CHAPTER 6

HEALTH SERVICE LOGISTICS

6-1. The Health Service Logistics System

Health service logistics support is an integral part of the HSS system. Health service logistics includes medical supplies and equipment, medical equipment maintenance, and optical fabrication. Without the proper mix of supplies and equipment on hand, there is no HSS.

a. Medical supplies (Class VIII) consist of medical materiel to include medical-peculiar repair parts used to sustain the HSS system. The Class VIII system is under the direction of The Army Surgeon General. It is a specialized subsystem of the Army's logistics system. The Class VIII system basically follows the requirements of the AR 700 series with exceptions provided in AR 40-61. (See Appendix K for a description of the classes of supply.) Certain *characterstics* set the Class VIII system apart from the other commodities, and they place unique requirements on Army medical materiel managers. These characteristics are—

- The protected status afforded Class VIII supplies under the provisions of the Geneva Conventions. It is therefore necessary to store and distribute medical materiel separately from other classes of supply for it to be considered protected materiel.

- The overriding requirements for a materiel system that is immediately and completely responsive to the health care providers.

- The integral function that health service logistics plays in the patient treatment and evacuation system for which The US Army Surgeon General has sole responsibility.

- The highly technical nature of the commodity and its extensive regulation by the federal government. Medical materiel must be stored under tightly controlled conditions and managed by highly trained professionals who are thoroughly knowledgeable in the specialized requirements of this commodity.

b. Medical equipment maintenance ensures that life-sustaining equipment is fully mission capable. This support must be provided as far forward as possible. Maintenance planning must be conducted concurrently with supply planning as the two areas are closely related. A good maintenance program will relieve strain on the supply system by identifying and repairing equipment that would otherwise require replacement. Proper authorized stockage list management improves maintenance turnaround time when repair parts are required beyond prescribed load list stockage capability.

c. Optical support includes–

- Fabrication of single-vision and multivision prescription lenses.

- Fabrication of standard spectacles.

- Fabrication of aviation spectacles.

- Fabrication of protective mask inserts.

- Military standard spectacle frame repair.

6-2. Development of Health Service Logistics

The TA surgeon advises the TA commander in the development of the health service logistics system. The TA surgeon—

- Provides medical staff advice to the commander on health service logistics.

- Ensures that an adequate health service logistics system exists to meet the needs of the Service.

- Recommends policy and sets priorities.

- Plans and supervises technical inspections of the system.

- Determines TA requirements for medical equipment and supplies.

- Exercises staff supervision over the requisitions, procurement, storage, maintenance,

distribution, and documentation of Class VIII supplies and equipment.

• Provides support to other military Services and to civilian communities, as required. The HSS for military operations is normally provided on an area basis and must be coordinated with the component concerned. Requirements to support civilian communities are developed in coordination with the Deputy Chief of Staff, Host Nation Activities.

6-3. Command and Control

a. The MEDCOM and medical brigade(s) or group(s) exercise command and control over the MEDSOM units.

b. To TA, the basis of allocation for MEDSOM units is as follows:

• In the CZ, one MEDSOM unit per four-division corps.

• In the COMMZ, one MEDSOM unit per corps supported.

c. The successful operation of the health service logistics system is directly dependent upon—

• Integration with the complete HSS effort.

• Supervision by appropriate command surgeons.

• Anticipatory and proactive support rather than reactive support.

6-4. Communications

The MEDSOM units operating in either the CZ or the COMMZ communicate with supporting and supported units by voice, teletype, and data transmission. Corps MEDSOM units deal with the medical supply activities of divisions and brigades supported. They also serve all corps hospitals that rely on them for medical supplies. In the CZ and the COMMZ, communications are established with the appropriate movement control center for throughput of supplies. Other units with whom communications are established include personnel and administration, supply and services, engineers, and nonmedical maintenance. See Chapter 13 for a discussion on the TAMMIS Medical Supply, Medical Maintenance, and Optical Fabrication (MEDSUP, MEDMNT, and MEDOPT) System.

