

## CHAPTER 6

## MEDICAL REGULATING

**6-1. General**

Medical regulating is the coordination and control of moving patients to MTFs which are best able to provide the required specialty care. This system is designed to ensure the efficient and safe movement of patients.

**6-2. Purposes of Medical Regulating**

a. Medical regulating entails identifying the patients awaiting evacuation, locating the available beds, and coordinating the transportation means for movement. Careful control of patient evacuation to appropriate hospitals is necessary to—

- Effect an even distribution of cases.
- Ensure adequate beds are available for current and anticipated needs.
- Route patients requiring specialized treatment to the appropriate MTF.

b. The factors which influence the scheduling of patient movement include the following:

- Patient's medical condition (stabilized to withstand evacuation).
- Tactical situation.
- Availability of evacuation means.
- Locations of MTFs with special capabilities or resources.
- Current bed status of MTFs.
- Surgical backlogs.
- Number and location of patients by diagnostic category.
- Location of airfields, seaports, and other transportation hubs.
- Communications capabilities to include radio silence procedures.

**6-3. Medical Regulating Terminology**

As medical regulating may include coordination with

other services, it is necessary to use the correct terminology. These terms include—

a. *Intracorp Medical Regulating (Figure 6-1)*. This is the system by which patients are transferred or evacuated from an FSB or main support battalion (MSB) to a corps hospital (MASH or CSH).

b. *Intratheater Medical Regulating (Figure 6-2)*. This is the system by which patients are transferred or evacuated from one hospital to another within the TO. This includes evacuations between CZ hospitals, between COMMZ hospitals, or from CZ hospitals to COMMZ hospitals.

c. *Intertheater Medical Regulating (Figure 6-3)*. This is the system by which patients are evacuated from hospitals located in the TO to hospitals located in the ZI.

d. *Patient Administrator*. The patient administrator (PAD) accomplishes the medical regulating function at the hospital level in addition to his normal duties. His medical regulating functions include consolidating all evacuation requests within the hospital and forwarding an evacuation request to his next higher headquarters for action. The PAD is also responsible for keeping his next higher MRO apprised of current beds available and operating room (OR) status.

e. *Medical Regulating Officer*. The MRO functions as the responsible individual at command and control headquarters for receiving and consolidating evacuation requests. These requests are initiated by the DMOCs, medical battalions, or subordinate hospitals. The MRO also maintains the current patient status, bed status, and the surgical backlog at subordinate hospitals. His duties include—

- Managing what patient classes are regulated into his facility.
- Determining what resources are available to move the patients and coordinating for the use of these assets.
- Maintaining accountability of patients within the MTFs.
- Preparing reports as required.

