# CHAPTER 11

# THEATER COMBAT HEALTH SUPPORT

## References

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**(New version in draft; will be renumbered FM 4-02)**
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FM 8-10-4, Medical Platoon Leader's Handbook—TTP, 16 Nov 90 Initial Draft Revision, May 2000
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FM 4-02.10, Theater Hospitalization, 29 December 2000.
FM 4-02.24, Area Support Medical Battalion, TTP
FM 8-10-25, Employment of the Forward Surgical Teams, 30 September 1997
FM 8-10-26, Employment of the Medical Company (Air Ambulance), 8 October 1998
FM 8-42, Combat Health Support in Stability Operations and Support Operations, 27 October 1997.
FM 100-10, Combat Service Support, 3 October 1995
FM 100-16, Army Operational Support, May 1995

## Objectives

- Relate the medical process of Combat Health Support to the units that perform the mission
- Recognize the medical units and the level of CHS associated with their unit
- Understand the role of Class VIII
- Identify the broad aspects of medical evacuation

## Background

The mission of the Army Medical Department (AMEDD) is to conserve the fighting strength. The Combat Health Support (CHS) mission is a continuous and integrated function throughout the theater of operations and extends from the combat zone (CZ) through the communications zone (COMMZ) to the CONUS base.

The **objectives of the AMEDD** are to:

- Save lives
- Evacuate casualties from the battlefield. This allows the combat commander to continue his mission
- Reduce the incidence of disease and non-battle injury (DNBI) through preventive medicine programs
- Examine, treat, and return soldiers to duty as far forward as possible
- Provide the utmost benefit to the maximum number of personnel by synchronizing HSS resources

The Army Medical Department (AMEDD) has developed **medical battlefield rules** to aid in establishing priorities and resolving conflicts for the above competing requirements within CHS activities. These battlefield rules are (in order of their priority) to:

- Maintain medical presence with the soldier
- Maintain the health of the command
- Save lives
- Clear the battlefield
- Provide state-of-the-art care
- Return soldiers to duty as early as possible

The theater medical command (MEDCOM) commander is the principal advisor to the Army service component commander (ASCC) in regard to staff planning, coordinating, and developing policies for CHS in the theater per the theater evacuation policy, each theater's evacuation policy is unique. **The theater surgeon recommends a theater evacuation policy through the combatant commander (COCOM) in conjunction with the Joint Chiefs of Staff, for approval by the Secretary of Defense. The policy establishes the number of days an injured or ill soldier may be allowed to remain in the theater to return to full duty**. Soldiers who will not return to full duty within the established time are evacuated to definitive care facilities in CONUS or other designated locations. FMs 8-10-6 and 8-10-26 have more details on evacuation.

In general, patients are examined, treated, and identified as return to duty (RTD) or non-return to duty (NRTD) as far forward as medically possible. Patients requiring evacuation outside of the division who are expected to RTD within the theater evacuation policy are evacuated to corps and/or COMMZ hospitals. Those classified as NRTD follow the evacuation chain out of the theater. Evacuation policies are also established at the corps and division level.

The CHS planner must foresee actions beforehand to be able to plan for positive, responsive support to each element supported. As the medical logistician he must be prepared to meet the requirements for these 10 functional areas:

- **Patient Evacuation (to include training of non-medical personnel to serve as litter bearers) and Medical Regulating** -- Patient evacuation is the timely, efficient movement of wounded, injured, or ill persons from the battlefield and other locations to medical treatment facilities (MTF). Evacuation continues for each patient until they can be returned to duty (RTD) or discharged from the

service. Medical regulating is a system of coordinating and controlling the movement of patients through the various levels of care.

- **Hospitalization** – Hospitalization is part of the theater wide system for managing sick, injured, and wounded patients. It is designed to provide patients with surgical and medical resuscitative, definitive, and specialty treatment. Patients are evacuated to hospitals that can provide them with the needed specialized treatment.

- **Combat Health logistics (including blood management)** – Health service logistics includes medical supplies and equipment, medical equipment maintenance, and optical fabrication. Blood bank services are provided in a theater of operations to support US military and, as directed, allied military and indigenous civilian medical establishments. Specialized blood bank units operate in the theater and provide command and control, and collect, process, and distribute blood product within the theater.

- **Preventive medicine (PVNTMED) services** – Preventive medicine serves as a combat multiplier by enhancing unit effectiveness and reducing individual soldier's exposure to disease and environmental threats. There are six broad categories involved in preventive medicine: heat injuries caused; cold injuries; diseases caused by arthropod/animal bites, environmental conditions and wetness; diarrheal diseases caused by drinking impure water, eating contaminated food, lack of good individual and unit PM measures; disease, trauma, or injuries caused by physical or mental unfitness; and environmental or occupational injuries caused by carbon monoxide, noise, blast overpressure, and solvents.

