Sufficient space in proximity to the hospital receiving or triage area is also needed for a

helicopter landing site. Special consideration should be given to the x-ray exposure area caused by the facility's x-ray equipment.

h. Special Consideration for Hospitals Within the Communications Zone. General hospitals must be appropriately located to support patients received from the CZ and patients transferred from other MTFs within the COMMZ. Sites are selected to take advantage of available road, rail, and water routes and to ensure proximity to air and rail terminals used by US Forces. Other COMMZ hospitals should be located to support large troop populations. Station hospitals are located to support permanent troop populations, and field hospitals (FHs) are located to support populations such as temporary troop concentrations, transients, and prisoners of war. (See FM 8-55 for a discussion on base development.)

i. Existing Buildings. The advantages of using existing buildings such as schools or other buildings of opportunity are numerous, especially in terms of NBC contamination avoidance.

5-3. Passive Defense of Hospitals

The degree to which MTFs should apply passive defense measures concerns both the tactical commander and the medical unit commander. The overriding fact is that the tactical commander is responsible for all decisions incident to the conduct of tactical operations within his area of responsibility. (See Chapter 3 for a discussion on passive defense.)

5-4. Relocation of Hospital Units

a. Hospitals within the corps area are not always moved to coincide with redeployment of combat units. Consideration is given to–

- Distance.
- Anticipated duration of the tactical operation.
- Requirements for the movement of the physical facilities.
- Requirements for movement and disposition of the patients.

The capability to treat patients is severely degraded during movement of hospital facilities. This must be considered before a decision to move is made. The displacement of hospitals temporarily reduces the number of beds available. This may result in a greater number of patients being evacuated out of the CZ during the period of relocation.

b. Relocation of a hospital will require assistance from many sources to include air and ground ambulances, supporting transportation units, and units with rough terrain forklift capability. Nonorganic transportation requirements are coordinated with the medical headquarters to which the hospital is assigned. The type of transportation used depends upon the means of air and ground transportation available, road and weather conditions, and accessible airfields.

c. Personnel must be available to–

- Pack, load, and unload medical supplies and equipment.
- Provide patient care simultaneously at both the old and the new hospital sites.

Personnel requirements for relocation can be reduced by the diversion of incoming patients to another hospital in the area at the time relocation is imminent. Another alternative is to have a separate medical company (clearing) temporarily assume responsibility for patients on hand prior to movement of facilities.

d. Health service logistics support must remain responsive even though the hospital is relocating. Sufficient medical supplies and equipment must be on hand to sustain patient care at both old and new hospital sites.

e. Hospitals and other medical units in the rear area should be incorporated into the base cluster. The rear area operations center must try to provide security for the MTFs whenever possible. These facilities are so numerous that in many cases the ideal type security will not be available. (See Chapter **3** for a discussion on medics in the defense.)

Medical units that are part of base clusters will be provided security as part of the base defense plan.

5-5. Corps Hospitalization

Corps hospitalization is provided by hospitals subordinate to the medical brigade/groups. Hospitalization is provided as close as practical to the troops requiring it. The hospital system is comprised of the MASH, CSH, evacuation hospital, and, if required, FHs. The basis of allocation of hospitals in support of a division is one MASH, one CSH, and two evacuation hospitals. The FH (normally a COMMZ hospital) is allocated as required to augment corps hospitalization. The maximum number of personnel are returned to duty within the CZ. All corps-type hospitals are being equipped with Deployable Medical Systems (DEPMEDS). (See Training Circular [TC] 8-13, Deployable Medical Systems–Tactics, Techniques, and Procedures.)

5-6. Mobile Army Surgical Hospital, TOE 08-063H000

a. Mission. The MASH provides resuscitative surgery and medical treatment necessary to prepare critically injured and wounded patients for further evacuation.

b. Assignment. The MASH is assigned to the medical brigade or to a medical group.

c. Capabilities. On a 24-hour basis, the MASH provides–

- Resuscitative surgery and medical treatment necessary to prepare critically injured or wounded patients for further evacuation to definitive treatment facilities.
- Preoperative and postoperative intensive care for a maximum of 60 patients.
- Surgical capability based on staffing to operate four operating rooms on the first shift and two operating rooms on the second shift.
- Laboratory, pharmacy, radiology, and blood banking services.

d. Basis of Allocation. The MASH is allocated on the basis of one per division. It is allocated on the basis of one per separate brigade when the brigade is not otherwise supported by a CSH.

e. Concept of Operation and Employment.