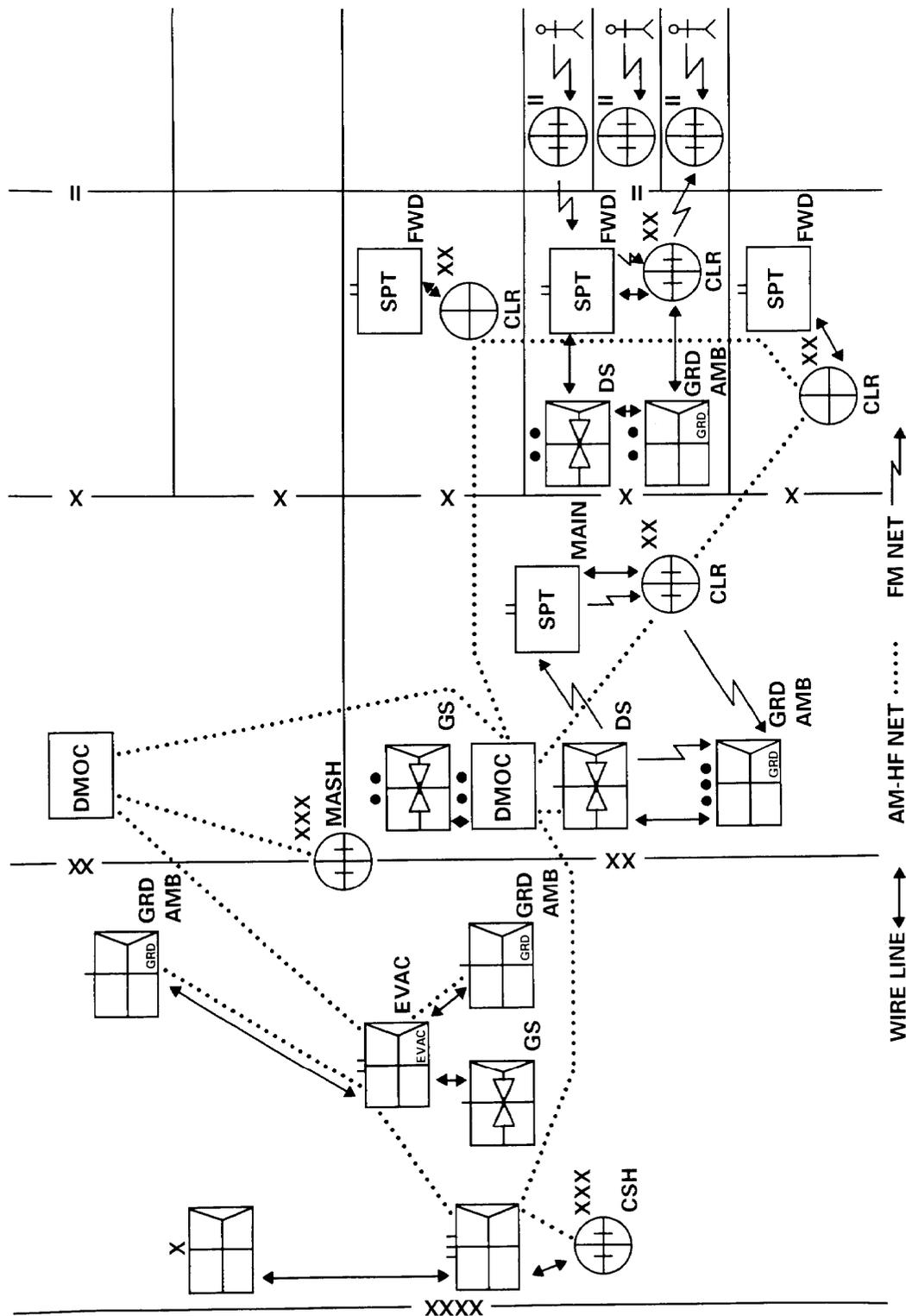


Figure 6-1. Intracorporeal medical regulating.