6-5. Health Service Logistics in the Combat Zone

a. Medical Resupply.

(1) Although the combat medic carries a basic load that includes the same items that the combat lifesaver carries, it is unlikely that he will have the time or the capability to handle the logistical burden of resupplying the combat lifesaver. Therefore, resupply of the combat lifesaver is accomplished through the normal resupply channels of the maneuver company. The combat lifesaver is resupplied with Class VIII materiel in the same manner as any individual soldier/section/team is resupplied with other classes of supply. However, the exception is that the BAS is the forward supply point for Class VIII materiel. The maneuver unit, therefore, reorders those lines required by the combat lifesaver from the supporting BAS, medical company, or division medical supply office (DMSO). Combat lifesavers in nondivisional units will obtain resupply support from the nearest medical unit capable of supporting them.

(2) Resupply of the combat medic is the responsibility of the BAS. This mission is handled and supervised by medical personnel. The combat medic requests his supplies from the BAS. This action is not a formal request so it can be oral or written. The requests are delivered to the BAS by whatever means available. Usually this will be accomplished by the driver or the medic in the ambulance returning to the BAS with patients. The ambulance will then transport the requester's supplies forward from the BAS to the combat medics. This system is referred to as backhaul. Commonality of supplies between the combat medic and the ambulance equipment set may allow the ambulance crew to fill the combat medic's request from onboard stock. The ambulance crew can then replenish their stocks upon returning to the BAS.

(3) Resupply of forward deployed BASs in a heavy division is the responsibility of the medical company of a FSB. In those divisions not under the MS13/FSB design, resupply of the BAS is the responsibility of the supporting medical company. Medical supply personnel operate a resupply point for the BAS of the maneuver battalions based on supply point distribution. When normal transportation is not available, backhaul transportation of medical supplies using returning ambulances, both air and ground, is an alternative method of moving medical supplies to the maneuver battalions. Coordination for forward movement is the responsibility of the medical platoon leader of the maneuver battalion.

(4) Resupply of the medical companies of the heavy or the light division is by the DMSO. The DMSO has the responsibility to provide medical supply support to all units within the division area. Requests may come by message with returning ambulances (ground or air), by land line, or through existing FM command nets within the division. Requests for medical supplies from BASs and medical companies are filled or forwarded to the supporting CZ ME DSOM. Whenever possible, the DMSO should anticipate demands and push supplies forward based on known operational objectives.

(5) Resupply of the DMSO is provided by the CZ MEDSOM unit. Liquid blood supply of the DMSO is provided by the CZ blood supply unit.

(6) Resupply of the CZ MEDSOM is received through the COMMZ MEDSOM or by direct shipments from CONUS. The CZ MEDSOM unit is normally under the direct command and control of the medical brigade headquarters. It provides medical supply, medical equipment maintenance, and optical fabrication services for units in the CZ area. The CZ MEDSOM establishes the Class VIII supply point in the corps area. Shipment of medical supplies forward is coordinated with the corps movement control center. Emergency resupply will be accomplished by air ambulance.

b. Medical Maintenance.

(1) Medical maintenance is the responsibility of the unit commander. The scope of medical maintenance ranges from the maintenance functions for basic mechanical equipment to complicated medical electronic equipment such as x-ray machines. If an item of medical equipment in the BAS requires unit maintenance, it is transported to the medical company for maintenance. Medical maintenance support is provided by the medical equipment repairer (unit) assigned to each medical company. If an item of equipment cannot be repaired at unit level (UL), then the unit must notify the DMSO who will transport the equipment to the corps MEDSOM unit supporting it or request a mobile support team from the MEDSOM unit. The equipment will be serviced if the maintenance service falls within the capability of the MEDSOM unit. Any equipment requiring service beyond the capability of the CZ MEDSOM will be evacuated to the COMMZ MEDSOM unit.