(1) The MASH is employed near the supported division's rear boundary. Under certain conditions, it may be necessary to employ the MASH forward of the division's rear boundary.

(2) The MASH has no formal evacuation policy. The length of stay is dependent upon the patient's stabilization and readiness for further evacuation.

(3) Patients stabilized for evacuation at the MASH will be further evacuated to the evacuation hospital for definitive treatment or evacuation out of the CZ.

(4) The MASH is the only hospital facility that is considered 100-percent mobile.

5-7. Combat Support Hospital, TOE 08-123H000

a. Mission. The CSH provides hospitalization for general classes of patients in the CZ.

b. Assignment. The CSH is assigned to the medical brigade and is normally attached to a medical group.

c. Capabilities. On a 24-hour basis, the CSH provides–

- Resuscitative surgery and medical treatment of critically injured, ill, or wounded patients requiring highly specialized care which wiIl prepare them for further evacuation.
- Surgical and medical services for patients held for definitive treatment.
- Intensive, intermediate, and minimal care for up to 200 patients (40 intensive care patients, 80 intermediate care patients, and 80 minimal care patients).
- Consultation services for outpatients referred from other MTFs.

- Oral surgery and emergency dental treatment to inpatients and hospital staff.

- Clinical laboratory, pharmacy, and radiology services for up to 200 inpatients and for outpatients referred to the hospital for consultation.

- Organic laundry for hospital linens, patient hospital clothing, and unit-owned duty personnel work garments.

d. Basis of Allocation. The CSH is allocated on the basis of one per division or division equivalent or one per separate brigade.

e. Concept of Operation and Employment.

(1) The CSH is routinely employed farther to the rear of the division boundary than the MASH. It retains the capability to receive and treat those critical patients not regulated to the MASH and provides hospitalization support for the critical and noncritical patients from the division and corps units on an area support basis.

(2) The CSH will routinely evacuate stabilized patients directly to the MASF for evacuation out of the CZ.

(3) The CSH will be employed in an area which may require movement. When the tactical situation demands relocating the unit, its patients must be regulated to other MTFs.

(4) The CSH is capable of transporting 250,000 pounds (13,900 cubic feet) of equipment with organic vehicles. The CSH has 392,000 pounds (44,650 cubic feet) of equipment requiring transportation.

5-8. Evacuation Hospital, TOE 08-581H400

a. Mission. The evacuation hospital provides the most definitive care for all classes of patients within the CZ.

b. Assignment. The evacuation hospital is assigned to the medical brigade and normally attached to a medical group.

c. Capabilities. On a 24-hour basis, the evacuation hospital provides–

- Resuscitative surgery and medical treatment of critically injured or sick patients requiring highly specialized care which will prepare them for further evacuation.

- Surgical, oral surgical, and medical services for patients held for definitive treatment.

- Intensive, intermediate, and minimal care ward nursing service for 400 patients. Four intensive care wards provide nursing care for up to 40 patients, eight intermediate care wards provide nursing care for up to 160 patients, and ten minimal care wards provide nursing care for up to 200 patients.

- Consultation services for patients referred from other MTFs.

- Primary medical outpatient service for organic personnel only.

- Clinical laboratory, pharmacy, and radiology services for up to 400 patients and for outpatients referred to the hospital for consultation.

- Medical administrative services to support work loads designated above.

- Dental treatment to staff and patients and oral surgery support for military personnel in the immediate area plus patients referred by area support dental detachments.

d. Concept of Operation and Employment.

(1) Some patients will be evacuated to the evacuation hospital either for additional treatment or stabilization prior to evacuation to the MASF.

(2) The evacuation hospitals are located in the corps rear and receive patients from throughout the CZ.

(3) The evacuation hospital will normally be employed in an area which does not require frequent relocation.

(4) This unit is capable of transporting 159,000 pounds (7,700 cubic feet) of equipment with organic vehicles. It has 572,600 pounds (65,500 cubic feet) of equipment requiring transportation.