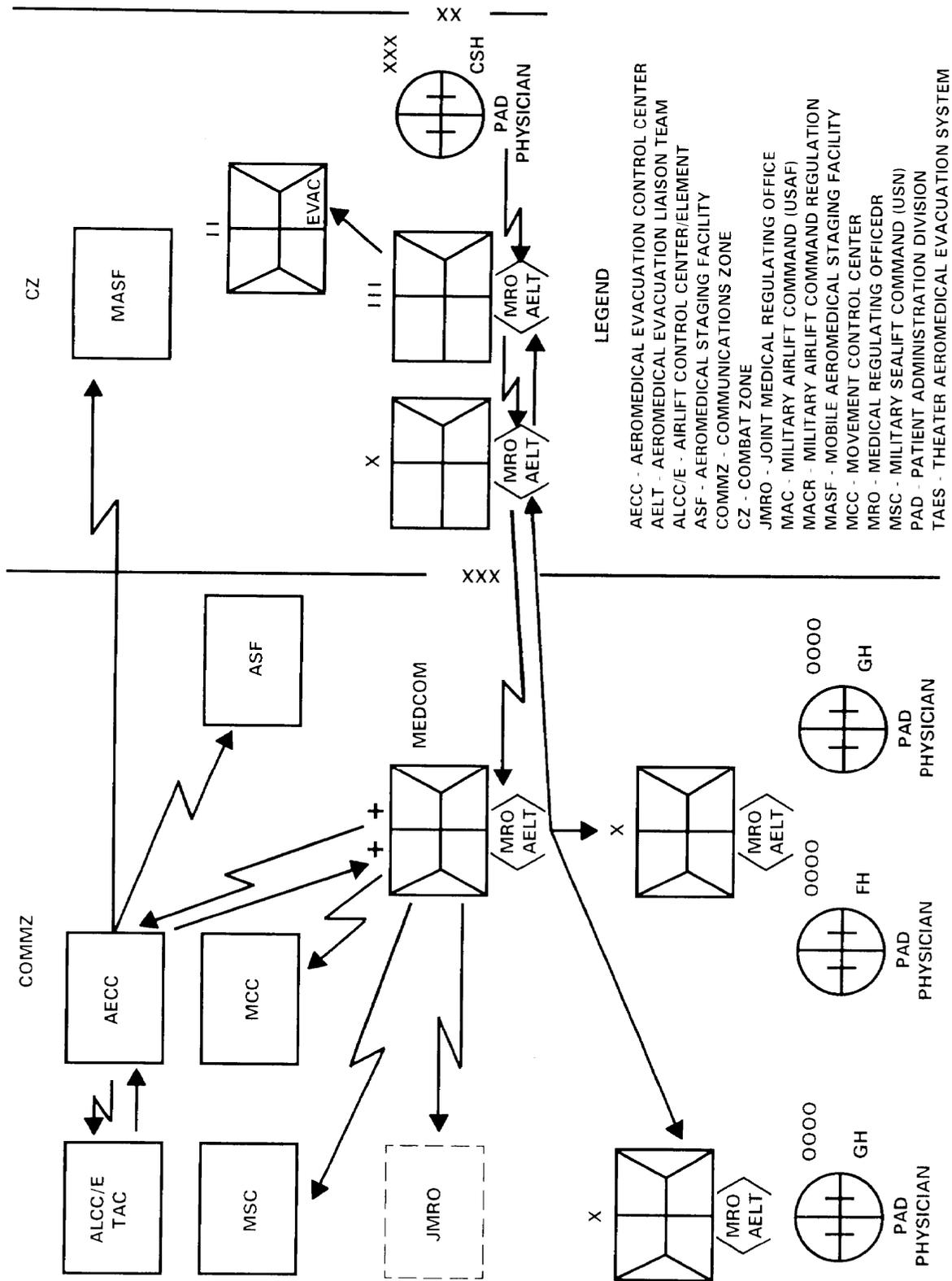


Figure 6-2. Intratheater medical regulating.

