

## CHAPTER 7

### Combat Health Support

This chapter discusses the purpose of combat health support (CHS) at the operational level and the current HSS force organization. The basic HSS mission is to conserve the fighting strength. Health services are employed to provide the most benefit to the maximum number of personnel. Patients are examined and treated and returned to duty as close to their unit as possible or, if unable to return to duty, evacuated further to the rear.

#### INITIAL COMBAT HEALTH SUPPORT

During the initial stages of establishing a CSS base, it may become necessary to perform CHS operations in one or more areas simultaneously. With assured ALOC and signal/satellite communications capabilities, medical units may provide support from an intermediate support base, a lodgment area, at CONUS installations, or afloat. Army medical facilities will be able to provide real-time diagnostic consultative services to forward MTFs. An enhanced telecommunications capability also reduces the requirement to employ the most critical skilled physicians into

forward deployed facilities. It permits strategic managers to centralize critical professional skills and services. Examples of where CHS operations may be conducted are--

- In a forced-entry operation into an area that would not be amenable to the employment of an Echelon III hospital, such a facility could be established in a third country near the operational area or afloat.
- In situations where SLOC have not been established, pre-positioned medical stocks may be maintained afloat.

#### JOINT COMBAT HEALTH SUPPORT

In joint operations, each military service operates its own CHS system, and health services—including hospitalization—may be provided. Health care facilities may provide service on a joint basis when directed by the JFC to maximize the availability of beds and services. Although joint staffing is not a requisite to joint use, staff augmentation from service components may be required. When one service uses personnel or medical elements from another service, the borrowing service assumes OPCON over those elements. However, administrative responsibility remains with the lending service.

Upon activation of a JTF, a command surgeon is designated from one of the component services as the JTF surgeon. The surgeon's staff should be jointly manned when possible and of sufficient size to effectively facilitate joint coordination of CHS initiatives, regionalization, standardization and inter operability, review of plans, and

integration with the overall operation. The joint force surgeons must assess component command CHS requirements and capabilities and provide guidance to enhance effectiveness of CHS through shared use of assets. They usually have responsibility for—

- Assisting the JFC in formulating a recommended patient evacuation policy for the theater of operations.
- Assisting component commands in identifying what CHS each component requires and who is responsible for providing it.
- Advising the JFC on CHS aspects of combat operations, combat stress control and reconstitution policies, preventive medicine (PVNTMED), and other factors that could affect operations.
- Informing the JFC about the status of CHS units, highlighting problems and other areas of interest or concern.

- Monitoring the status of patient beds, health service logistics (including blood products), staffing, and other issues affecting medical readiness; resolving shortfalls; and recommending solutions to the JFC.
- Informing the JFC about the status of CHS and assistance required by and provided to civilians, detainees, and EPW.
- Coordinating CHS provided to or received from allies or other friendly nations.
- Coordinating medical intelligence support for CHS organizations.
- Supervising the activities of the Joint Medical Regulating Office (JMRO) and Joint Blood Program Office (JBPO).
- Preparing CHS portions of CSS annexes to joint force plans.
- Preparing patient estimates based on casualty planning factors established by the component commands.
- Coordinating veterinary support within the theater.
- Advising the JFC on CHS aspects of the *Geneva Conventions*.

Liaison must be established between the joint force command surgeon and each component command surgeon to ensure that mutual understanding of technical medical and dental procedures, unity of purpose and action, and joint service support are maintained.

### THEATER ARMY MEDICAL MANAGEMENT INFORMATION SYSTEM (TAMMIS)

The TAMMIS supports the information management requirements of field medical units during war and MOOTW. It aids Army medical personnel in their mission of transporting, treating, and tracking patients, as well as managing medical materiel at field medical activities worldwide. It assists them by providing timely, accurate, and relevant medical management in the following functional areas: medical patient accounting and reporting (MEDPAR), medical regulating (MEDREG), and medical logistics (MEDLOG).

The MEDLOG functional area is further divided into medical supply, medical

maintenance, medical optical fabrication, and medical assembly management. Readiness is enhanced and transition to combat operations facilitated by the use of the medical supply system in both fixed and deployable medical treatment facilities. TAMMIS will interface with other services' systems, but each service will utilize its own independent system. The requisite interfaces among TAMMIS and other key management information systems, for example, SIDPERS, will strengthen the Army accounting and management processes in the theater.