(2) Low-density lifesaving diagnostic and therapeutic equipment will be repaired or replaced immediately. The ME DSOM units will maintain a medical standby equipment program (MEDSTEP) of designated items. Direct exchange of low-density lifesaving equipment through the use of ME DSTEP may be employed if necessary. Reparable exchange (RX) assemblies, modules, and/or printed circuit boards (PCBs) will also be used to maintain high operational availability rates.

6-6. The Division Medical Supply Officer

a. The DMSO, located in the division's medical battalion (light division) or the MSB (heavy division), is responsible for providing medical supply and medical maintenance support to the medical treatment element within the division. As stated previously, the division surgeon (with the assistance of the DMOC in the heavy division) plans for HSS. The DMSO executes health service logistics plans. He exercises his responsibilities by–

- Procuring, storing, and issuing Class VIII supplies.
- Coordinating with the supported elements to determine requirements for Class VIII materiel and liquid blood.

• Developing and maintaining authorized stockage levels of contingency medical supplies. These levels should be based upon transportation and storage constraints as well as characteristics of the area of operations.

• Managing the division's health service logistics quality control program.

• Supervising the unit-level medical equipment maintenance program.

• Monitoring the division medical assemblage management program.

• Coordinating logistical planning for the assembly, packing, and delivery of standard medical supply sets and locally developed, unit-peculiar resupply bundles.

• Providing guidance to units for calculating unit requirements for preventive medicine.

• Establishing and operating a division Class VIII supply point.

b. The reconstitution duties of the DMSO include—

• Reconciling by brigade the shortages in each medical company and treatment platoon as reported by the commander, platoon leader, or the battalion headquarters element.

• Coordinating with the medical battalion commander or the DMOC to determine and acquire the number of medical assemblages required to ensure units maintain medical readiness.

• Coordinating with the CZ MEDSOM to monitor the status of requisitions for medical assemblages due in.

• Coordinating through the medical battalion commander or the DMOC–

• With the DMCC for movement of bulk supplies or assemblages from the DMSO to forward units when backhaul would be inadequate. (The commander or the DMOC directs quick fixes using available assets and controlled exchanges for medical equipment to maximize the capability of returning trained soldiers to duty.)

• With the corps movement control center (MCC) for delivery of supplies from the MEDSOM unit to the DMSO.

• Alerting the appropriate company when modular systems are due to arrive.

• Distributing modular medical assemblages to the units based on guidance from the commander or the DMOC. (The DMSO coordinates with the DMCC, through the DMOC, for transportation assets to deliver modular medical assemblages to the unit being reconstituted.)

• Preparing the critical items listing and consolidating the critical shortages by brigade.

c. Division medical maintenance services are provided by organic personnel.

(1) *Operator/user* maintenance. Responsibilities of personnel include—

• Performing operator preventive maintenance checks and services (PMCS).

• Coordinating maintenance services beyond their capability with unit maintenance specialists.

• Maintaining equipment by performing routine services. (Some examples of these services are cleaning, dusting, washing, and checking for frayed cables and loose hardware.)

• Performing equipment operational testing.

• Replacing operator-level spare and repair parts that will not require—

• Extensive disassembly of the end item.

• Critical adjustment after replacement.

• Extensive use of tools.

(2) *Unit-level maintenance.* Responsibilities of divisional medical equipment repairers include—

- Scheduling and performing services. (Services include PMCS functions. electrical safety inspections and tests, and calibration, verification, and certification.)

- Performing unscheduled maintenance functions with emphasis upon the replacement of assemblies, modules, and PCBs.

- Operating a medical equipment repair parts program to include Class VIII as well as other commodity class parts.

- Maintaining a technical library of operator and maintenance technical manuals (TMs) and/or associated manufacturers' manuals.

- Conducting inspections for new or transferred equipment.

- Maintaining documentation of maintenance functions in accordance with the provisions of Technical Bulletin (TB) 38-750-2 or DA standards automated systems.

- Collecting and reporting data for readiness reportable medical equipment.