- **Veterinary services** – The US Army veterinary service provides support for Army, Navy, Air Force, and Marine Corps units as directed. They provide: inspection of subsistence, control of food borne disease, examination of animals, control of disease transmitted from animals to humans, treatment and hospitalization for military animals, examination and wholesomeness determination of food and food producing animals in NBC environments, and other veterinary preventive medicine activities as assigned.

- **Dental services** – Dental support in a theater enhances combat readiness by maintaining oral health. It is provided by a combination of divisional dental support, hospital dental support, and area dental support.

- **Combat stress control (CSC)**—CSC services prevent or treat battle fatigue casualties, misconduct combat stress behaviors, and delayed post-traumatic stress problems. Some causes of battle fatigue are: sustained operations; weapons of mass destruction; exposure to killed or wounded; the potential for forces to become intermingled in high intensity conflict; and a 360 degree battlefield with no defined boundaries.

- **Command, Control, Communications, Computers, and Intelligence (C4I)** – Those activities that allow for efficient CHS throughout the theater.

- **Medical laboratory services** – Medical laboratory assets function CHS operations by analyzing body fluids and tissues to determine disease processes or to identify microorganisms. The equipment and personnel available are limiting factors in the scope of services provided. The sophistication of laboratory services improves at each successive level of care.

- **Medical Treatment (Area medical support)** -- Area medical support entails the provision of CHS by a designated unit to other units within a specified AO. This support is provided by Role I and Role II medical treatment facilities (MTF) operating in both the CZ and COMMZ.

## Roles Of Medical Care (formerly echelons of care)

**Combat health support is arranged in five roles of care. Each role or level of care reflects an increase in medical capabilities while retaining the capabilities found in the preceding level. (Figure 11-1)**