### COMBAT HEALTH SUPPORT FUNCTIONS

The theater CHS system is a single integrated system from the FLOT to CONUS. Since forward-site medical treatment facilities (MTFs) are light and mobile (battalion aid stations, clearing stations), a system of echelons of care is used to provide continuity as the patient is evacuated from forward areas to MTFs staffed and equipped to handle their medical needs. These facilities are normally in the corps and COMMZ.

The dynamics of our global responsibilities require a flexible CHS system to support the diversity of military operations. Designed to sustain and protect the health of service

members, the system extends from the point of wounding, injury, or illness, through the theater of operations, to CONUS medical centers. CHS is organized forward from CONUS, throughout the theater, and laterally within the operational zones. It is provided at echelons of care referred to as Echelons (or Levels) I through V. Echelon V refers to care provided at CONUS medical centers. The capability of each echelon of care is designed to -

- Meet the characteristics of the operational environment.

- Provide a specific scope of care within the boundaries of its resourced capabilities as part of the progressive (echelon) treatment, hospitalization, and evacuation of sick, injured, or wounded soldiers.

From the FLOT to the CONUS base, each successive echelon of medical care has the capability to perform functions of the lower echelon and additional capability that cannot be located farther forward. This concept allows higher echelons of care to reconstitute lower echelons. Figure 7-1 illustrates the echelons of the CHS system in a theater and CONUS.

Overall responsibility for CHS for the Army component in a theater rests with the senior Army commander. Normally, a medical command (MEDCOM) headquarters commands and controls the theater CHS structure. However, a medical brigade may be the C<sup>2</sup> unit of the medical support elements based on the size of the operational-level medical force in a force. It provides the flexibility to shift assets to support additional theater buildup, reallocate medical assets to accommodate patient workload, and reconstitute lower-echelon medical units. If the operation expands into a multicorps force, the medical support headquarters may upgrade to a fully staffed MEDCOM headquarters. CHS will normally be established on a regional basis.

The commander of the operational-echelon-of-care medical support element will function as the Army component chief surgeon responsible for providing information, recommendations, and professional medical advice to the senior Army commander and his staff. The surgeon maintains current data on the status, capabilities, and requirements for CHS in the theater. The surgeon plans, coordinates, and develops policies for the support of Army forces as a whole. Theater CHS functions include-

- Patient evacuation.
- Medical regulating.
- Hospitalization.
- Health service logistics.
- Blood management.
- Dental services.