- Notifying the CZ MEDSOM battalion of requirements for maintenance support services, RX, or MEDSTEP assets.

6-7. Health Service Logistics in the COMMZ

a. The COMMZ MEDSOM unit provides health service logistics support in the COMMZ. This includes providing backup support to the CZ. The COMMZ MEDSOM unit is organized under the same TOE as the CZ MEDSOM unit. The organization is shown in Figure 6-1. It is assigned to the MEDCOM on the basis of one per corps supported.

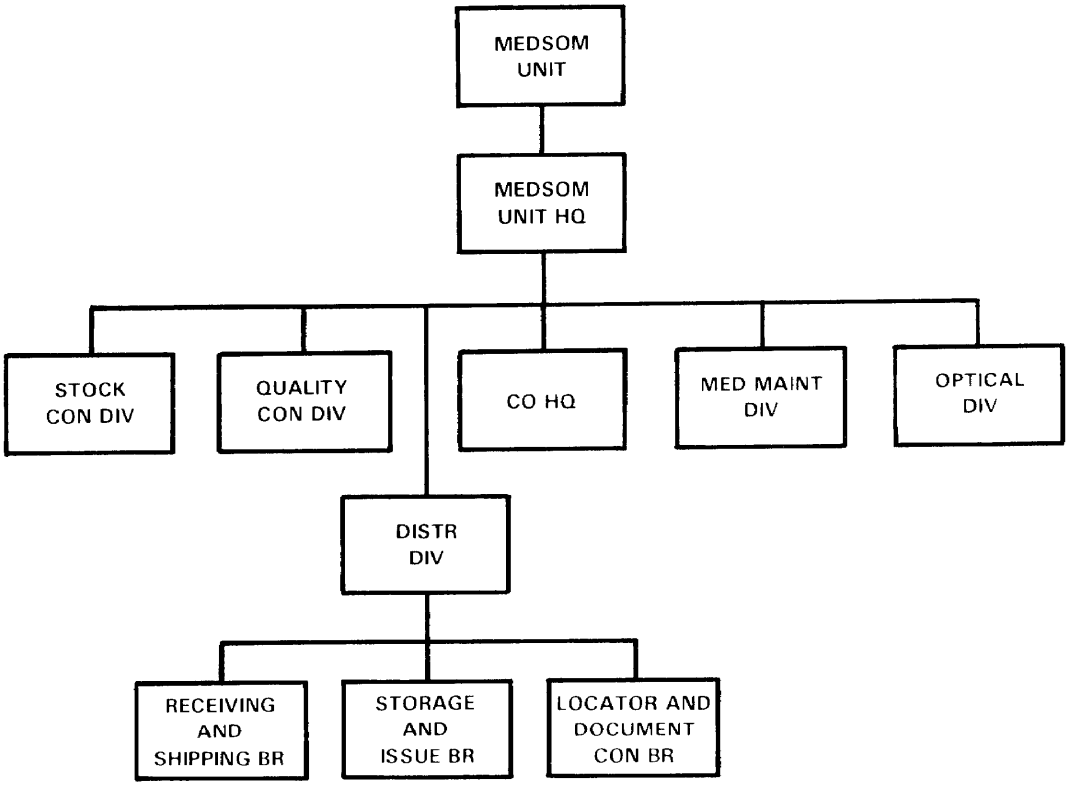

Figure 6-1. Medical supply, optical and maintenance unit.

b. The MEDCOM may have a COMMZ MEDSOM unit augmented with medical logistics support teams as outlined in paragraph 6-8. This unit will work under the direction and supervision of the MEDCOM assistant chief of staff for supply, maintenance, and services. The COMMZ MEDSOM unit with required augmentation will be responsible for–