5-9. Hospitalization Within the Communications Zone

a. Hospitalization in the COMMZ is provided by units subordinate to the MEDCOM. Hospitalization is provided for Army patients originating in the COMMZ and for those received from the CZ. Hospitalization of patients of other Services is provided as directed by higher headquarters. Hospitalization requirements must be forecast so that MTFs can be constructed in advance of the time they are to be occupied. All COMMZ-type hospitals are being equipped with DEPMEDS. These hospitals depend on the availability of technical assistance, labor, and support from engineer units. Two or more GHs and other supporting medical units may be grouped under the command and control of a hospital center headquarters.

b. The types of TOE hospitals normally employed in the COMMZ are the 400-bed FH, the 300- or 500-bed station hospital, and the 1,000-bed GH. The number of each type of hospital and the total number of beds may be determined by computing total bed requirements in the COMMZ. (See FM 8-55 for a discussion on estimating bed requirements.)

5-10. Field Hospital, TOE 08-510H600

a. *Mission.* The FH provides hospitalization for troops in the COMMZ when temporary hospital facilities are required in certain designated areas. It may also be employed within the corps.

b. Assignment. The FH is assigned to the TA MEDCOM (the medical brigade in the CZ) and normally is attached to a medical group headquarters.

c. Capabilities.

(1) At full strength, it is capable of providing hospitalization and treatment for up to 400 patients when operating at a single location. This unit can also provide oral surgery and emergency dental treatment to inpatients and hospital staffs. It maybe divided into three 100-bed MTFs (called "hospitalization units" [HU]), each of which is capable of operating in a separate location for a limited period of time. Each HU is capable of separate operations and provides nursing care for up to 10 intensive care patients, 60 intermediate care patients, and 30 minimal care patients.

(2) The three HUs also provide additional capabilities in the handling of mass casualties by performing the functions of receiving and sorting patients, providing emergency medical and surgical care, and preparing patients for further evacuation. The hospital receives patients from its area of responsibility and evacuates those patients requiring care beyond its capabilities to the nearest hospital that can provide the required treatment.

d. Mobility.

(1) This unit is capable of transporting 78,000 pounds (9,750 cubic feet) of equipment with organic vehicles.

(2) This unit has 211,000 pounds (17,750 cubic feet) of equipment requiring transportation.

e. Concept of Operations. The FH and its HUs normally are employed in any area of the COMMZ to provide temporary area HSS. For example, an FH or HU is often located in the marshaling area for a large airborne operation. The marshaling area is the general area in which unit camps and departure airfields are located and from which the air movement is initiated. In amphibious operations, it is the designated area in which as part of the mounting process–

- Units are reorganized for embarkation.
- Vehicles and equipment are prepared to move directly to embarkation areas.
- Housekeeping facilities are provided for troops by other units.

When operating independently from the hospital headquarters element for extended periods, each

HU must be augmented with administrative and logistical personnel. As stated earlier, the FH may also be employed in a corps area to augment CZ hospitals, and it may be assigned a mission of providing care and treatment for an indigenous population, displaced persons, or EPW, and as a holding facility for recovering patients.

5-11. Station Hospital, TOE 08-233H700 (300 Beds) and TOE 08-253H700 (500 Beds)

a. Mission. The station hospital provides hospitalization to include limited outpatient services to the military population of an installation or specified geographical area.

b. Assignments. The station hospital is assigned to the MEDCOM and is normally attached to a medical group. It may be attached to a hospital center.

c. Capabilities. Station hospitals provide hospitalization in two configurations: 300- and 500-bed hospitals. Hospitalization for the 300-bed hospital includes up to 30 intensive care patients, 180 intermediate care patients, and 90 minimal care patients. Hospitalization for the 500-bed hospital includes up to 50 intensive care patients, 300 intermediate care patients, and 150 minimal care patients. Station hospitals also provide–

- Area optometry service.
- Dental service to inpatients.
- Limited outpatient services in specialties provided.
- Four operating rooms during the first shift and two operating rooms during the second shift (TOE 08-253H0).

d. Concept of Operations. These hospitals operate in semipermanent or permanent facilities and receive all classes of patients in their assigned geographical areas of responsibility. When the situation requires, they may receive patients as overflow from the GHs or directly from CZ hospitals. Patients requiring treatment beyond the capabilities of station hospitals require evacuation to the nearest GH. Those patients who cannot be RTD within the theater evacuation policy and who have been stabilized for evacuation to CONUS are processed through the USAF to ASF for evacuation. Patients who can be returned to duty in-theater but who require the reconditioning available in a convalescent center will be transferred to that facility without first going to a GH.

e. Mobility.