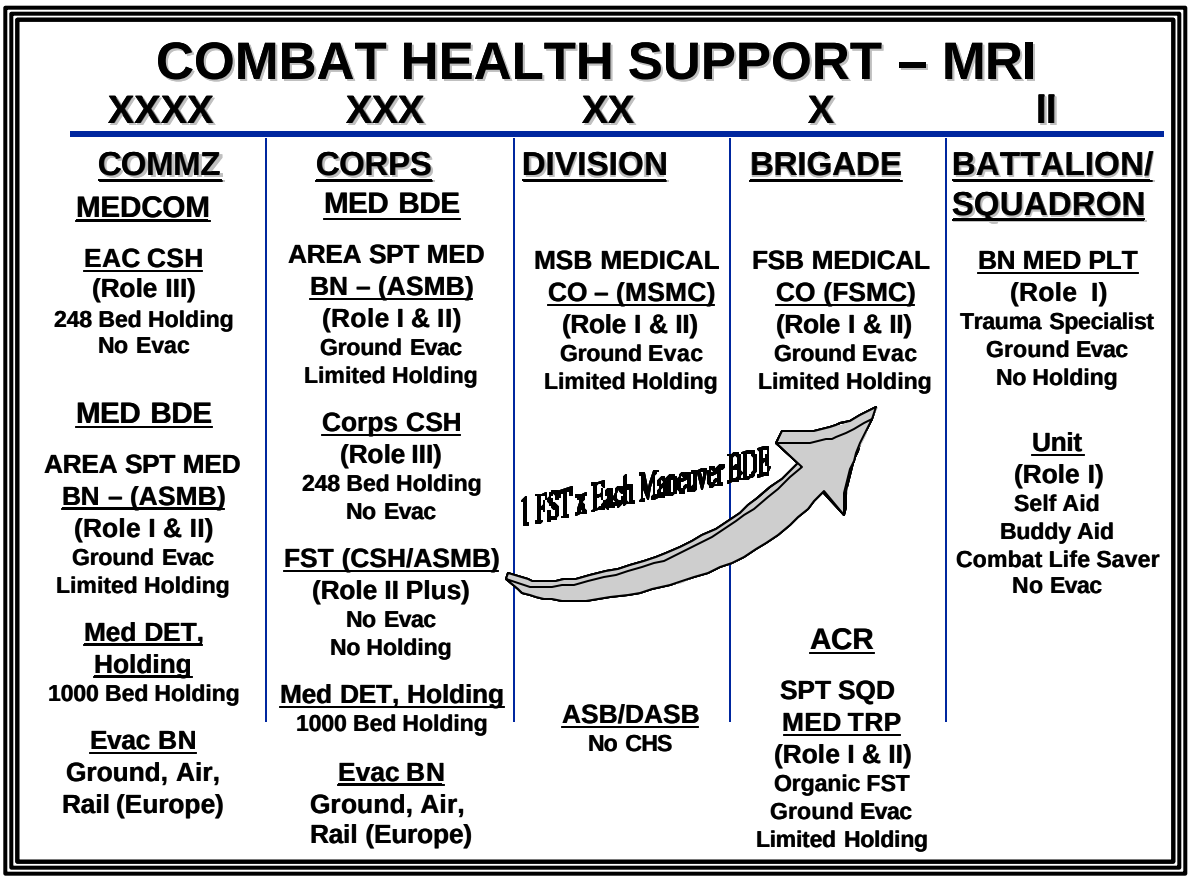


Figure 11-1. Combat Health Support (CHS) Units

**Role I (Level I)** is the first medical care a soldier receives. Designated soldiers perform this level of care or elements organic to combat and combat support units as well as elements of Area Support Medical Battalion (ASMB). This level of care includes

those measures necessary to stabilize the patient and allow for evacuation to the next level of care. Typical action at this level includes: maintain airway, stop bleeding, and prevent shock.

Non-medical personnel performing first-aid procedures assist the combat medic in his duties. First aid is administered by an individual (self-aid or buddy aid) and by the combat lifesaver.

- **Self-aid and buddy aid**. Each individual soldier is trained to be proficient in a variety of specific first-aid procedures. These procedures include aid for chemical casualties with particular emphasis on lifesaving tasks. This training enables the soldier or a buddy to apply immediate first aid to alleviate a life-threatening situation.

- **Combat lifesaver**. The combat lifesaver is a member of a non-medical unit selected by the unit commander for additional training beyond basic first-aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit should be trained. The primary duty of this individual does not change. The additional duty of the combat lifesaver is to provide enhanced first aid for injuries based on his training before the combat medic arrives. The combat lifesaver's training is normally provided by medical personnel assigned, attached, or in direct support (DS) of the unit. The senior medical person designated by the commander manages the training program.

- **Trauma Specialist (formerly combat medic).** This is the first individual in the CHS chain who makes medically substantiated decisions based on medical specific training. First aid providers listed above support the trauma specialist.

- **Treatment Squad.** The treatment squad consists of a field surgeon, a physician assistant (PA), two NCOs and four medical specialists. This element provides advanced trauma management (ATM) to battlefield casualties designed to resuscitate and stabilize patients for evacuation to the next level of care. Treatment squads are organic to medical platoons/sections of maneuver battalions and designated CS units and medical companies located throughout the theater.

**Role II** (Level II) care is provided at a division or corps clearing station and by Forward Surgical Teams (FST), which is operated by the treatment platoon of a medical company. Here, the patient is evaluated to determine his priority for continued evacuation to the rear or is treated and returned to duty. Emergency care, including beginning resuscitation, is continued and, if necessary, further emergency measures are instituted; however, these measures do not go beyond the measures dictated by the tactical situation. Those patients who can RTD within 72 hours are held for treatment. A division clearing station has blood replacement capability, limited X-ray and laboratory services, patient holding capability, and emergency dental care. Clearing stations also provide Role I CHS functions on an area basis to units without organic medical elements. Units providing Role II care are located throughout the combat zone (CZ) in the brigade support

area (BSA), division support area (DSA), corps support area (CSA), and the communications zone (COMMZ).

The FST is a corps augmentation element for divisional and non-divisional medical companies. It provides emergency/urgent initial surgery and nursing care for critically wounded/injured personnel until they are stable for evacuation to a corps hospital. The FST is organic to a corps medical command or corps medical brigade and is normally assigned to a combat support hospital. It will be attached to a division when required. More detail on the FST is covered later in this chapter.

**Role III** (Level III) medical care is provided by hospital facilities equipped to provide resuscitation, initial wound surgery, and postoperative treatment. At this level patients are stabilized for continued evacuation or returned to duty. The corps combat surgical hospital (CSH) is the first hospital to provide this level of care. Those patients expected to return to duty (RTD) within the theater evacuation policy will be regulated to an echelon above corps hospital (EAC CSH).

**Role IV** (Level IV) medical care is provided by a EAC CSH for those patients expected to be RTD within the theater evacuation policy. Those patients not expected to be RTD will be evacuated out of the theater to CONUS.

**Role V** (Level V) medical care is provided in CONUS hospitals. These hospitals provide the ultimate treatment capability for patients generated within the theater. Department of Defense hospitals (Army, Navy, and Air Force military hospital) and Department of Veterans Affairs (DVA) hospital will be specifically designated to provide the soldier with maximum return of function through a combination of medical, surgical, rehabilitative, and convalescent care. Under the National Disaster Medical System, patients overflowing DOD and DVA hospitals will be cared for in designated civilian hospitals.