- Monitoring the operation of medical logistics units under the jurisdiction of the TA.
- Monitoring the receipt and processing of Class VIII requisitions for medical logistics units.
- Reviewing and analyzing demands and computing theater requirements for critical Class VIII supplies, equipment, optical fabrication, and medical equipment maintenance.
- Monitoring and evaluating the work load, capabilities, and asset position of the supported MEDSOM units, and recommending cross-leveling of work load or resources to achieve maximum efficiency.
- Implementing plans, procedures, and programs for medical materiel management systems.
- Providing medical materiel management data and reports required by the MEDCOM and/or TA surgeon.
- Functioning as the management interface with CONUS-based Class VIII national inventory control points and service item control centers.
- Providing management of critical items and analysis of production capability.

c. The CZ and COMMZ hospitals, as well as MEDSOM units, operate as requisition, receipt, storage, and issue sites. Stockage levels will be established by the TA surgeon. Supplies may be requisitioned by and shipped directly to any of these units.

d. Supply point distribution is also used in the COMMZ; however, movement elements of the USTRANSCOM may be used for unit distribution. Movement of supplies into the corps is normally accomplished by the USTRANSCOM. In addition, supplies are shipped into the corps directly from CONUS, using throughput procedures.

e. The MEDCOM assistant chief of staff for supply, maintenance, and services exercises staff supervision over medical equipment maintenance within the COMMZ. The COMMZ MEDSOM unit provides direct and general support maintenance to medical units located within the COMMZ. The COMMZ MEDSOM units also provide backup general support maintenance to the CZ MEDSOM units. Most items that exceed the capability of COMMZ MEDSOM units may be returned to CONUS.

6-8. Augmentation Teams

Corps and COMMZ MEDSOM units may require "tailoring" to individual support requirements by the use of TOE 08-610H0, medical logistical support teams. Capabilities of support teams follow.

a. Team BA, medical supply (small), increases the manual stock control capability of a medical supply element by 500 line items stocked in excess of the unit's basic capability.

b. Team BB, medical supply (medium), increases the capability of a MEDSOM unit (CZ or COMMZ) to support an additional division force equivalent.

c. Team BC, medical supply (large), provides medical supply support to a force of 50,000 troops or major fraction thereof not supported by a MEDSOM unit.

d. Team BD, medical inventory control (small) and Team BE, medical inventory control (large), furnish medical inventory control services for medical supply Teams BB and BC and for a CZ or COMMZ, respectively.

e. Team BE, medical inventory control (large), provides supply management inventory control service for CZ or COMMZ as required.

f. Team EA, medical equipment maintenance (small), Team EB, medical equipment

maintenance (medium), and Team EC, medical equipment maintenance (large), provide direct medical equipment maintenance support for medical facilities. Team EA (small) supports fixed strength medical units. Team EB (medium) augments facilities that support a force of 50,000 and Team EC (large) augments facilities that support a force of 100,000.

g. Team GA, spectacle fabrication (small), provides presurfaced single-vision spectacle prescription fabrication and repair services for a force of 50,000.

h. Team GB, spectacle fabrication (medium), provides the same services as Team GA plus special type spectacle prescription fabrication for a force of 200,000.

6-9. Optical Services in the Theater of Operations

a. Optical services include optical repair and fabrication of standard spectacles, aircrew spectacles, and protective mask inserts. Optical services in the theater of operations are important aspects of the total HSS system. Normally, more than one-third of all Army personnel require corrective lenses.

b. Spectacle fabrication beyond the capability of the division optometry section is provided by the MEDSOM unit supporting the division. The MEDSOM units in both the CZ and COMMZ provide a full range of optical services. Teams GA and GB, optical fabrication, may be employed to augment a MEDSOM unit, as required.

c. Optical support in both the CZ and the COMMZ is provided by Team OH, optometry service. This detachment can provide the full range of optometric service and limited single-vision optical fabrication to include standard spectacles.

d. A limited spectacle repair capability is provided in GHs, station hospitals, and convalescent centers. Spectacle fabrication orders and major spectacle repairs are forwarded to the optical fabrication section of the COMMZ MEDSOM unit.