(1) Table of organization and equipment 08-233 H700.

(a) This unit is capable of transporting 31,500 pounds (2,250 cubic feet) of equipment with organic vehicles.

(b) This unit has 52,950 pounds (6,100 cubic feet) of equipment requiring transportation.

(2) Table of organization and equipment 08-253 H700.

(a) This unit is capable of transporting 31,500 pounds (2,250 cubic feet) of equipment with organic vehicles.

(b) This unit has 261,400 pounds (20,850 cubic feet) of equipment requiring transportation.

5-12. General Hospital, TOE 08-303H800

a. Mission. The GH provides specialized and definitive hospitalization to the theater army.

b. Assignment. The GHs are assigned to the MEDCOM and normally are attached to a hospital center. These hospitals are the primary recipients of patients from all hospitals in the theater. These hospitals will receive patients from direct admissions on an area basis.

c. Capabilities. Capabilities of the GH include specialized care and treatment, as well as facilities for studying, observing, and treating serious, complicated, or obscure conditions. The GH operates in relatively permanent facilities and would rarely be moved. Nearly all medical and

surgical specialties are available within the hospital. Patients at the GH may be designated for RTD, moved to a convalescent center, transferred to another GH, or evacuated to CONUS. At full strength the GH provides–

(1) Hospitalization for 1,000 patients (up to 100 intensive care, 600 intermediate care, and 300 minimal care patients).

(2) Area optometry service.

(3) Dental service to inpatients and hospital staff.

(4) Limited area HSS and outpatient services in medical specialties.

(5) Six operating rooms during the first shift and two operating rooms during the second shift.

d. Mobility.

(1) This unit is capable of transporting 60,500 pounds (5,100 cubic feet) of equipment with organic vehicles.

(2) This unit has 587,850 pounds (49,850 cubic feet) of equipment requiring transportation.

e. Concept of Operations. General hospitals are the major link in the chain of evacuation and treatment for patients who cannot be returned to duty within the CZ. They provide the most definitive and sophisticated hospitalization and treatment in the TA. Patients at the GH may be designated for RTD, moved to a convalescent center, or evacuated out of the theater.

5-13. Nonhospitalization Facilities

There are two nonhospitalization facilities that provide inpatient care in the theater: the medical company (clearing) and the convalescent center.

a. Although not a hospital by definition and not included in planning for theater bed requirements, the medical company (clearing) is in the hospitalization category. It provides temporary holding capacity and limited inpatient care. Medical companies (clearing) attached to corps or medical battalions establish clearing stations through the corps area to receive patients from nondivisional areas.

b. While the convalescent center is not a hospital, it is the facility where the convalescent care phase of HSS is provided. This phase entails guiding the patient from the time he has recovered from his injury or disease to the time when he has sufficient physical strength and stamina to perform his job effectively. A convalescent center may be assigned to the medical brigade to permit rapid restoration of patients to full duty. Patients from corps hospitals requiring only convalescent care and reconditioning are transferred to the convalescent center pending their RTD.

5-14. Medical Company (Clearing), TOE 08-128H400

a. Mission. The mission of the medical company (clearing) is designed to–

- Receive, sort, and provide emergency or resuscitative treatment for patients until they are evacuated.

- Provide definitive treatment for patients with minor illnesses or injuries.

b. Assignment. The medical company (clearing) is assigned to the TA MEDCOM on the basis of one per division supported in the CZ or to corps medical brigade as required. It normally is attached to a medical group or nondivisional medical battalion for command and control.

c. Capabilities. At full strength, the medical company (clearing)–

- Operates a single treatment facility with a maximum capacity of 240 patients or up to three clearing facilities, each of which has a maximum capacity of 80 patients.

- May be employed either to expand hospital capacities or to serve as a provisional holding convalescent facility. When augmented with medical professional and ancillary service

teams, this unit can provide increased specialty support.

- May be assigned the responsibility forproviding area or Echelon II HSS.

- Provides a holding capability when augmenting the medical treatment platoon of a division medical company or the medical support company when they are awaiting reconstitution.

- Provides laboratory, pharmacy, and radiology services commensurate with level of treatment provided.

- Provides Echelon I medical supply and resupply support.

- Provides outpatient consultation services for patients referred from Echelon I care.

d. Mobility.