## Modular Medical Support System – Role I and II care

### General

The modular medical support system was designed to standardize all medical sub-elements of **Level I and Level II** care. The divisional medical units and other Level II units in the corps and COMMZ are based on this design. This system enables the medical resources manager to rapidly tailor, augment, reinforce, or regenerate CHS units as needed. This system is designed to acquire, receive, and triage patients and to provide emergency medical treatment (EMT) and advanced medical treatment (ATM). Combat health support originates in the forward areas (divisions) with the combat medic (Role I). From this point, the patient is evacuated to the battalion aid station (BAS) (Role I) and then to the division clearing station (Role II). The area support medical company (ASMC) provides Role I/II CHS on an area basis to units operating in the corps and COMMZ. Regardless of where the medical treatment facility (MTF) is located on the battlefield, they all share the same basic modules. That is, a medical company (MTF) in a forward support battalion (FSMC) has the same basic capability as a medical company in a main support battalion (MSMC) or area support battalion (ASMC).

### Modular Medical Support System

The modular medical support system is built around six modules. These modules are oriented to casualty collection, treatment, and RTD or evacuation. The six modules are:

- **Trauma Specialist (formerly combat medic)**. The combat medic module consists of one combat medical specialist and his prescribed load of medical supplies and equipment. Combat medics are organic to the medical platoons or sections of combat and CS battalions and are attached to the companies of the battalions.

- **Ambulance squad**. An ambulance squad is comprised of four medical specialists and two ambulances. This squad provides patient evacuation throughout the division (and/or corps and COMMZ) and medical care enroute. Ambulance squads are organic to the medical platoons or sections in the maneuver battalions and division/non-divisional medical companies and the ASMCs. In the division medical company, ambulance squads maybe collocated with the BAS or sited forward with the companies of the maneuver brigades.

- **Treatment squad**. This squad consists of a primary care physician, a physician's assistant (PA), and six medical specialists. The squad is trained and equipped to provide Advanced Trauma Management (ATM) to the battlefield casualty or to treat and return him to duty. ATM is physician or PA directed emergency medical care designed to resuscitate and stabilize the patient for evacuation to the next Role of medical care. To maintain contact with the combat maneuver elements, each squad has two vehicles equipped with trauma treatment medical equipment sets (MES). Each squad can split into two treatment teams (one team is headed by the physician and the other by the PA). These squads are organic to medical platoons or sections in maneuver and designated CS units, as well as being the basic building block of the medical company.

- **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 is organic to the medical companies within the BSA, DSA, Corps LSA, or COMMZ.

- **Patient-holding squad**. This squad consists of two practical nurses and two medical specialists. It is capable of holding and providing minimal care for up to 40 (20 in the light infantry division [LID]) RTD patients. This squad is also organic to the medical companies within the BSA, DSA, Corps LSA, or COMMZ.

- **Forward Surgical Team (FST) – see discussion below**

### Forward Surgical Team (FST)

The **FST replaces the medical detachment, Surgical and the Mobile Army Surgical Hospital (MASH).** It is the first unit capable of performing surgery on life-threatening wounds in the maneuver brigade and ACR. The FST (Corps) and the FST

(airborne/air assault division/armored cavalry regiment [ACR]) are clinically standardized modules regardless of their assignment. This 20-person unit is organized into **four functional areas**: **triage-trauma management, surgery, recover, and administration/operations**. It provides a rapidly deployable immediate surgery capability, enabling critically injured patients to withstand further evacuation. The FST provides surgical support forward in division, separate brigade, and ACR operational areas; the requirement to project surgery forward increases as a result of an extended battlefield. This **small, lightweight surgical team is designed to complement and augment emergency treatment capabilities for a brigade-sized task force**.

The corps FST is assigned to a medical brigade and is normally attached to a CSH or area support medical battalion (ASMB) until needed forward. When deployed forward, the FST will be in direct support of an FSB medical company (FSMC). An FST is organic to the airborne/air assault division and is normally assigned to a main support battalion and deployed forward to collocate with a FSMC in support of a maneuver brigade as METT-TC dictates. The FST organic to the ACR (light) is assigned to the support squadron and operates with the medical troop. See FM 8-10-25 for a more detailed discussion of the FST.

