

## CHAPTER 3

## THE HEALTH SERVICE SUPPORT SYSTEM

**3-1. Mission**

The mission of HSS, to “conserve the fighting strength,” is accomplished by prevention, treatment, and evacuation. The HSS system provides medical care as far forward on the battlefield as the tactical situation will permit, allowing the maximum number of combat soldiers to return to duty (RTD) as early as possible.

**3-2. Health Service Support, The Basic Doctrine**

*a.* The objective of the HSS system is to reduce the incidence of disease and nonbattle injury (DNBI) through sound preventive medicine programs, to provide care and treatment for acute illness, injury, or wounding, and to promptly return to duty those soldiers who have recovered.

*b.* The major tenets of this doctrine are—

- Far forward medical treatment including advanced trauma management (ATM).
- Selectivity of RTD and nonreturn to duty (NRTD) patients at Echelon III medical units.
- Standardized Echelon I and II medical units under the modular medical support system throughout the division, corps, and communications zone (COMMZ).
- Standardized air and ground evacuation units are integrated under a single manager (the medical evacuation battalion [Evac Bn]).
- Flexible, responsive Echelon III and IV systems provided by four modularly designed hospitals and patient holding units.
- Enhanced ancillary and functional support systems with advanced technologies.
- A medical system that provides continuous medical management throughout all echelons of care and evacuation.

**3-3. Principles of Health Service Support Operations**

*a. Conformity.* Conformity with the tactical plan is the most fundamental element for effectively providing HSS. The HSS planner must participate in the development of the commander's operations plan to ensure adequate HSS at the right time and place. Medical intelligence data must be considered in all HSS planning see Appendix C and FM 8-10-8. All HSS planning is forward oriented and makes full use of the HSS system. A plan for the rapid reinforcement/replacement of forward echelons of the HSS structure is essential. For additional information on planning, refer to FM 8-55.

*b. Continuity.* The HSS system is a continuum from the forward line of own troops (FLOT) through the continental United States (CONUS) base; it serves as a primary source of trained replacements during the early stages of a major conflict. The medical structure is modular in design; procedures are standardized for flexibility, rapid reinforcement by identical modules, and simplified for tailoring a force for varying situations. The patient evacuation system (integrated ground and air) is an integral part of the HSS system; it has been organized to optimize resource use; it is staffed to provide continued care and maintain the physiology of the patient while being transported between MTFs.

*c. Control.* To ensure that the scarce HSS resources are efficiently employed and support the tactical plan, medical units are under the control of a single medical manager. Centralized control with decentralized execution permits the medical commander and his staff to rapidly tailor and adjust HSS assets. Assets can be realigned in response to major shifts in the location and volume of casualties; changes in supported unit composition and mission, and changes in the intensity of conflict. The modular medical support system provides the flexibility to task organize for any situation, or replace like units; however, optimum benefits are only derived through centralized control of all medical functions and subsystems.

*d. Proximity.*

(1) The location of medical assets in support of combat operations is dictated by the—

- METT-T factors.
- Requirements for far forward stabilization of patients.
- Early identification and forward treatment of RTD category patients.
- Forward orientation of evacuation resources, thereby reducing response time.
- Other logistical units/complexes.

(2) Medical commanders and staffs, through constant coordination, ensure that HSS units are not placed in areas that interfere with combat operations; or that are subject to direct intervention by enemy forces. Conversely, tactical commanders must realize the fact that fully committed HSS resources with a forward orientation will optimize their effectiveness.

*e. Flexibility.* Standardized, like-modules provide HSS from the FLOT to the rear boundary of the theater of operations (TO). The ability to rapidly shift HSS resources to areas of greatest need is a cornerstone of the modular medical support system.

*f. Mobility.* The mobility of HSS units organic to maneuver elements must equate to forces being supported. Major medical headquarters (HQ) in the TO (medical group [Med Gp], medical brigade [Med Bde], medical command [MEDCOM]) continually assess and forecast echelonment of medical units; through collective use of all transportation resources, they rapidly move units to best support combat operations.

### 3-4. System Design

The system is designed to acquire, triage, and provide medical care for all personnel operating in the division's sector. Health service support to the division is influenced by many considerations such as:

- The nature of operations, including the intensity of combat.
- The type of threat force to be encountered.
- The geographical area of operations.
- The potential for NBC attack.
- The climatic conditions and endemic disease health hazards.
- Air superiority.