(1) This unit is capable of transporting 162,000 pounds (8,100 cubic feet) of equipment with organic vehicles.

(2) This unit has 20,000 pounds (1,350 cubic feet) of equipment requiring transportation.

e. Concept of Operations. The medical company (clearing) is attached to a medical battalion or group and used where required. The company, or one or more of its platoons, may operate as a provisional holding unit at such points as airstrips, railheads, ports of debarkation and embarkation, and on feeder roadnets. The company may be used to establish and operate small specialized treatment centers such as psychiatric treatment stations by augmentating it with psychiatric service detachment, Team OM, TOE 620. The clearing company has no significant postoperative capability; therefore, when the company is established as a specialized treatment center involving the care of postsurgical patients, it must be augmented with appropriate nursing service personnel and equipment. The medical company (clearing) is the lowest echelon of care that stores and transfuses blood. All blood will be liquid Group O packed red cells.

5-15. Convalescent Center, TOE 08-590H500

a. Mission. While the convalescent center is not a hospital, its mission is to provide facilities for recuperating patients who require additional reconditioning before they are returned to duty. The convalescent care phase guides the patient from the time he has recovered from his injury or disease to the time when he has sufficient physical strength and stamina to perform his job effectively.

b. Assignment. The convalescent center is assigned to the TA MEDCOM and further attached to a hospital center on the basis of one per 10,000 beds required or a corps medical brigade on an as needed basis.

c. Capabilities. The convalescent center consists of a headquarters; an administrative service, a clinical service, and a reconditioning battalion. It is also capable of providing outpatient medical, dental, and optometric care.

(1) The operation of the clinical service is supervised by a senior Medical Corps officer designated by the center commander. The clinical service is comprised of medical, surgical, dental, pharmacy, laboratory, and x-ray sections. The service provides examining, treating and reclassification at periodic intervals so that patient reconditioning may take place in the least amount of time. During the time a patient is at the center, the clinical service is provided with information concerning his exercise tolerance, rate of progress, and reconditioning activities. Whenever practicable, patients originating from the same unit are assigned to the same reconditioning company to maintain morale and esprit de corps.

(2) The reconditioning battalion consists of a headquarters and six reconditioning companies. Each company has a capacity of 200 patients and is designed to provide the type of exercise (light, moderate, or heavy) required by patients. The initial assessment of patients and their rate of progress through the various reconditioning companies are based upon a medical appraisal of their physical status and the evaluation of their exercise tolerance, rate of progress, noncommissioned officer patients are used whenever possible as platoon leaders and instructors in the various phases of the

reconditioning program, including athletic, recreational, and educational activities. Screening for qualifications, special abilities, and combat experience of all patients upon admission affords the opportunity for selecting an individual with the proper background and training for the performance of these duties. When these convalescent patients are physically and mentally fit, they are designated for RTD.

d. Mobility.

(1) This unit is capable of transporting 50,000 pounds (3,850 cubic feet) of equipment with organic vehicles.

(2) This unit has 151,300 pounds (10,750 cubic feet) of equipment requiring transportation.

e. Concept of Operations. The convalescent center is established in either the CZ or the COMMZ. Its purpose is to prevent unnecessary evacuation of patients who require only convalescent care and physical reconditioning prior to returning to duty. It is not considered a hospital when estimating bed requirements. Its primary function is not that of an MTF.

5-16. Army Medical Department Cellular Units

As stated in Chapter 2, AMEDD cellular units may be needed to perform certain medical support functions or to augment capabilities. The following teams provide some of these functions or augment capabilities:

a. Medical Administrative Teams, TOE 08-610H0. Medical administrative teams provide facilities or augment existing services of fixed MTFs or provide special type services in the COMMZ as indicated below:

- Team PA, medical illustration.
- Team PB, admission and disposition.
- Team PC, patient records (small).
- Team PD, patient records (medium).
- Team PF, patient records, reports, and statistics.
- Team PG, patient holding.

b. Area Medical Support Teams, TOE 08-620H0. Area medical treatment teams provide area HSS for troops not otherwise supported, as follows:

- Team OA, dispensary, provides dispensary service for approximately 1,000 troops.
- Team OB, general dispensary, provides dispensary service for an area with a troop population of 1,000 to 5,000 troops.
- Team OC, general dispensary, provides dispensary service for an area with a troop population of 5,000 to 10,000 Troops.

c. Medical Professional Teams, TOE 08-630H0. These teams increase the patient treatment capabilities of fixed strength medical units where less than company size functional augmentations are required. They are allocated on the basis of the troop strength supported and are attached to the hospitals where the particular specialties are most needed.