## Theater Hospital System – Level III and Level IV Medical Care

**Hospitals in the theater can provide any level of care identified in the theater evacuation policy**. The hospital system in the theater consists of a single CSH structure; a medical detachment, minimal care; a medical detachment, telemedicine; two hospital augmentation teams; three medical teams; and an FST:

- **Combat Support Hospital (CSH)** – The CSH mission is to provide hospitalization and outpatient services for all classes of patients within a theater. A CSH will normally be assigned to a medical brigade but may be assigned to a MEDCOM or a joint/combined task force. It can provide hospitalization for up to 248 patients. Surgical capacity is based on six operating rooms staffed for 96 operating hours per day. Surgical capabilities include general, orthopedic, thoracic, urological, gynecological, and oral maxillofacial. There are two modular designed CSH configurations for the corps area (corps CSH) and echelons above corps (EAC CSH). The Corps CSH consists of an HHD, an 84-bed hospital company, and a 164-bed hospital company and is capable of split-based operations. The EAC CSH has the same company assignments as the corps CSH but has no split-based operation capability.

    - Additional capabilities of each CSH include: C2 of organic and attached elements; emergency treatment to receive, triage, and resuscitate casualties; consultation for inpatient and outpatients throughout its area; pharmacy, psychiatry, community health nursing, clinical laboratory, blood banking, radiology, physical therapy, and nutrition care; medical administrative and logistical services; and routine and emergency dental treatment. A CSH is 35 percent mobile with organic assets.

    - Support requirements. The CSH requires support from its headquarters in several key areas of note to logisticians. Among them are personnel services, finance, mortuary affairs, and legal services. A CSH is 35percent mobile with organic assets and must receive transportation support to enter a theater or to relocate. A

corps CSH can provide laundry and bath to patients but requires laundry and bath services for staff and EAC CSH requires full laundry and bath services for patients and staff. Transportation and re-equipping of RTD personnel is not a CSH responsibility. Finally, during deployment and sustainment operation, the CSH requires engineer support to establish and modify the hospital site and to construct or modify waste disposal areas.

- **Medical Detachment, Minimal Care** – This unit replace the Medical Company, Holding. It provides minimal care/convalescent care hospitalization, nursing, and rehabilitative services in support of Role III and Role IV hospitalization. It is assigned to a medical brigade and normally attached to a hospital. It can support 120 patients that can RTD within the theater evacuation policy. Basis of allocation is 2.604 detachments per 1,000 hospital patients in the corps and 4.792 detachments per 1,000 patients in the EAC.

- **Medical Detachment, Telemedicine** – This is a new organization that provides telemedicine service in support of medical treatment facilities (MTF) within the division, corps, or theater. The detachment is normally assigned to a CSH and its teams are further attached to medical companies (FSMC, MSMC, and ASMC). One detachment can provide up to seven augmentation teams that provide integrated telemedicine, teleconsultation, telementoring, teleradiology, telepathology, and other forms of telemedicine in the form of video, voice, high-resolution still images, and text data. Basis of allocation is one detachment in support of two CSH, one ASMC, one MSMC, and three FSMCs (basically, one per division).

- **Hospital Augmentation Team, Head and Neck** – This is a new organization that replaces and consolidates the functions of the Medical Team Head and Neck, Medical Team Neurosurgery, and Medical Team Eye Surgery. It provides ear, nose and throat surgery, neurosurgery, and eye surgery in support of a CSH. This team is normally assigned to a medical brigade or MEDCOM and allocated based on one team per four corps CSH.

- **Hospital Team, Special Care** – This is a new organization designed to augment a MTF with necessary health personnel and equipment to provide CHS to military operations other than war (support operations and stability operations). It provides pediatric inpatient, consultation, and nurse practitioner services; obstetrics/gynecology (OB/GYN) and specialty nursing services; preventive medicine services; community health nursing services; and family physician services. It will normally be assigned to a medical brigade or MEDCOM and will be attached to an EAC CSH or other MTF (ASMC, MSMC, FSMC). One team can be allocated per theater.

- **Hospital Augmentation Team, Pathology** – This is a reorganized version of the Medical Team, Pathology. It provides pathology augmentation in support of theater hospitals and consultative services as required. It is assigned to a medical brigade or MEDCOM and will normally be attached to an EAC CSH. It provides theater hospitals with enhanced anatomic pathology, enhanced chemistry, and enhanced microbiology. It is allocated on the basis of one per theater.

- **Medical Team, Renal Hemodialysis** – This unit continues from the previous theater hospitalization system. It provides renal hemodialysis care for patients with acute renal failure to corps and EAC hospitals. It is assigned to a medical brigade or MEDCOM and may be attached to a subordinate hospital as required. There is one team allocated per theater.