6-10. Medical Supplies for Enemy Prisoners of War and Others

a. The Army is responsible for providing medical care and treatment for wounded and sick soldiers who fall into our hands. Under certain circumstances, the Army may also be responsible for medical care and treatment of civilians. (See Chapter 3.)

b. In computing requirements for supplies and equipment needed to perform this function, available intelligence data should be used.

6-11. Captured Medical Supplies and Equipment

Representative samples of all captured medical supplies and equipment items must be preserved and reported according to AR 700-99 and FM 8-10-8. The medical supplies or materiel shall first be used to treat enemy wounded and sick and only after their needs have been fully met may such supplies be used to treat others. If these supplies are unfit for use or not needed, they may be abandoned for enemy use. Under no circumstances will captured medical supplies be destroyed.

6-12. Imminent Capture of US Medical Supplies and Equipment

When capture by enemy forces is imminent, medical materiel must not be purposefully destroyed. The Geneva Conventions preclude willful destruction of medical materiel. When a commander, because of military necessity, has decided to abandon patients, he is obligated, as far as military considerations permit, to leave sufficient and adequate medical personnel and materiel for the care of these abandoned patients. Under all other conditions, every attempt must be made to evacuate all medical materiel and equipment. It is a command decision to abandon supplies. The destruction of supplies, other than medical, is also a command decision. Medical units should have an SOP for the evacuation and destruction of their own supplies and equipment (other than medical) based on command priorities.

6-13. Flexible Medical Supply Units

Medical supply units must remain flexible to meet changing situations. The threat of nuclear attacks

and the rapidly changing military situation make it necessary that alternative medical supply plans, procedures, and operations be formulated. In certain instances, it may be advisable to establish duplicate records, especially when automated procedures are used, to serve as a backup system. Medical supply levels of units in forward areas should be kept at a minimum to permit relocation of such units whenever necessary.

6-14. Storage Facilities

a. Class VIII supplies generally require covered storage. Consideration must be given to any special climatic conditions in such areas as deserts, mountains, jungles, or the arctic. Preservation and packing procedures as prescribed in TB MED 1 should be followed. Existing buildings should be considered. They may offer required security, refrigeration, flammable protection, or controlled humidity and temperature storage.

b. Overall space requirements are determined from supply control data and from experience factors for handling medical supplies. Detailed space requirements should be based on specific assignments of support missions, supply levels to be carried, area and troops served, and types of supplies. The HSS unit commanders and staff officers should have an appreciation of storage problems to establish appropriate policies concerning storage of medical supplies.

c. Efficient use of storage space is basic to economical supply operations. Such factors as accessibility of stored medical supplies and protection from deterioration, fire, weather, theft, rodents, and enemy actions must be considered in ensuring efficient storage procedures.

d. Proper medical supply practices require that continuous care be exercised in the surveillance of all medical supplies. Items should be stored and cared for according to the following codes: shelf life months (SLM), storage code (STC), special requirements code (SRC), and additional requirements code. Deteriorating and potency items must receive special consideration in inspections and the rotation of stocks.

6-15. Transportation

a. Proper methods should be employed to minimize unnecessary shipments, transshipments, and rehandling of medical supplies. Shipments of medical supplies should be accomplished in one move. Movement of supplies through successive supply installations causes delays, risk of damage, misrouting, pilferage, or loss. See paragraph 6-18.

b. The availability of transportation assets must be analyzed. Many Class VIII items require special transportation or storage (security and flammable precautions). An efficient and effective transportation system will lessen requirements for strong safety measures and large storage areas. FM 55-1 contains additional transportation planning guidance.

6-16. Operations Plans and Administration and Logistics Plans

Health service logistics planners must possess a detailed understanding of all contingency plans their units may be tasked to support. These plans must be reviewed continuously and their portion must be updated as required to ensure adequate support for the mission. The mission must be analyzed both from the tactical and HSS viewpoint.