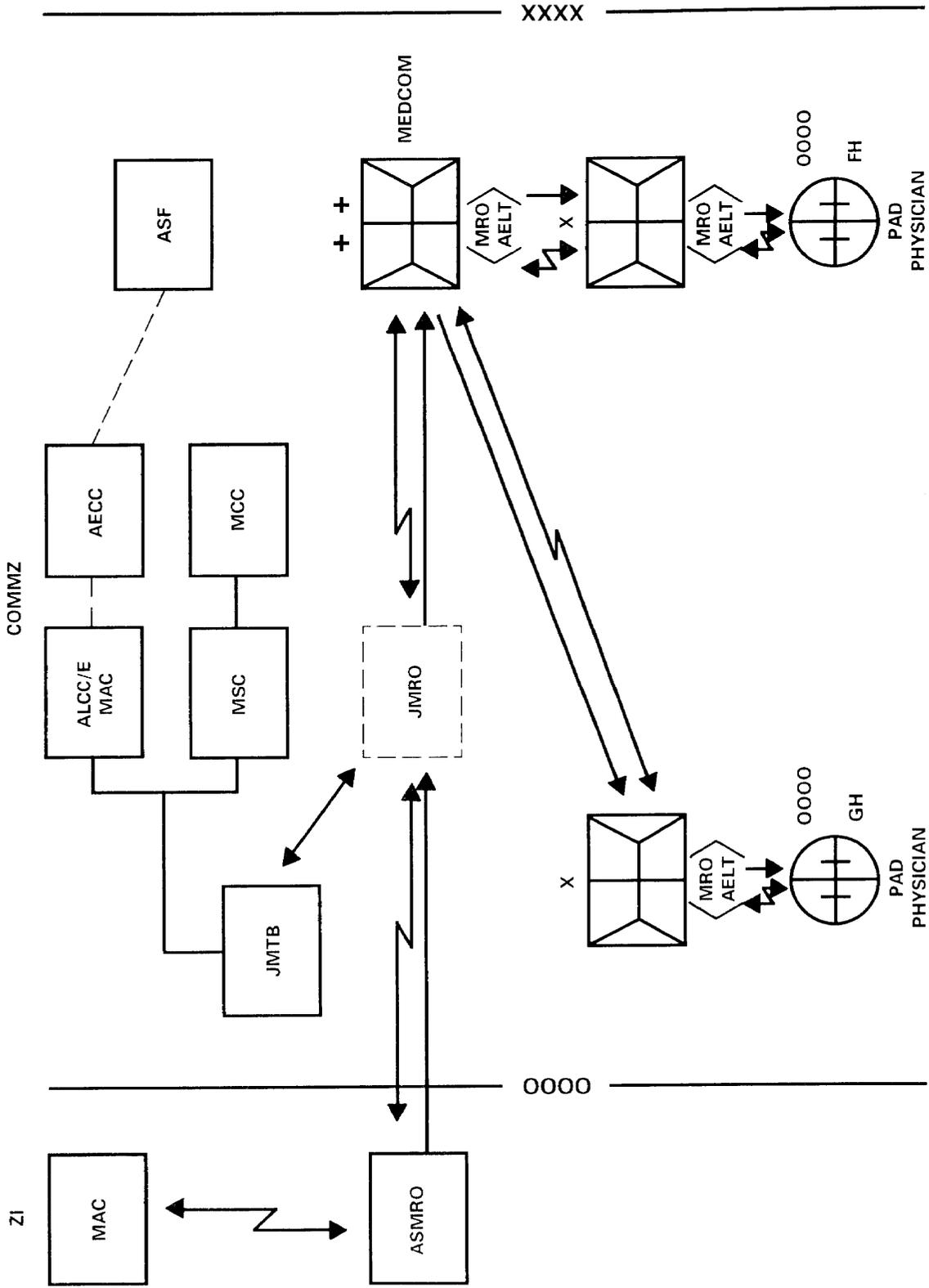


Figure 6-3. Intertheater medical regulating.

*f. Joint Medical Regulating Office.* The Joint Medical Regulating Office (JMRO) is a joint agency normally located at or near the theater headquarters. The theater surgeon supervises the functions of this office. These functions include—

- Maintaining direct liaison with the Armed Services Medical Regulating Office (ASMRO), MROs of component services, and the transportation agencies which furnish evacuation transportation.
- Obtaining periodic reports of available beds from the services' MROs providing hospitalization.
- Selecting hospitals based on the reported bed availability to receive patients within the COMMZ.

*g. Armed Services Medical Regulating Office.* The ASMRO is a joint agency which receives requests from the JMRO or MEDCOM MRO for evacuations from the COMMZ to ZI. The ASMRO authorizes patient transfers by providing ZI hospital destinations for designated patients. The destination hospital determination is based upon the patient's medical needs. Wherever possible, the hospital closest to the patient's home is selected.

*h. Theater Aeromedical Evacuation System.* The theater aeromedical evacuation system (TAES) is a functional organization which is provided by the USAF and performs the mission of theater aeromedical evacuation. It is composed of the following:

- Aeromedical evacuation control center (AECC).
- Mobile aeromedical staging facility.
- Aeromedical evacuation liaison team (AELT).
- Aeromedical evacuation crews.

*i. Aeromedical Evacuation Control Center.* The AECC is a USAF element and is responsible for the USAF aeromedical evacuation mission within the TO. The AECC also coordinates for evacuation from the COMMZ to ZI. The AECC is a component of the Military Airlift Command (MAC) and is

normally collocated with the Airlift Control Center (ALCC) which coordinates intertheater and intratheater logistical and personnel movements by USAF aircraft.

*j. Military Sealift Command.* The Military Sealift Command (MSC) is the US Navy element responsible for coordinating movement of supplies, equipment, and personnel into the TO by Navy ships. Further, it coordinates through the JMRO medical evacuation of patients by ship from the TO to the ZI, as required.

*k. Movement Control Center.* The MCC is the Army unit which coordinates and controls the movement of Army aircraft and ground transportation within the theater. When USAF capabilities are exceeded, the MCC coordinates requests for additional air and ground resources. It also obtains the necessary clearances to support the evacuation mission from the CZ.