- **Medical Team, Infectious Disease** -- This unit continues from the previous theater hospitalization system. It provides infectious disease investigative and consultative services to a health service unit to which attached. It is assigned to a medical brigade or a MEDCOM and may be attached to a corps or EAC hospital. It is allocated based on one team per corps

## Combat Health Support - The Flow

**Combat health support begins with the soldier using self-aid**. Units also have **combat lifesavers** that have additional training beyond the basic first aid level to administer enhanced first aid. **Trauma specialists**, assigned to the battalion medical platoon, provide emergency medical treatment. The battalion **medical platoon** operates a **battalion aid station (BAS**) to provide level I advanced trauma management (ATM) for soldiers who will either be returned to duty or immediately evacuated for further treatment. The **MSB, FSB and ACR have medical companies/troops** (MTFs) to provide Role I/II medical treatment to soldiers in their respective areas. These medical companies have the capability to provide emergency care, can temporarily hold a limited number of patients, and can coordinate to evacuate patients to the next level of medical care.

Assigned to the corps medical brigade, **Combat Support Hospitals (CSH)** provide level III surgical, resuscitative, and hospital support in the corps area. **Forward surgical teams are deployed to the division area to provide a forward surgical capability to stabilize non-transportable patients for further evacuation to the rear. The FSTs are normally collocated with division medical companies to provide emergency life saving surgery support in the forward combat area. CSH units** operate in the corps area and provide general surgery, orthopedic surgery, and limited psychiatric care to patients expected to return to duty within the established theater evacuation policy.

**Area Support Medical Companies (ASMC) assigned to Area Support Medical Battalions (ASMB)** provide level I/II care to non-divisional units in the corps rear and EAC/COMMZ on an area basis. The **EAC CSH Hospitals** located in the theater provide Role IV extended hospital care to soldiers throughout the COMMZ who are expected to return to duty within the established theater evacuation policy.

A **Medical Battalion (Evacuation**) is assigned to the ASCC MEDCOM or a corps medical brigade. It may be further attached to the medical brigade in the theater or medical group in the corps. This battalion is allocated based on one per a combination of three to seven medical, air ambulance and or ground ambulance companies. This battalion provides level I CHS and aviation medicine. Medical evacuation operations and communication are staffed on a 24 hour two shift basis. See FM 8-55, 8-10-6, and 8-10-26 for more information.

**Medical Evacuation and Medical Regulating**

Medical evacuation is the timely, efficient movement and enroute medical care of sick, injured, or ill persons from the battlefield or other locations to MTFs**. It is the responsibility of the gaining level of CHS to evacuate or coordinate the evacuation from the lower level.** That is, a receiving unit goes to the sending unit and picks up the patient. The attending physician at the aid station or casualty collection point determines the mode and precedence of evacuation for each patient. **Air evacuation is the primary means of medical evacuation.**

In the combat zone, ground ambulance squads organic to medical companies evacuate patients within their areas of operations. Medical evacuation battalions evacuate patients from level II MTFs to level III hospitals. The battalion also evacuates patients laterally from hospital to hospital within the corps area, and from hospitals to USAF medical staging facilities for evacuation out of the combat zone. Strategic evacuation is a function of the USAF aero-medical evacuation system.

**Medical regulating** is the **coordinated movement of patients to MTFs that are best able to provide timely and definitive care**. The corps medical brigade medical regulating office (MRO) provides medical regulating in the combat zone. In the COMMZ, the medical command (MEDCOM)/medical brigade MROs and the Theater Patient Movement Requirements Center (TPMRC) provide support. The TPMRC provides both intratheater and intertheater medical regulating. For example, if hospitals of other services within the theater have the necessary capabilities, the TPMRC regulates Army patients to them. It also coordinates intertheater evacuation with the Global Patient Movement Requirements Centers (GPMRC). The TPMRC coordinates patient movement with the USAF aero-medical evacuation control center or, if air evacuation is not available or advisable, with the Military Sealift Command.

## Class VIII Supply Flow

**Class VIII --** Medical material including medical peculiar repair parts and equipment. The following subclasses apply to Class VIII:

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|---|---|
| 1 | Controlled substances |
| 2 | Tax free alcohol. |
| 3 | Precious metals. |
| 4 | Nonexpendable medical items, not restricted. |
| 5 | Expendable medical items, not restricted. |
| 6 | All drugs and related items Federal Supply Classification 6505 not otherwise restricted. |
| 7 to 9 | Commander designated controlled items. |
| 0 | US Army Medical Materiel Agency controlled sensitive items. |

Medical activities at all levels maintain sufficient Class VIII supplies to provide continuous support to units in their area of responsibility. Medical personnel at each level determine what supply stocks should be on hand based on unit personnel requirements. The combat battalion's **medical platoon** provides medical supplies to combat lifesavers in the maneuver companies from the Battalion Aid Station (BAS). The BAS is located in the combat trains with support elements often dispersed to the company trains. The BAS will normally maintain three to five days of supply for Class VIII.