This paragraph implements STANAG 2105

6-17. Local Procurement

With certain restrictions, specified items and categories of items of medical supply are authorized for local procurement within the theater. Procurement of certain medical supplies from non-US sources must be authorized by The Army Surgeon General. Consideration in the procurement of medical items from local sources should include manufacturer technical know-how, sterilization techniques, raw material availability, production capabilities, and impact on the economy of the host nation. The high standards established by the US Government make it difficult to consider the use of manufacturers in many areas of the world as possible sources of drug supplies. Drug standards vary in different countries; therefore, drugs from other countries are normally used *only* when US

drugs are not available. (STANAG 2105 provides a cross-index to member nation's combat essential medical materiel.) In practice locally procured materiel is identified and segregated from similar items of US manufacture. Quality control procedures must be followed as prescribed in AR 40-61 and SB 8-75-9. Field Manual 14-7 discusses the guidelines for making local purchases. The following information may only be available from medical intelligence sources:

a. Identification of types and sources of indigenous medical materiel available in a given, foreign, geographic area.

b. The quality of this type of medical materiel.

c. Idiosyncrasies in terms of usage.

d. Important technical data such as side effects and contraindications.

6-18. Location of Units

a. The general locations of medical logistics units are chosen as far forward as possible based on current and projected combat operations. The goal must be to reduce the turnaround time for supplies for using units. When selecting specific locations, however, planners must consider such factors as adequate dispersion because of the nuclear threat, defensibility of installations, local roads, disposition of troops, rail sidings, adequacy of local communication facilities, existing buildings and structures, utilities, and the availability of local labor.

b. Within limitations of the tactical situation, medical supply installations must have access to railheads, ports, airfields, and highways to facilitate movement of medical materiel. Medical logistics units have only enough organic transportation assets to relocate supplies and equipment within storage areas. Medical materiel must be delivered to these units by corps and TA transportation assets. To minimize impact on transportation assets, the "throughput" concept is used whenever possible. Throughput allows for the direct delivery of supplies to the using unit whenever possible. This reduces handling and shipping delays and affords the maximum savings to the transportation community, See paragraph 6-15.

6-19. Property Exchange

In the process of patient evacuation, litters, blankets, pillows, splints, and like items of supply accompany patients. To ensure items to accompany patients are available, an exchange system must be established. Wherever practicable there is a direct item-for-item exchange. The increased use of AE imposes severe restrictions upon the property exchange system. Ultimately, however, the originating facility is responsible for providing the property necessary for the comfort and safety of the patient. To avoid depletion of property exchange supplies, plans should provide for the stockpiling of such items in areas of probable usage. In addition to normal supplies, items to be authorized for hospitals and other MTFs involved in property exchange will be determined by the medical brigade and MEDCOM commanders. In anticipation of combat operations, stocks of exchange items should be considered in all supply planning.

NOTE

Property used during aeromedical evacuation should be accounted for and reported to a central point within the theater of operations. This central point would be tasked to track these items. Aircraft returning from missions should load and return the property to the theater of operations. Within the theater of operations, the equipment could be transported and returned to the owning organization.

6-20. Disposal

a. Excess, unserviceable, or unidentifiable medical materiel that is not authorized for return to a MEDSOM or a CONUS source, redistribution within the theater, or retention at the MTF will be disposed of in accordance with ARs 40-5, 40-61, 200-1, and the SB 8-75 series. Excess materiel is often generated as a result of inadequate supply

controls and procedures. Measures must be implemented by logistics managers to ensure that medical materiel supply levels are sufficient to meet current needs and to prevent excesses. Excess materiel reduces mobility and increases accounting, storage, surveillance, and security requirements.

b. Many pharmaceuticals may pose serious environmental hazards if disposed of improperly. Other medical materiel may pose hazards or may be subject to abuse and may also require controlled disposal methods. Economically recoverable precious metals constitute another category of materiel requiring special disposal techniques.

6-21. Conversion of Health Service Logistics Units

Health service logistics units described in this chapter are organized under the H-edition TOE and are in the current structure. However, units will be converted (or are in the process of conversion) to L-edition TOE described in Appendix C.