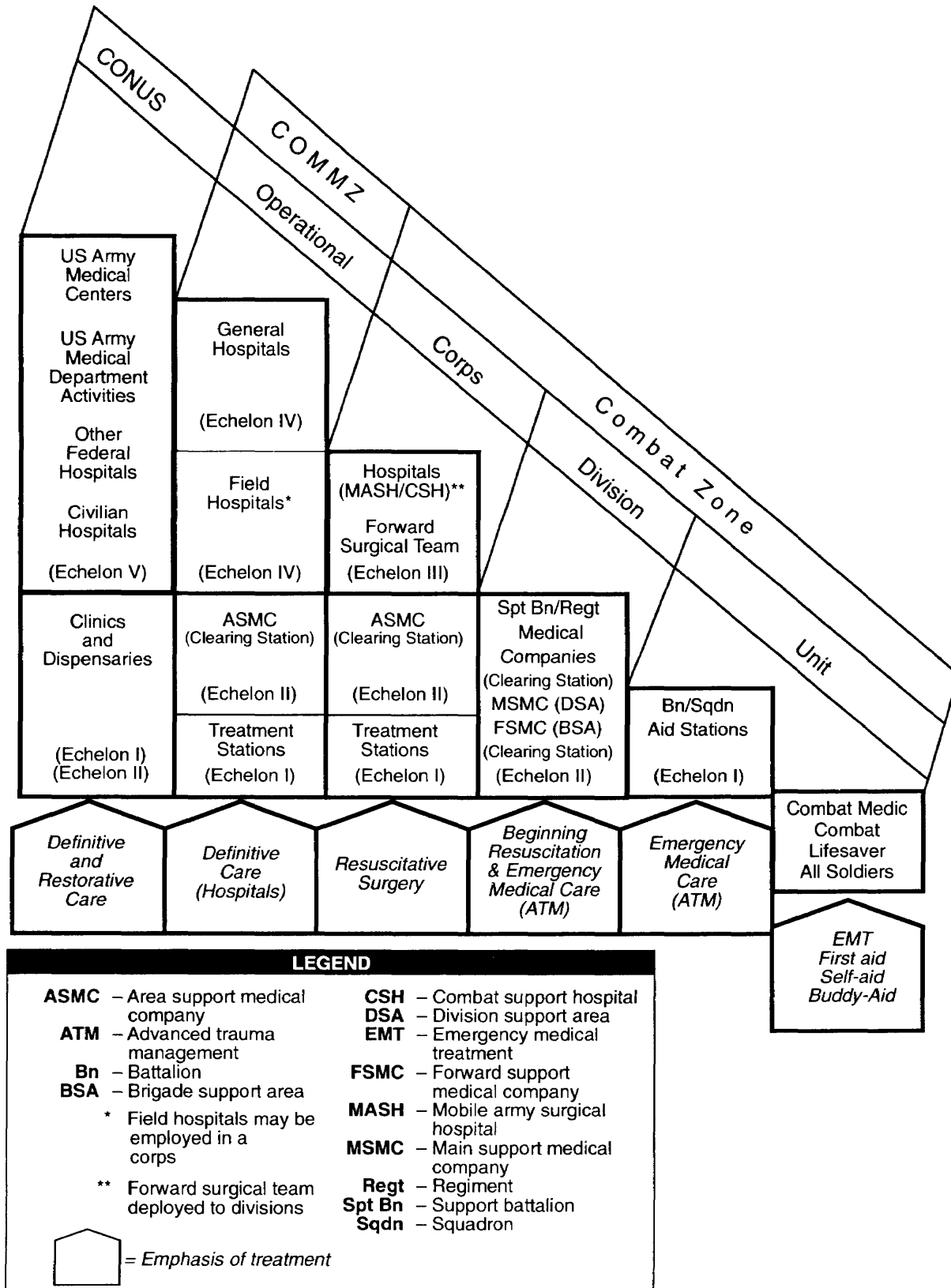
- Veterinary services.
- Preventive medicine.
- Combat stress control (CSC).
- Area medical support.
- Medical laboratory services.
- Medical information management.

## PATIENT EVACUATION

Patient evacuation is the timely, efficient movement of wounded, injured, or ill persons from the battlefield and other locations to an MTF. Patient movement is coordinated with the US Air Force Aeromedical Evacuation Control Center (AECC), the MEDEVAC element, and the senior MC element as appropriate.

USAF aeromedical evacuation liaison teams (AELTs) are located at the senior medical C<sup>2</sup> headquarters or MTF as required to assist in coordinating evacuation missions. In coordination with the Armed Services Medical Regulating Office (ASMRO) and the military services, USTRANSCOM provides MEDEVAC of patients to CONUS in support of worldwide requirements of supported CINC, USTRANSCOM component commands have the following responsibilities:

- The Air Mobility Command is responsible for providing theater, strategic, and domestic AE. The MSC assists, as required, in arranging or providing patient movement by sea. However, it does not normally provide medical personnel or hospital ships for MEDEVAC. Hospital ships are US Navy assets operated by the CINCs, Atlantic Command and Pacific Command, as part of the Ready Reserve fleet. Embarked medical personnel are also US Navy assets assigned to various naval medical units, none of which are part of MSC.
- The MTMC assists, as required, in the arrangement or provision of patient movement from the theater APOD to the CONUS medical treatment facility. For this movement, MTMC requests priorities and allocation of civil ground and air transportation resources with the exception of dedicated civil air transportation provided by the AE CRAF from the Department of Transportation.



7-1. Echelon of Care

The MEDCOM MEDEVAC battalion performs ground, air, and rail (if available) MEDEVAC of Army personnel within the COMMZ. This mission is accomplished with organic ground and air ambulance companies and attached rail ambulance detachments.