(1) The following surgical service teams (except for Team KC) are used to augment any medical unit or facility that is organically capable of performing major surgery:

- Team KA, surgical.
- Team KB, orthopedic.
- Team KC, shock intensive care. (Provides special procedures directed toward prevention and treatment of shock. It may be used to augment any MTF which requires additional resources for prevention or treatment of shock or for intensive care.)
- Team KD, maxillofacial.
- Team KE, neurosurgical.
- Team KF, thoracic.
- Team KG, anesthesiology.

- Team KH, ophthalmology.
- Team KI, ears, nose, and throat.

(2) The following medical service teams may augment any MTF providing patient care within their indicated specialities:

- Team LL, dermatology.
- Team LN, renal and electrolyte metabolism, augments a fixed hospital in the COMMZ by providing specialized care for patients with acute renal failure.

(3) The following miscellaneous service and support teams may augment any medical facility which has professionally qualified supervisory personnel and, for Team MP, required cleaning and sterilizing equipment.

- Team MM, laboratory.
- Team MN, radiology.
- Team MO, pharmacy.
- Team MP, central materiel service.

d. Medical Facility Expansion Teams, TOE 08-640H1. These teams perform medical professional and ancillary service functions in support and as a part of expanded fixed strength MTFs. They are allocated on the basis of the number of beds by which a hospital's patient capacity is expanded.

(1) The following physical reconditioning teams are normally attached to a convalescent center to expand its capabilities.

- Team LO, reconditioning battalion headquarters, provides command and control for two to six reconditioning companies (Team LP).
- Team LP, reconditioning company, provides reconditioning for up to 200 patients expected to RTD under existing evacuation policies.

(2) Pharmacy, laboratory, and x-ray teams include–

- Team MQ, pharmacy, lab, and x-ray control, provides coordination, professional supervision, and control for Teams MR, MS, and MT.
- Team MR, pharmacy, which is allocated on the basis of 1 per 200 expansion beds required.
- Team MS, clinical laboratory, which is allocated on the basis of 1 per 200 expansion beds required.
- Team MT, x-ray, which is allocated on the basis of 1 per 100 expansion beds required.

(3) Medical and surgical service teams include–

- Team QA, medical service control, provides supervision and control for treatment elements providing services for 100 to 300 medical inpatients.
- Team QB, surgical service control, provides supervision and control for surgical elements providing services for 100 to 300 surgical inpatients.
- Team QC, outpatient service, provides hospital units with an additional outpatient capability to support a population of 3,000 to 5,000 troops.
- Team QD, inpatient medicine, expands the inpatient capability of a MTF by 30 to 50 inpatients.
- Team QE, inpatient surgery, performs surgery, normally as a single operative team.
- Team QF, inpatient convalescent care, provides professional services and control of 75 to 100 convalescent patients and up to 400 patients undergoing reconditioning.
- Team QG, physical therapy (PT), provides PT services for 30 to 50 inpatients per day.

(4) Nursing service teams provide professional nursing services for up to the number of expansion beds as follows:

- Team SA, nursing service control, supervises nursing personnel in support of 100 to 300 inpatients.
- Team SB, nursing ward control, supervises and controls two Teams SF, two to four Teams SG or SH, or one Team SI.
- Team SE, centralized materiel service control, supervises and controls two to six Teams SJ.
- Team SF, intensive care ward nursing, which is allocated on the basis of 1 per 10 intensive care expansion beds required.
- Team SG, intermediate care ward nursing, which is allocated on the basis of 1 per 20 intermediate care expansion beds required.
- Team SH, minimal care ward nursing, which is allocated on the basis of 1 per 20 minimal care expansion beds required.
- Team SI, convalescent care ward nursing, which is allocated on the basis of 1 per 100 convalescent care expansion beds required.
- Team SJ, centralized materiel service, prepares, processes, sterilizes, stores, and issues medical and surgical supplies in support of up to 100 expansion beds.