*l. Movement Control Agency.* The Movement Control Agency (MCA) provides the theater with movement management services and highway traffic regulations. The MCA coordinates with allied and host-nation movement control agencies. It also coordinates with the transportation component commands (such as MAC and MSC) and prepares movement and port clearance plans and programs.

*m. Mobile Aeromedical Staging Facility.* The MASF is a USAF holding facility employed at forward airfields in the CZ to provide a temporary holding capability for preparation of patients being evacuated from corps to COMMZ hospitals.

*n. Aeromedical Staging Facility.* The ASF is a USAF holding facility employed at or near airfields in the COMMZ and CZ. It also provides a temporary holding capability for patients being evacuated from the COMMZ or another theater to CONUS.

*o. Joint Military Transportation Board.* The Joint Military Transportation Board (JMTB) is a joint staff composed of members of the Army, Air Force, and Navy that coordinates transportation requirements for patients requiring intertheater evacuation.

*p. Defense Medical Regulating Information System.* The Defense Medical Regulating Information System (DMRIS) is an on-line interactive

computer system for reporting patients requiring evacuation (Appendix D).

*q. Automated Patient Evacuation System.* The Automated Patient Evacuation System (APES) is the system that automates the patient movement portion of medical evacuation (Appendix D).

#### 6-4. Medical Regulating from the Division

a. Medical regulating in and from the division is the responsibility of the DMOC (the patient disposition and reports branch). Medical regulating in the division is not as formalized as the rest of the HSS system. It is usually operated procedurally so as not to depend solely on communications to effect rapid evacuation. The medical regulating function in the DMOC is concerned primarily with—

- Tracking the movement of patients throughout the division MTFs and into the corps facilities.
- Monitoring the use of ambulance assets.
- Coordinating with the corps medical evacuation battalion when it becomes obvious that more assets are needed.

b. Corps air and ground ambulances placed in general support of the division are usually field sited in the division rear and tasked by the DMOC. When these assets go forward to the FSMC or the MSMC to evacuate patients to corps MTFs, they have corps MTF destinations predetermined (blocks of beds). The DMOC, in coordination with the medical group MRO, establishes the number of patients a supporting corps hospital can accept during a particular period of time. These blocks of available beds are then provided to the general support ambulances prior to the call for missions.

(1) Once an evacuation mission is completed, the originating division MTF contacts the patient disposition section of the DMOC and provides—

- Patient numbers by category and precedence.

- Departure times.
- Modes of transportation.
- Destination MTFs.
- Any other information required by SOP.

(2) The DMOC, in turn, notifies the medical group MRO via the patient administration net which is monitored by the corps MTFs. Since corps ground ambulances have no on-board communications ability and air ambulances have no amplitude-modulated—high-frequency (AM-HF) capability at present, all patient information is passed to the gaining MTFs via the patient administration nets. To reduce the turnaround time for ground ambulances and to move more serious patients to the CSHs in the corps rear—

- Air ambulances are given blocks of beds in the corps hospitals farther to the rear.
- Ground ambulances are normally given blocks of beds in the more forward deployed CSHs.

c. Patient regulating from the FSMC directly to the MASH will normally be accomplished by the DMOC directly to the PAD at the supporting MASH.

d. Medical evacuation can be effected immediately, procedurally, and under conditions of communications silence without interrupting the continuum of care by—

- Preparing casualty estimates.
- Prioritizing and task-organizing ambulance support.
- Assigning blocks of hospital bed designations prior to the start of the mission.

#### 6-5. Medical Regulating Within the Combat Zone

a. The requirement to transfer patients from one hospital to another within the CZ occurs. This results from—

- Surgical backlogs.
- Mass casualty situations.
- Specialty care requirements.
- Planned movement of an MTF.

*b.* When it is necessary to transfer a patient, the attending physician notifies the hospital PAD. The PAD consolidates all such requests from the hospital and requests movement authority from the medical group MRO.

*c.* If the medical group MRO can transfer the patient or patients to its subordinate hospitals, he designates the hospitals to receive the patients and notifies both the requesting and receiving hospitals of the transfer. The medical group MRO also tasks subordinate medical evacuation units for the assets to transfer the patients.