### 3-5. Echelons of Health Service Support

Health service support is arranged in echelons (levels) of care (Figure 3-1). Each echelon of care reflects an increase in HSS capabilities while retaining capabilities found in preceding levels of care. The division contains two levels of care: unit level and division level. Echelon I HSS is provided by the medical platoon/section organic to combat battalions and some combat support battalions. It is supported by first aid in the form of self-aid/buddy aid and the combat lifesaver (CLS). Echelon II HSS is provided by medical companies of the FSB and MSB of the DISCOM (heavy) or the forward support medical company (FSMC) of the medical battalion (light). This level provides an increased medical treatment capability plus—

- Emergency dental care.
- X-ray and laboratory services.
- Patient holding facilities.
- Preventive medicine.
- Mental health services.
- Management of Class VIII (medical) supplies, equipment, and repair parts.

Nondivisional units operating in the division sector receive medical support on an area basis from the nearest medical treatment facility. For information on CLS training, see Appendix B.

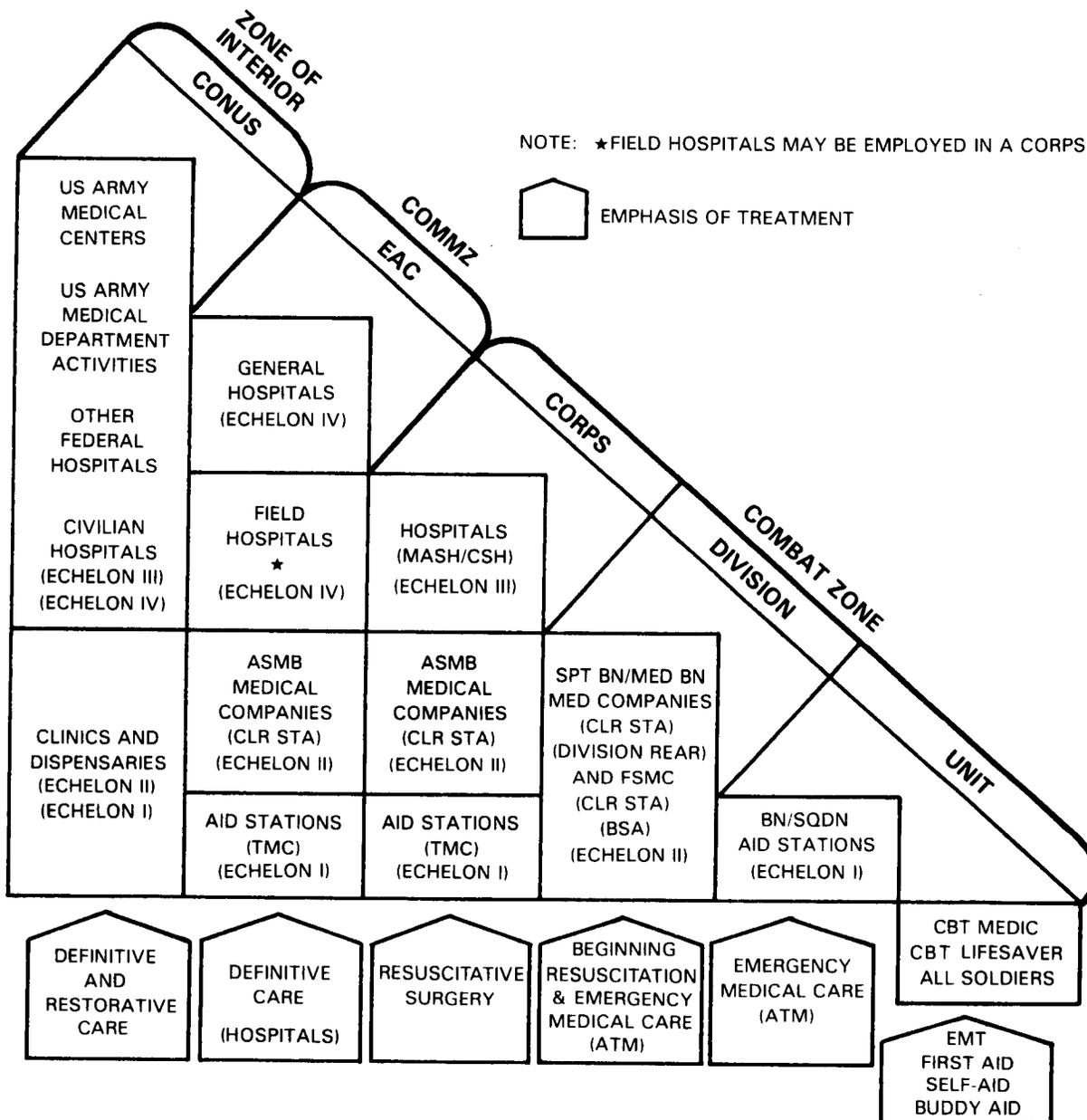


Figure 3-1. Echelons of health service support.