### **Aeromedical Evacuation**

The US Air Force AE System is the primary mode for evacuating patients from the corps to the COMMZ and from COMMZ to CONUS in the initial stages of military operations. If military operations expand or become prolonged, feasible surface transportation may also be employed. Coordinating patient evacuation plans with the flow of tactical and logistical traffic into and out of the CZ is essential. Both air and ground ambulances of the COMMZ MEDEVAC battalion are employed in the COMMZ area. Requirements for Army air ambulances are reduced if adequate airheads, hard-surface roads, railroads, and/or inland waterways exist.

### **Strategic Aeromedical Evacuation**

The strategic AE system normally operates between an overseas theater and CONUS. Strategic AE during combat operations may be accomplished on the retrograde portion of the USTRANSCOM-assigned airlift missions or on dedicated AE CRAF missions. The aeromedical CRAF may be employed to augment military aircraft returning selected patients to CONUS. The strategic AE system begins in the theater at the fixed aeromedical staging facilities (ASFs) and other established airfields within the theater, illustrating that strategic lift occurs within the theater as well as between the theater and CONUS. This is also true for strategic lift within the theater during the CINC's concentration of forces and CSS prior to going to war.

### **Operational-Level Aeromedical Evacuation**

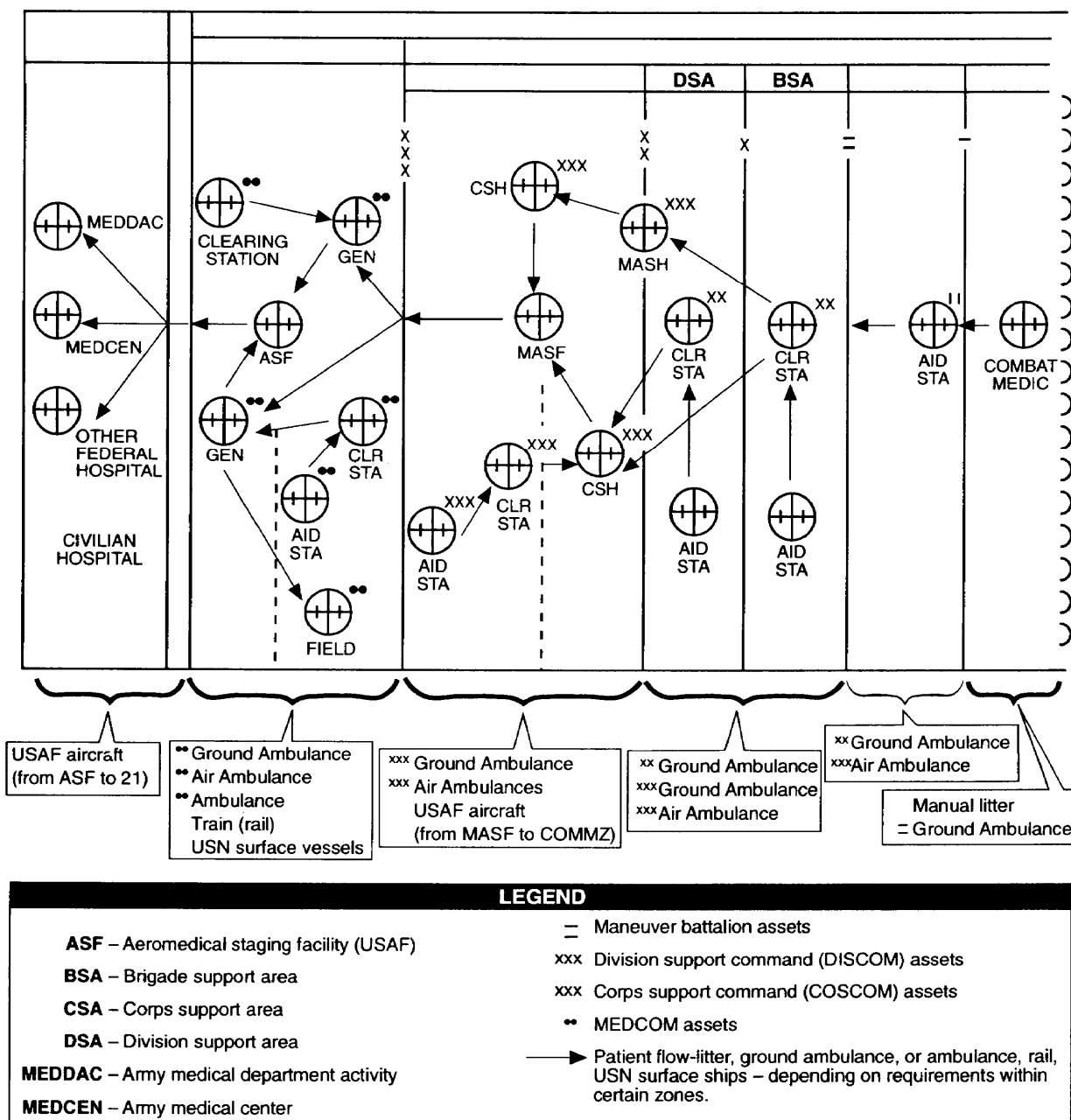
The theater AE system is the responsibility of the Air Mobility Command in coordination with the Air Force component commander. The theater system differs from the strategic system in that it is highly mobile and designed to deploy on short notice to any airfields and