*d.* If the medical group cannot provide the needed hospitalization within its own resources, the MRO forwards the request to the medical brigade MRO for action. The medical brigade MRO then designates the receiving hospitals and notifies the subordinate MROs. The medical group MROs disseminate the information to the hospital PADs and coordinate the evacuation resources for the transfer. The MRO also coordinates the regulation of patients to—

- Other US military service hospitals and naval hospital ships.
- Allied nations' military hospitals.
- Host-nation support hospitals.

#### **6-6. Medical Regulating from the Combat Zone to the Communications Zone**

*a.* Hospital attending physicians and oral and maxillofacial surgeons submit daily reports to the hospital PAD listing the patients requiring evacuation. The PAD assembles this information and transmits the report to the medical group headquarters. This report is a request for transportation, as well as a notification of the number of patients

requiring evacuation. The report classifies the patients according to—

- Diagnostic category.
- Desired on-load points.
- When the patients will be available for evacuation.

*b.* The medical group MRO consolidates these reports from each hospital attached to the medical group and forwards his report to the medical brigade MRO. The medical brigade MRO consolidates the reports and transmits the data to the MEDCOM MRO.

*c.* If a JMRO has been activated within the theater, the MEDCOM MRO consolidates all reports from the CZ medical brigades and forwards them to the JMRO. The JMRO designates hospitals in the COMMZ to receive the patients. The designation is based on the previously received bed status reports from all service components. The JMRO then notifies the MEDCOM MRO of designated hospitals. The MEDCOM MRO accomplishes this task if the JMRO is not activated.

*d.* The primary means of moving patients from the CZ to the COMMZ is USAF aircraft. With the elements of the TAES deployed, it is possible to find AELTs/NCOs at each level and as far forward as the corps hospitals. The AELT monitors the MRO patient evacuation requests. At the same time he uses his organic communications capabilities to pass the requirements through the TAES to the ALCC, seeking an aircraft to perform the evacuation mission. The AELT at the MEDCOM level requests the AECC to move patients. Included in the request are the originating medical facility (OMF) and the destination airfields. The airfields selected are those serving the hospitals designated to receive patients.

*e.* The AECC is a component of the TAES and performs the mission of coordinating the movement of and providing in-flight medical care to patients while under the USAF control. The AECC forwards the request to the ALCC.

*f.* The ALCC coordinates the forward movement of cargo and personnel aboard USAF aircraft with other USAF units, Army transportation

representatives, and Navy agencies. Certain of these aircraft are scheduled to evacuate patients on their return trips. These aircraft seldom go forward solely to evacuate patients.

*g.* After the schedules have been arranged, the AECC returns the detailed flight schedule to the MEDCOM AELT and the parent aeromedical evacuation squadron. The MEDCOM MRO can then determine whether or not USAF resources are sufficient to evacuate all patients from the CZ. If the request exceeds USAF capabilities, the MRO coordinates additional ground or air resources and movement clearances from the MCC.

*h.* The MEDCOM MRO issues these instructions to both the medical brigade MROs (with the authority to move patients in Army CZ facilities) and the receiving hospitals. The hospitals must prepare to receive the patients at the destination airfields. The patients are sorted by destination hospital and moved by Army medical evacuation means. The instructions mentioned above include, as a minimum, the—

- Number of patients to be moved.
- On-load airfield.
- Destination airfield.
- United States Air Force aircraft mission number.
- Estimated time of arrival at the destination airfield.

*i.* The medical brigade MRO issues the flight and movement instructions to its subordinate medical group MROs. The medical group MROs then direct the evacuation units and hospitals within their AOs to move the patients to the on-load airfield according to the arrival time of the aircraft. This movement must be closely controlled, as a MASF can accommodate only a limited number of patients. The patients cannot be delivered to the MASF earlier than 3 hours prior to arrival of the aircraft and no later than 1 hour prior to arrival.

### 6-7. Medical Regulating Within the Communications Zone

*a.* Medical regulating within the COMMZ is similar to the system used within the CZ. Attending

physicians or oral and maxillofacial surgeons within the Level III hospitals notify the hospital PAD of patients requiring evacuation to GHs. The PAD then consolidates the requests from the hospitals and forwards the consolidated request to the medical group MRO. He, in turn, consolidates the requests and forwards them to the MEDCOM MRO.