### 3-8. The Health Service Support Challenge

The HSS planner must be proactive rather than reactive to changing situations. He must shift medical resources as the tactical situation changes. Only in this way can the Army Medical Department (AMEDD) “conserve the fighting strength.” The challenges for HSS planners at the medical platoon level include the following elements:

#### a. Planning.

(1) Mission. Health service support planners must understand the tactical commander's plans, decisions, and intent. Health service support planning is an intense and demanding process. The actions of the HSS planner must be proactive, not reactive. The planner must know—

- will do.
- What each supported element
  - When it will be done.
  - Where it will be done.
  - How it will be done.

(2) Requirements. The HSS planner must plan to meet the requirements of—

- Acquisition and treatment of patients.
- Evacuation.
- Health service logistics.
- Dental services (available at supporting medical company).
- Veterinary services.
- Preventive medicine services.
- Mental health consultation services (available at supporting medical company).
- Command, control, and communications.

*b. Prevention.* The most effective, least expensive method of providing the commander with sustained combat power is prevention. Prevention begins with the individual soldier's awareness of the means to protect himself through health and personal hygiene, stress management, nutrition, physical fitness, and similar measures (soldier health maintenance programs). Prevention is enhanced by—

- The application of self-aid/buddy aid training programs.
- The CLS.
- Continuous interface with unit- and division-level medics.
- Division-wide preventive medicine (PVNTMED) programs.

- Combat stress control (CSC) programs.
- Leadership emphasis at all levels of command.

Ultimately, whether it is individual or collective, prevention is the unit commander's responsibility.

*c. Far Forward Care.* Far forward care is the identification and treatment of battlefield casualties as close to the forward edge of the battle area (FEBA)/FLOT as the tactical situation permits. This includes first aid, in the form of self-aid/buddy aid and the CLS, and unit-level medical support. The CLS, found in each squad, crew, section, or team, is responsible for the application of first aid measures with a higher degree of skill than self-aid/buddy aid. However, the CLS's primary role is the performance of his duties as a member of the squad, crew, section, or team, and his first aid duties are performed as the mission permits. Far forward care is provided to the front-line soldier by the combat medic attached to the maneuver platoon/company. More comprehensive care is provided by a physician-directed treatment squad (BAS) capable of administering initial resuscitation and stabilization (ATM) to battlefield casualties. This care maintains the physiology of wounded soldiers who are unlikely to RTD and allows for their rapid evacuation. The BAS treatment squad also treats soldiers with minor wounds/injuries and returns them to duty. A primary goal of unit-level medical care is that the combat medic reach the casualty and begin treatment within 30 minutes of wounding. This rapid application of medical treatment greatly enhances survivability.

*d. Evacuation.* Evacuation starts with the collection of the wounded soldier from the point of injury and continues with his rearward movement through the HSS system. An important element of the evacuation system is the medical care provided en route. Ground ambulances are used in the division area and, where indicated, are assisted by corps air evacuation assets. Normally, ground evacuation will be used for slightly wounded, ill, or injured soldiers who are expected to return to duty. Air evacuation will be used, when feasible, for seriously wounded, sick, or injured soldiers who are not expected to RTD. (Remember, air evacuation may be restricted but only to the extent other

aviation operations are restricted in the immediate area.) The responsibility for medical evacuation rests with the next higher echelon of HSS. For example, the medical platoon is responsible for evacuating patients out of the forward maneuver company/battery/troop area to the BAS. The medical company is responsible for evacuation from the aid station to the division clearing station (DCS). Plans for the use of nonmedical vehicles should be established and supplemented when casualties exceed the capability of medical evacuation assets. For specific information on the use of nonmedical vehicles for patient evacuation, see FM 8-10-6.

#### NOTE

It is the responsibility of unit commanders to ensure that wounded personnel are evacuated to established patient collecting points.