**Class VIII resupply in the division is obtained from the Division Medical Supply Office (DMSO) assigned to the MSMC**. The BAS, FSMC, and MSMC submit their Class VIII requests to the DMSO. Requests for class VIII supplies may come by messenger (with ambulances), through a land-line, or other communications net within the division. The DMSO will fill the requests or forward them to a MEDLOG battalion (Forward).

**The DMSO, located in the MSB's medical company**, is responsible for maintaining the division's medical supplies and normally maintains ten days of supply. The DMSO provides Class VIII supply to the DSA units, FSBs, and BASs by using the division's medical supplies or by forwarding requisitions to the corps Medical Logistics Battalion (Forward) (MEDLOG BN FWD). **The Division Medical Operations Center (DMOC) of the DISCOM is responsible for managing Class VIII supplies in the division**.

The medical troop of the ACR receives primary Class VIII resupply from the MEDLOG BN FWD in the corps but may receive emergency fill from any medical unit. The squadron aid station operates similar to the BAS except that requisitions are filled at the Medical Troop.

The **theater MEDLOG BN REAR of the MEDCOM provides Class VIII support to units on an area basis behind the corps rear boundary and the MEDLOG BNs FWD in the corps area**; it can throughput class VIII to forward medical units in the division and the ACR if necessary. The **Theater Medical Materiel Management Center (TMMMC)** in the COMMZ directs the flow of Class VIII supplies throughout the theater of operations. The TMMMC is part of the ASCC Medical Command (MEDCOM), one of the "Big Six" commands in the theater army.

Supplies are **normally delivered using unit distribution** using logistical packages to a support area (FSB/DSA). Ambulance backhaul is the primary mode of transportation for the delivery of supplies from the support area to the BAS. **In emergency situations the combat units may obtain supplies from the FSB medical company, but the FSB medical company routinely stocks only enough supplies for its own medical mission**. See FM 8-10-9 for more information.

Blood Management requires special handling at all levels and includes blood products, colloids, and crystalloids. At the theater level, the Joint Blood Program Office (JPBO) serves as a single blood manager in theater and coordinates all additional requirements with the Armed Services Blood Program (ASBP) in CONUS. The **majority of all blood products enter the theater in a frozen state through USAF Blood Transshipment Centers (BTC) for further distribution to Army blood bank platoons located in MEDLOG battalions (Forward and Rear)**. Special blood collection units are located in theater to provide limited blood collection capability to augment pre-positioned frozen blood assets. Army MTFs are supplied blood products from these platoons. Role I care units receive only resuscitation fluids but no blood products. Role II care units receive resuscitation fluids and group “O” Red Blood Count (RBC). Role III and IV units operate a blood bank that can support liquid and frozen blood

services. Figure 11-2 below illustrates the units involved with Class VIII supply in the theater.