landing zones, particularly those used to resupply combat ground forces by theater airlift aircraft. The theater AE System is usually confined to a specific theater and provides evacuation from the CZ when requested by a service or joint force component commander.

### **Domestic Aeromedical Evacuation**

AMC in CONUS operates the domestic AE System and moves patients from aerial ports to final destination hospitals and between CONUS MTFs. Figure 7-2 depicts the patient evacuation flow and types of MEDEVAC resources that may be available for movement of patients. For additional details, refer to Joint Pub 4-02.2. The responsibilities and functions of the elements of the domestic AE System follow:

- The AECC maintains, directs, and coordinates all functions pertaining to the efficient movement of patients using the AE system. When movement requirements exceed the capability of the system, the AECC notifies the command surgeon of the joint force command to seek alternative modes of transportation.
- To facilitate patient movement, an AELT provides a direct communication link between the medical treatment element of any user service providing patients for AE and elements of the AE System. The AELT coordinates with component medical regulating officers (MROs), the AECC, and the mobile aeromedical staging facility (MASF).
- ASFs, used for strategic AE, link theater and strategic systems. Medical treatment elements provide medical supplies. ASFs are located on or in the vicinity of an air base or an airstrip.
- The MASF is a mobile, tented, temporary staging facility deployed to provide supportive casualty care and administration. Each one is capable of routinely holding and processing 25 patients. However, they are not intended to hold patients for extended periods or even overnight. MASFs have no organic patient transportation capability. Therefore, the user service is responsible for



**Figure 7-2. Patient Evacuation Flow and Theater MEDEVAC Resources**

patient transportation to and from the MASF.

- The AE control element is the functional manager for AE operations at its airfield. It is under the OPCON of the AECC responsible for its area.

### MEDICAL REGULATING

Medical regulating is a patient management system designed to control and coordinate the movement of patients from site

of injury or onset of disease through successive echelons of medical care to an MTF that can provide the appropriate care and treatment. Prompt movement of patients to the required echelon is necessary to avert morbidity and mortality. The wartime regulation and evacuation of patients within the CZ between Echelons I through III MTFs are the responsibility of the service component commander. In the CZ, the service components are responsible for planning, organizing, and

executing patient evacuation from an injury site to the nearest MTF. The regulation of casualties from Echelons III and IV and the subsequent regulation from the theater to CONUS are accomplished jointly by the JMRO and the ASMRO.

### **Joint Medical Regulating Office**

The JMRO, which functions as part of the joint force surgeon's section, is responsible for ensuring that patients are moved to medical facilities within the theater of operations that can provide the required care. It also coordinates the movement of patients to CONUS with the ASMRO. In the CZ, component commanders are responsible for patient regulating within their AOs. The command surgeon may establish area joint medical regulating offices (AJMRO) to provide regional regulating. The JMRO and AJMRO have responsibility for—

- Developing and recommending to the command surgeon overall policies, procedures, and guidance for reporting MEDEVAC requirements.
- Maintaining direct liaison with the ASMRO, MEDREG offices of the component commands, and agencies that furnish MEDEVAC transportation.
- Obtaining reports of available beds from the component commands.
- Selecting facilities to receive patients requiring medical care at another MTF.
- Coordinating with ASMRO for beds in CONUS for patients requiring movement out of the theater of operations.
- Obtaining, consolidating, and disseminating current and projected estimates of MEDEVAC requirements within the joint force and to CONUS.