### 3-7. Modular Support System

Health service support to the division is provided by a modular support system (Echelons I and II) that standardizes all medical subunits within the division. The modular design provides duplicate systems at each level of care enabling the medical resources manager at the appropriate level to rapidly tailor, augment, or reinforce the battlefield in areas of most critical need. The system is derived by recognizing those common medical functions which are performed across the division and designing like subunits (modules) to accomplish those tasks. The modular medical support system is built around several modules. The modules are oriented to casualty assessment, collection, evacuation, treatment, and initial surgical intervention. When effectively employed, they provide greater flexibility and mobility, and the ability to rapidly tailor the medical force to meet changes in patient workloads and locations.

*a. Combat Medic Module.* The combat medical module consists of one combat medical specialist and his basic load of medical supplies and equipment. The combat medic is organic to the medical platoon/section of combat/combat support

battalions/squadrons and is attached to platoons, companies, batteries, or troops.

*b. Ambulance Squad.* An ambulance squad is comprised of four medical specialists and two ambulances (two teams). The squad provides evacuation of patients throughout the division and ensures continuity of care en route. Ambulance squads are organic to the medical platoon/section in combat battalions; selected combat support battalions: medical companies of the FSB and MSB (heavy); and the medical company of the medical battalion. Medical company ambulance squads are positioned to best support the maneuver battalions/surgeons. The medical platoon ambulance squads are likewise positioned to support the companies/batteries/troops.

*c. Treatment Squad.* This squad (BAS) consists of the medical platoon leader (a primary care physician), a PA, two emergency medical treatment (EMT) NCOs, and four medical specialists. The squad is trained and equipped to provide ATM to the battlefield casualty. To maintain contact with the combat maneuver elements, each squad has two emergency treatment vehicles (such as M577s). Each squad can split into two trauma treatment teams. The treatment squad is organic to medical platoons/sections in maneuver battalions and designated combat support units. It is the basic building block in the medical company. The treatment squad (treatment teams) may be employed almost anywhere on the battlefield.

*d. Area Support Squad.* This squad is comprised of one dentist trained in ATM, a dental specialist, an x-ray specialist, and a medical laboratory specialist. The squad employs light-weight specialized equipment which can be quickly and easily moved. The squad is organic to the medical company and, if necessary, may be deployed forward with the BAS to support the maneuver battalion.

*e. Patient Holding Squad.* This squad consists of two practical nurses and two medical specialists. The squad is capable of holding and providing minimal care for up to 40 RTD patients; however, in the light division this squad can only hold and care for 20 RTD patients. This squad is organic to the medical companies. A treatment

squad/team, an area support squad, and a patient holding squad are collocated to form the area support section (DCS).

*f. Surgical Detachment.* This detachment is a corps asset which must be collocated with the patient holding squad for support. It consists of two surgeons (a general surgeon and an orthopedic surgeon), two nurse anesthetists, a medical surgical (intensive care) nurse, two operating room specialists, and two practical nurses. The detachment is organized to provide early resuscitative surgery for seriously wounded or injured casualties, to save lives, and to preserve physical function. Early surgery will be performed whenever a likely delay in the evacuation of a patient threatens life or the quality of recovery. The TF surgical detachment will normally be employed in the division support area (DSA) but may be employed in the brigade support area (BSA) during brigade TF operations.

NOTE

The surgical detachment (squad) is organic to the medical battalion of the airborne and air assault divisions.

**3-8. Health Care Logistics in the Combat Zone**

*a. Medical Resupply.*

(1) Resupply of the CLS is accomplished through the normal resupply channels of the maneuver company. Combat lifesavers are resupplied in the same way combat soldiers are provided camouflage sticks, foot powder, or other individual health care items.

(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 an informal request; it can be oral or written. The requests are delivered to the BAS by whatever means available. Usually this is accomplished by the driver or the medic in the ambulances returning to the BAS with patients. Ambulances then transport the supplies from the

BAS to the combat medics. This system is referred to as backhaul.

(3) Resupply of forward deployed BASS in a heavy division is the responsibility of the medical company of the FSB. In those divisions not under the MSB/FSB design, resupply of the BAS is the responsibility of the FSMC of the medical battalion. Medical supply personnel operate a resupply point for the BAS of the maneuver battalions based on supply point distribution. Backhaul of medical supplies using returning ambulances, both air and ground, is the preferred method of moving medical supplies to the maneuver battalions. If backhaul is not the method used, coordination for forward movement is the responsibility of the medical platoon leader of the maneuver battalion.