5-17. Patient Care at Staging Facilities

The USAF Military Airlift Command has the responsibility for AE of patients from the CZ to the COMMZ and from the COMMZ to the ZI. This responsibility includes patient care while in flight and at staging facilities. Two types of staging facilities support patient care in the USAF system:

a. Fixed Aeromedical Staging Facilities. These facilities, operating transient patient beds, are located on or in the vicinity of an enplaning or deplaning air base or an airstrip. The ASFs vary in capacity from 50 to 250 beds. For patients entering, en route, or leaving the AE system, ASFs provide–

- Reception.
- Limited administrative support.
- Ground transportation.
- Feeding.
- Supportive (rather than definitive) medical care.

b. Mobile Aeromedical Staging Facilities.

(1) The MASF is a mobile, tented, temporary staging facility deployed to provide supportive casualty care and administration. Each MASF is capable of routinely holding and processing 25 patients at any given time. It is not intended to hold casualties overnight or for an extended period of time.

(2) MASFs are located near the runways or taxiways of airfields or forward operating bases that are used by tactical airlift aircraft to resupply combat forces. Each MASF deploys with sufficient medical supplies and equipment to sustain its casualty staging operation for 5 days. If it is to be deployed for a longer period or will receive more casualties than normal capability, it must be resupplied. The MASF is dependent upon the host base to supply food, water, billeting, petroleum, oils, and lubricants (POL), and provide general support.

(3) The MASFs have no organic patient transportation capability. Therefore, the user service is responsible for patient transportation to and from the MASF.

(4) Patients entering the AE system at a MASF should be on a litter with two straps and a blanket; they must be accompanied by required medical supplies and equipment such as respirators and cardiac monitors to allow continuation of required therapy.

(5) The MASFs have no organic patient food service and are dependent on local base food service support, or provision of patient needs by the using Service.

(6) Staffing in a MASF includes flight nurses, AE technicians, and radio operators. Supportive medical care to casualties transiting the MASF is provided by AE technicians under the supervision of a flight nurse. There are no physicians assigned. The radio operators operate the MASF high-frequency radio linking the MASF to the AE communication net.

(7) The MASFs are responsible for–

- Receiving casualties designated for AE from the user service forward MTFs.
- Providing supportive, not definitive, medical care to casualties while awaiting airlift.
- Performing limited administrative support.

5-18. Military Police Support of Hospitals and Convalescent Centers

Military police support for medical facilities is provided on an area basis as part of their area security mission. Additional military police support to such facilities should be coordinated through the commander responsible for rear area security.

5-19. Communications

a. Communications are essential for gathering data, planning hospital operations, performing command and control functions, and supervising performance. Effective management depends greatly upon adequate communications to keep abreast of changing situations. Hospital commanders and their staff must carefully plan for available communications systems, to include host-nation systems.

b. Each hospital within the CZ and COMMZ is required to establish and maintain continuous communications with–

- Its higher headquarters.
- Other hospital units, the supporting medical supply, optical, and maintenance (MEDSOM) unit, and the supporting blood supply unit.
- Other medical headquarters whose units are providing medical evacuation and other specialized medical support.
- Agencies providing them with essential base support.

c. Essential base support includes–

- Staff judge advocate (legal) services.
- Appropriate civil affairs agencies.
- Supporting signal units.
- Supporting personnel units for replacements.
- Supporting maintenance units.

d. Hospital units are equipped with organic communications systems which include combat net radios (with FM and improved high-frequency radio [IHFR] capabilities), computers, and mobile subscriber equipment. Other capabilities include telephones with data ports, mobile telephones, facsimile, and teletype. The hospital commander, as well as all medical commanders, must fully understand the total Army communications system, communication systems redundancy, and the area support capabilities provided by the supporting signal element to ensure that their unit's signal requirements can be met. For example, if the area signal system cannot support the automatic transfer of data within the capabilities of the available automated data processing system, then a disk transfer (courier service) may have to be used. In the case of voice telephone incapability during an employment phase, the FM radio or IHFR may become the primary means of communications. (See FM 24-1 and FM 24-35 for a more complete and detailed discussion on Army communications. Also see Chapter 13 for a discussion on the TAMMIS.)

5-20. Other Services

Other support services are provided by augmentation or separate units. These include finance, laundry and bath, personnel, and mortuary affairs.

5-21. Hospitalization in the Zone of the Interior

Hospitals in the ZI furnish the fifth echelon of HSS. They are fixed hospitals and consists of–

• US Army medical centers (MEDCEN).

• US Army medical department activities (MEDDAC).