### **Armed Services Medical Regulating Office**

The ASMRO is a joint agency operated by the Chief of Staff, US Air Force, as Executive Agent, and subject to the direction of the CJCS. ASMRO performs a supporting role to the combatant commands. It regulates patients from theaters of operation based on requests from a JMRO to CONUS MTFs capable of

providing the required care. In making the medical regulating decisions, ASMRO coordinates with USTRANSCOM to make optimum use of transportation assets. The ASMRO is also responsible for MEDREG within CONUS. To accomplish the MEDREG mission, ASMRO must maintain continuous liaison with the JMRO.

## **HOSPITALIZATION**

Hospitalization is part of the theaterwide system for caring for sick, injured, and wounded patients. It is designed to provide patients with surgical and medical resuscitative, definitive, and specialty treatment. Patients with rare and unusual or complex conditions are evacuated to hospitals that can provide them with needed specialized treatment. Within the medical system, the scope of patient care and treatment capabilities can be adjusted to provide maximum effort to the individual patient and to manage the mass casualty situation (resources to workload).

The four types of hospitals that may be employed in a theater of operation are general hospital (GH), field hospital, combat support hospital (CSH), and mobile army surgical hospital (MASH).

- The number of GHs and field hospitals employed in the COMMZ will depend on the theater evacuation policy, the size of the CZ force supported, the amount of warning time prior to hostilities, and the availability of US Air Force evacuation assets. If a short theater evacuation-policy is established and the CZ force is corps-size or less, fewer hospitals are employed. GHs and field hospitals provide hospitalization for Army patients originating from within the COMMZ and for those patients received from hospitals in the CZ.
- CSHS and MASHs are normally employed in the CZ; however, they may be deployed in the COMMZ if the situation requires. The general, field, and combat support hospitals are capable of handling all categories of patients, whereas the MASH is limited to handling nontransportable surgical patients only.

### Forward Surgical Team

The forward surgical team is a corps augmentation for divisional and nondivisional medical companies that will replace the MASH. Organic to the airborne and air assault divisions, it will provide emergency/urgent initial surgery and nursing care after surgery for the critically wounded/injured patients until they are sufficiently stable for evacuation to a theater hospital.

### HN Hospitalization System

Wartime HNS is planned to augment joint medical assets for patient care. Health services may be provided to indigenous civilian personnel engaged in special or unconventional operations when authorized by the CINC. Allied patients treated in US MTFs will receive the same care as US patients. At the earliest possible time, allied patients are transferred to MTFs operated by their country. Theater army medical liaison teams coordinate transfers.

### Enemy Prisoners-of-War

In accordance with the *Geneva Convention* of 1949, EPW are provided the same medical care as that received by US personnel. A specific hospital in the COMMZ may be designated to treat them; however, all Army medical treatment facilities in the theater will treat EPW when required. For additional information on CHS for EPW, see FM 8-10.

## HEALTH SERVICE LOGISTICS

Health service logistics includes—

- Class VIII medical supplies—medical materiel to include medical-peculiar repair parts used to sustain the CHS system.
- Medical maintenance.
- Optical fabrication.
- Blood management and distribution.
- New technology like oxygen generation.

The system focuses primarily on health service logistics support where and when it is required in the fastest, most inexpensive, and most practical way possible.

The theater medical materiel management center (T MM MC) will serve as the management interface with CONUS-based Class VIII NICP and service item control centers. It coordinates logistics data flow with

the US Army Medical Materiel Agency (USAMMA) in CONUS and coordinates with the senior MC organization for movement of medical materiel assets in theater. The TMMMC will provide an advance team as part of the lead elements to ensure coordination of medical materiel to early mobilized medical units. See FM 8-10-5 and FM 8-55 for comprehensive discussions on this subject.

The MEDLOG battalion (rear) is responsible for resupplying Army medical units in the COMMZ and resupplying the corps MEDLOG battalion (forward). The MEDLOG battalion (forward), in turn, is responsible for resupplying corps divisional and nondivisional medical units. The MEDLOG battalion (rear) in support of joint/or multinational operations performs the single integrated medical logistical manager mission in conjunction with the TMMMC.

Initially, resupply to the theater is provided by preplanned, time-phased shipment of medical resupply sets from the CONUS strategic logistics system. When possible, medical supplies are shipped directly to the corps MEDLOG battalion (forward) from the CONUS wholesale logistics base. This happens when required supply echelons of care are determined and normal replenishment, based on theater demand, replaces the preplanned resupply system.