(4) Resupply of the medical companies in all divisions is performed by the division medical supply office (DMSO). The DMSO has the responsibility to provide medical supply support to all units within the division area. In contrast to the formal procedures normally associated with support between the combat zone (CZ) MEDSOM/MEDLOG battalion and the DMSO, requests submitted to the DMSO by division medical treatment elements are informal. Requests may come by message with returning ambulances (ground or air), by land line, or through existing frequency modulated (FM) command nets within the division. Requests for medical supplies from BASS and medical companies are filled or forwarded to the supporting CZ MEDSOM/MEDLOG battalion. The line of medical supply flow back to the requesting units will follow the principle of backhaul. Medical evacuation vehicles returning to the forward areas will be tasked with the transport of medical materiel. The DMSO uses supply point distribution at a site that is easily accessible to ground ambulances.

(5) Resupply of the DMSO is provided by the CZ MEDSOM/MEDLOG battalion.

(a) The DMSO, located in the division's medical battalion (divisions not under MSB/FSB design) or the MSB (divisions under MSB/FSB design division), is responsible for providing medical supply and medical maintenance

support to the medical treatment elements within the division. The division health services materiel officer (HSMO) executes health service logistics plans. He exercises his responsibilities by—

- Procuring, storing, and issuing Class VIII supplies for the division.

- Coordinating with the supported elements to determine requirements for Class VIII materiel.

- Developing and maintaining prescribed loads of contingency medical supplies. These loads 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 unit level medical equipment maintenance performed by medical equipment repairer unit level.

- Monitoring the division medical assemblage management program.

- Coordinating logistical planning for preconfigured Class VIII packages.

- Calculating unit requirements for preventive medicine items such as foot powder, water purification supplies, malaria pills, and ear plugs.

(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 or platoon leader or the battalion headquarters element.

- Coordinating with the medical battalion commander or the MSB commander to obtain the number of modular medical systems required to field an operationally ready treatment facility.

- Coordinating with the CZ MEDSOM/MEDLOG battalion to monitor the status and number of modular systems due in.

- Coordinating with the division movement control center to move supplies from the MEDSOM/MEDLOG battalion. (The DMSO directs quick fixes using available assets and controlled exchanges for medical equipment to maximize the capability of returning trained soldiers to duty.)

- Alerting the appropriate company when modular systems are arriving.

- Allocating modular medical systems to the unit based on the commander's priorities. The DMSO coordinates through the division medical operations center (DMOC) with the division movement control center to identify backhaul ambulances to transport modular assemblages to the unit being reconstituted.

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

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

*b. Medical Maintenance.* Division medical maintenance support is provided by DMSO medical maintenance personnel.

(1) Division medical equipment personnel provide unit level medical maintenance for repairs of their own equipment as well as area

support to units without such capabilities. The DMSO biomedical equipment maintenance NCO schedules, performs, and coordinates medical equipment maintenance for the FSMCs. Medical maintenance personnel from the DMSO are deployed forward as necessary to repair essential medical equipment. Maneuver BASs turn in their medical equipment in need of repair to the supporting FSMC. The FSMC will send this equipment to the DMSO when medical maintenance personnel are not deployed forward to the BSA. Medical equipment repairs beyond the capabilities of the DMSO are sent to the supporting corps MEDSOM/MEDLOG battalion for repair or the DMSO will request a mobile support team from the MEDSOM/MEDLOG battalion.

(2) The MEDSOM/MEDLOG battalion normally provides direct and general levels of maintenance support but may be directed to provide depot level support. Direct and general levels of medical maintenance provide the following services:

- Low-density lifesaving diagnostic equipment and therapeutic equipment-this type of medical equipment belongs to operating MTFs and is repaired or replaced immediately. The MEDSOM/MEDLOG battalion maintains

designated items under the Medical Standby Equipment Program (MEDSTEP). Direct exchange of low-density lifesaving diagnostic and therapeutic equipment through the MEDSTEP may be employed when repair time is determined to be excessive.

- Unserviceable and items, modules, or assemblies that are designed for discard-are replaced with serviceable items. The unserviceable item(s) are disposed of IAW disposition instructions.

- Items that cannot be repaired at the unit level-will be evacuated to the MEDSOM/MEDLOG battalions medical maintenance repair element. This element effects repairs if within their capability, and returns repaired items to user.

- Items that cannot be repaired or are not authorized to be repaired at the direct and general support levels-are evacuated to depot. Depot level maintenance is provided by the United States Army Medical Materiel Agency (USAMMA) or by designated MEDSOM/MEDLOG battalion as necessary when directed by the appropriate commander.