• Other federal hospitals (Navy, Air Force, and Veterans Administration).

• Contract civilian facilities.

Figure 5-1 depicts the echelons of HSS.

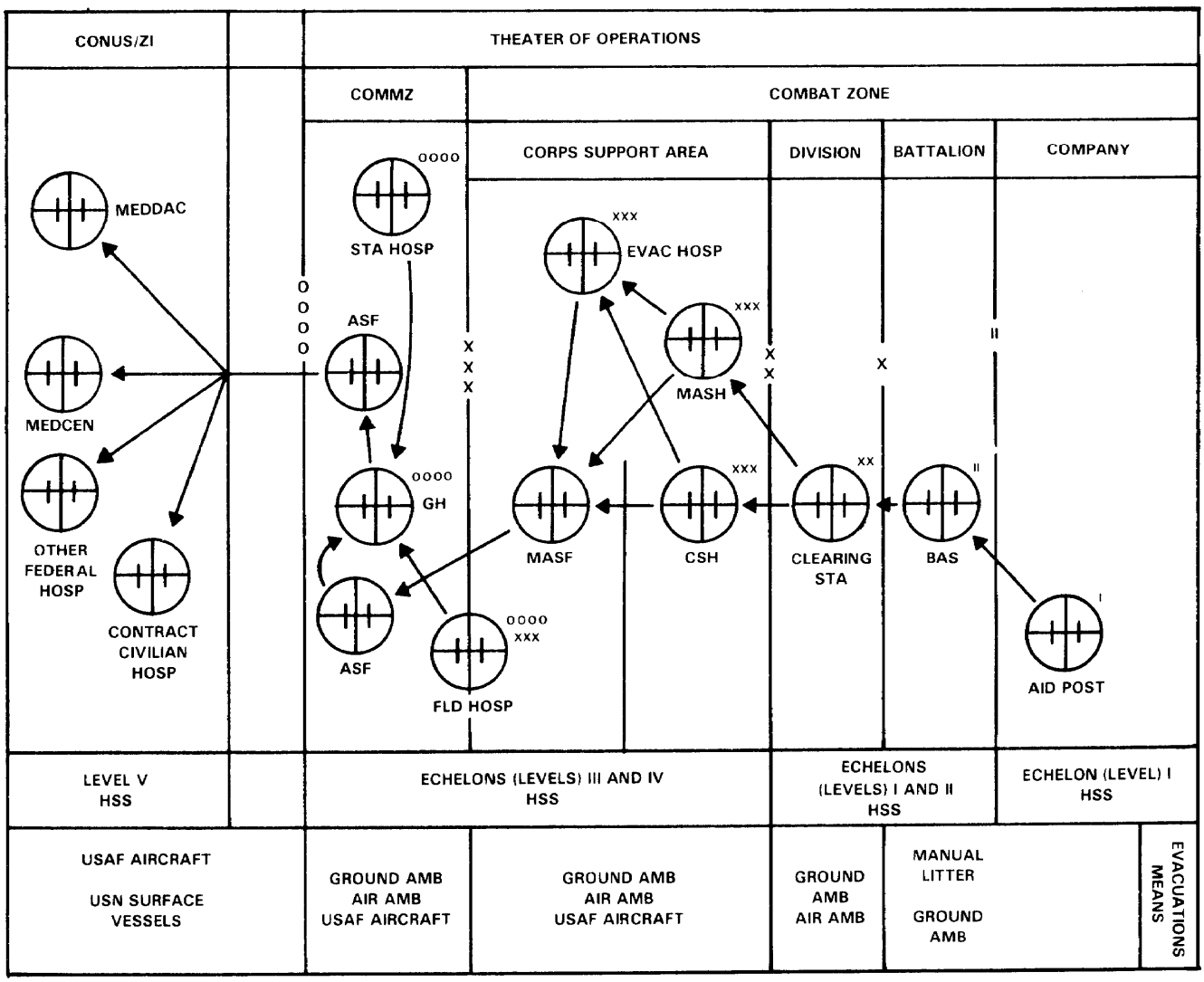

Figure 5-1. Echelons of HSS (current).

5-22. Medical Force 2000 Hospitalization Units

The TOE H-edition units will be rescinded when the units are converted to the Medical Force 2000 L-edition TOE. The hospital units envisioned under Medical Force 2000 are described in Appendix B.