*b.* The MEDCOM MRO, based on periodic bed status and availability reports from subordinate hospitals, designates specific hospitals to receive the patients. The hospitals are designated based on bed availability, to include specialty beds, to support the specific patient. The MEDCOM MRO then notifies the requesting medical group MRO of the designated hospitals and, in turn, notifies the designated hospitals.

### 6-8. Intertheater Medical Regulating

*a.* The patients who are evacuated to the COMMZ are treated there and then further evacuated to the ZI. The attending physicians or oral and maxillofacial surgeons at the hospital notify the PAD. The PAD then consolidates these requests and forwards them to the MRO at the medical brigade. This MRO forwards the consolidated request to the MEDCOM MRO who, in turn, consolidates and forwards a request to the JMRO (if established) or to the ASMRO.

*b.* Upon request of the JMRO for authority to evacuate patients to the ZI, the ASMRO directs the distribution of these patients into hospitals throughout the CONUS; advises the JMRO of the destination hospital; and provides the authority for such movement. As a rule, the destination hospitals are military facilities. Civilian national disaster medical system member hospitals and other federal hospitals may also receive patients. The Veterans Administration hospitals, for example, may receive patients who are expected to be discharged from service. The ASMRO continues to coordinate with and inform MAC concerning future movement of patients.

*c.* When the JMRO receives the authorization to move patients, it notifies the MEDCOM MRO of destination hospitals in CONUS. The MEDCOM MRO coordinates with the JMTB to arrange movement of CONUS-bound patients. The

MEDCOM MRO then authorizes the movement to ASFs which are collocated on or near air bases or airstrips capable of handling long-range aircraft. Transportation is arranged, within Army channels, to move patients from the hospitals to the staging facilities. The medical brigade then notifies the subordinate GHs of the flight schedule and the evacuation arrangements for movement to MAC terminals. At MAC terminals, there is an established ASF. When the patients are delivered to the USAF, the responsibility for those patients is transferred from the Army hospital to the MAC aeromedical evacuation system. Upon arrival in CONUS, the ASMRO assumes control, but further movement is the responsibility of the USAF.

*d.* All patients may not be able to be moved by air from the theater to CONUS. In that event, the MSC is used to move them by surface means. The movement authority also comes from the JMRO or MEDCOM MRO which has arranged with the theater Navy for the movement of patients by hospital ships. When the patients are moved by ships, the MEDCOM has to provide holding facilities at the port. Patients are delivered to these holding facilities and held there until loaded aboard the ships.

### 6-9. Mobile Aeromedical Staging Facilities

*a.* Mobile aeromedical staging facilities are air transportable temporary holding facilities. These units are equipped and staffed to receive patients, sustain life, and administratively process patients who are to be moved in the TAES.

*b.* This theater system is used to evacuate patients from—

- United States Air Force operational locations within the CZ to hospital facilities outside the CZ.
- Airhead or airborne objective areas where airborne operations include USAF forward logistics support.

*c.* Bases used for aeromedical staging are designated by the area or theater commander. Theater aeromedical evacuation crews—

- Provide supportive medical care.

- Prepare patients for evacuation.
- Ensure patient evacuation manifests are completed.
- Identify patient baggage tags.
- Fly aeromedical airlift missions to provide in-flight patient care.

*d.* Upon deployment, the originating MTF provides a minimum of 3 days supply of the patient's medication.

*e.* Units have an authorized strength of twenty-three personnel when deployed. Flight nurses, aeromedical technicians, and ground ramp operators constitute the unit. Each MASF has a 50-patient capacity with an average patient holding time of 3 to 5 hours. (Patients should be brought to the MASF no sooner than 3 hours and no later than 1 hour prior to the departure time of the designated aircraft.) One hundred patients per day can normally be processed and moved by each MASF; however, a surge capability to move 150 patients per day exists.

*f.* The MASF staff must also establish liaison with OMF. The liaison team (LT) is composed of the air evacuation liaison officer and two communications specialists. The team provides the initial interface between the user service and the TAES. The LT is located at any level of the combat forces' medical regulating chain that is required to ensure a smooth patient flow into the tactical aeromedical system.