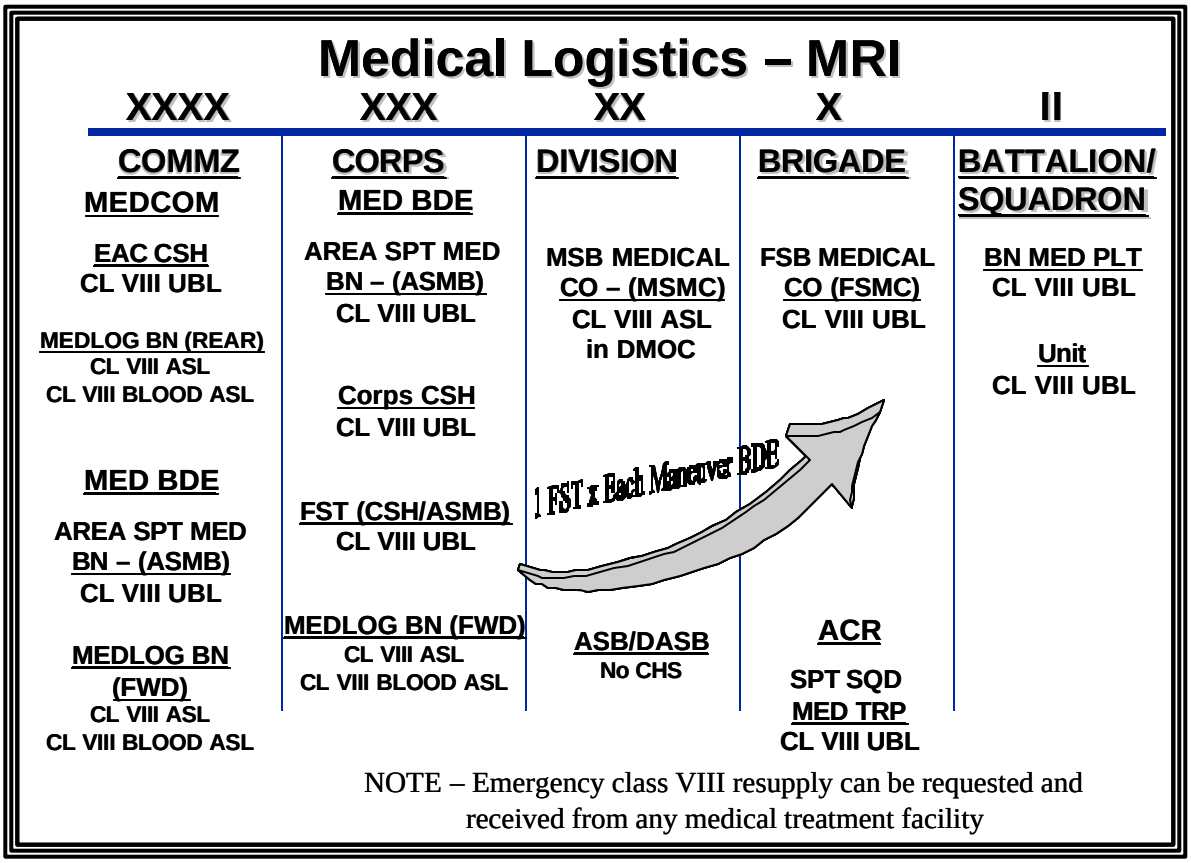


Figure 11-2. Class VIII

# Chapter 11: Combat Health Support

## Homework Assignment

Manuals Required to Complete Homework: Theater Logistics Handbook, FM 4-02.10, FM 100-10, FM 63-2, FM 63-20, FM 63-21, and FM 8-10.

1. The _____ recommends the theater evacuation policy through the _____ in conjunction with the _____ for approval by the _____. This policy establishes the _____ an injured or ill soldier may be allowed to
   _____
   _____. Ref. FM 4-02.10

2. List and briefly describe the ten medical functional areas. Ref: FM 4-02.10

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3. List and briefly describe the five roles/levels of CHS. Ref: FM 4-02.10.

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4. The modular medical support system operates at which levels of care?
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5. List and briefly describe the main components of the modular medical system? Ref. FM 4-02.10.

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6. A corps FST is assigned to a _____ and is normally attached to a _____ or a _____ _____ until needed forward. When deployed forward, the FST will be _____ of an FSB _____ _____. An FST is _____ to the _____ and _____ division and is normally assigned to the _____ until it is

_____ to _____ with the FSB medical company (FSMC). An FST is also organic to a _____ _____. Ref. FM 4-02.10.

7. In the corps area, level II CHS is provided on an _____ basis from _____ _____ companies assigned to an _____ battalion. These companies will generally collocate in the vicinity of a _____ _____. Ref. FM 4-02.24.

8. Under the Medical Reengineering Initiative (MRI), the theater hospital system consists of hospitals that can provide _____ level of care identified in the _____ _____. Ref. FM 4-02.10.

9. The theater hospital system contains two modular designed combat support hospital configurations. In the corps area the _____ CSH provides level _____ treatment and in the COMMZ the _____ CSH provides level _____ treatment. Ref. FM 4-02.10.

10. List and briefly describe the major components of the modular CSH hospital: Ref. FM 4-02.10.

    _____

    _____

11. List and briefly describe the augmentation teams that can be assigned to the modular CSH structure: Ref. FM 4-02.10.

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    _____

    _____

    _____

    _____

    _____

12. What is medical regulating? Ref: FM 8-10.

    _____
    _____
    _____

13. List and briefly describe the elements involved in the medical regulating process.

    _____

    _____

    _____

    _____

14. Explain the mission of the Division Medical Supply Office. Ref: FM 63-2.

15. How many days of supply do division level medical units maintain? Ref: FM 63-20.

16. In the corps area, class VIII support is provided by the _____ _____. Class VIII supplies are normally distributed to the user using _____ distribution via _____ operations. The class VIII distribution system uses _____ transportation assets assigned in the _____. Ref. FM 4-02.1.

17. The class VIII support organization in the division is the _____ _____ assigned to the _____ of the DISCOM. The DMSO receives direction and class VIII management from the ____ _____ on the DISCOM staff. Ref: FM 63-20.

18. Medical evacuation takes two forms _____ and _____. The priority means of evacuation is by _____. The corps Medical Evacuation Battalion is normally assigned to the _____ and provides support on an _____ basis. All aero-MEDEVAC assets are assigned to this battalion. Ref. FM 8-10-6.

## Notes

## Notes