### 6-10. Limitations of the United States Air Force Theater Aeromedical Evacuation System

There are a number of limitations which are inherent in the current system. These include the following:

- a.* There are no physicians assigned or attached to any element of the TAES.
- b.* Patients must be in a stable condition prior to being transported to the MASF.
- c.* There is limited equipment available and there is *no exchange of equipment* with the user service.

*d.* The MASF cannot hold patients in excess of 6 hours.

*e.* The MASF does not have the capability to provide patient meals.

*f.* The abbreviated information available on the patient, due to the restrictions of the tactical environment, limits the amount and extent of patient care.

*g.* Aircraft are not normally dedicated for aeromedical evacuation missions. Evacuation is accomplished through backhaul on logistical aircraft. The availability of aircraft fluctuates due to the demand for higher priority flights.

*h.* The logistical aircraft which are available are not equipped for patient comforts (latrine facilities, galleys).

*i.* The AECC ensures the initial 55-day medical resupply package arrives at the MASF. The MASF relies on the user service for all other logistical support.

*j.* The AELTs depend directly upon the user service for their logistical support. It is the Army's responsibility to provide quarters, food, and other logistical support required to include moving patients back to Army facilities should USAF aeromedical evacuation support be cancelled or otherwise delayed.

### **6-11. Originating Medical Facility's Responsibilities**

Once the authorization to move the patient has been given, the OMF must complete the following administrative procedures prior to entering the patient into the TAES:

*a.* The baggage tag, patient manifest, and patient evacuation tag are the specified evacuation forms for all services and will be completed as required by tri-service regulation. (Refer to Appendix E for instructions on completing these forms.)

*b.* All of the patient's medical records must be collected together and packaged. The dental records are forwarded separately in the event they are needed for identification.

*c.* At the appropriate time, the OMF provides transportation to the MASF and assists in the off-load.

*d.* The OMF must provide the necessary medications, medical supplies, and equipment to support the patient for a minimum of 3 days.

*e.* Any requirements for armed guards or attendants must also be met by the OMF.

*f.* A limited amount of personal baggage is authorized if each piece is properly tagged and delivered to the MASF with the patient. Patients will always be evacuated with NBC-protective equipment, less the protective overgarment.

*g.* Each patient must be clearly identified with a wrist band or equivalent identification, and properly classified as to his medical condition.

*h.* The OMF must ensure that each patient is properly briefed and is in stable condition prior to his arrival at the MASF.

### **6-12. Medical Regulation of Special Operations Forces**

*a.* As in medical evacuation, the medical regulating plan must be integrated with the ARSOF operational and logistic plan. Maximum use of opportune (operational and logistics) aircraft and command and logistics communications nets must be coordinated to expedite mission requests and ensure success.

*b.* The ARSOF medical planner must constantly coordinate with the battalion or group operations and logistics sections to obtain up-to-date information of opportune transportation assets to be used for evacuation. In a deep operation, or when the theater is not sufficiently developed to allow the TAES to be used effectively, the primary means of air evacuation will be those Special Operations Aviation (SOA) or USAF SOF airframes conducting the clandestine mission. It is essential that coordination is made through the theater Special Operations Command (SOC) or the highest command and control element for flight medics or

para-rescuemen (PIs) to accompany the flight when backhauling the casualties. Otherwise, a medic from the SOF unit being supported may have to accompany the casualty, leaving the mission without proper medical support, or the casualty may have to be transported without en route care.

*c.* For all other special operations, the supporting medical evacuation unit provides air and ground ambulances in accordance with standard doctrinal procedures. United States Air Force MASFs or AELTs may be collocated at SOF support bases, or command and control bases, particularly

during contingency operations where the build-up phase allows for pre-positioning of assets.

*d.* During sustained special operations missions, the theater SOC cannot afford to lose the services of ARSOF soldiers who become casualties, but who can be treated and returned to duty at hospitals within the COMMZ. As an exception to the theater evacuation policy, the Commander in Chief (CINC) retains these soldiers in the theater where they can be returned to their units for limited duty. There they can assume the support duties performed by other ARSOF soldiers, freeing the latter for operational duties.