## BLOOD MANAGEMENT

The theater and CONUS blood programs are a combined DOD effort. In the theater, the joint force command establishes a single blood management program to meet the needs of the command. The program is theaterwide and interfaces with the CONUS blood-banking system.

All components within the joint force command maintain a separate military blood program. Each service appoints a military blood program officer to manage its program. The senior medical headquarters' TMMMC manages the Army's blood program. The Army blood program officer (ABPO) interfaces with the JBPO, who is the single blood manager for the theater. The JBPO interfaces with the Armed Services Blood Program Office (ASBPO) in CONUS.



In contingency operations, if the vast majority of personnel are Army, the ABPO would become the JBPO for the COMMZ. In a relatively short contingency operation, blood would not normally be drawn from troops in the CZ because of the short amount of time involved and the lack of acclimatization of the personnel. Blood products would be provided from CONUS base through the ASBPO. See FM 8-10 and FM 8-10-5 for additional discussions.

An area joint blood program office (AJBPO) may be established, under the management of the command surgeon, upon activation of the JTF. The AJBPO (JTF) performs similar blood program management functions as the JPBO at the joint force command echelon of care, but with a lesser magnitude within a designated/assigned AOR. The AJPBO (JTF) is joint-service-staffed with personnel from the medical laboratory and administrative specialties and can include permanently assigned staff, reserve augmentation, and personnel provided by component services. See FMs 8-10 and 8-10-5 for additional discussions.

### DENTAL SERVICES

Initially, dental personnel organic to divisional and nondivisional medical companies perform dental *services*. Most care at this echelon (Echelon II) is emergency in nature and designed to relieve patients of pain, to prevent the recurrence of pain, and to return soldiers to their units as quickly as possible with minimum patient evacuations. FM 8-10-19 provides a comprehensive discussion of dental support.

### VETERINARY SERVICES

The Army veterinary service provides support to all component commands, including—

- Control of zoonotic diseases.
- Care for DOD-owned animals.
- When authorized, veterinary care for animals of local indigenous personnel in conjunction with medical civic action and CA programs.
- Veterinary laboratory support.
- Inspection and laboratory examination of subsistence items for wholesomeness and quality.

- The food safety service listed below to the Army, Navy, and Marine Corps components. The Air Force provides the same support to its own forces:
- Inspection of all food following NBC exposure that is received, stored, and issued in the theater of operations.
- Inspection of facilities supplying, storing, and issuing subsistence items.

### PREVENTIVE MEDICINE

The prevention of illnesses and disease is the most effective and least expensive means of providing commanders with the maximum number of vigorous soldiers. Timely implementation of preventive measures can significantly reduce the adverse impact that disease and nonbattle injuries (DNBI) have on the force. The results of these actions serve as a force multiplier.

PVNTMED support within the COMMZ functions as a wholly integrated system from the individual through the theater echelon of care. The PVNTMED detachment, sanitation; the PVNTMED detachment, entomology; and the PVNTMED section of the area support medical battalion (ASMB) provide PVNTMED both in the CZ and COMMZ. Elements from the AML also provide PVNTMED support. See FM 8-55 for a discussion of PVNTMED support in the theater of operations.

### COMBAT STRESS CONTROL

Main support battalion, separate brigade, armored cavalry regiment (ACR) medical companies and troops, and ASMBs provide CSC support. They receive further support from CSC companies or detachments assigned to the CZ/COMMZ medical brigade. CSC preserves fighting strength by minimizing losses due to battle fatigue and neuropsychiatric disorders. The focus of Army CSC is on—

- Promotion of positive mission-oriented motivation.
- Prevention of stress-related casualties.
- Treatment and early RTD of soldiers suffering from battle fatigue.
- Prevention of harmful combat stress reactions such as misconduct stress

behaviors and posttraumatic stress disorders.

### **AREA MEDICAL SUPPORT**

The ASMB provides area medical support in the CZ and COMMZ. This unit provides Echelons I and II CHS and medical staff assistance for all assigned and attached elements of the corps and COMMZ. It incorporates modular medical support systems that are found in the division medical structure. A secondary mission is to reconstitute the division medical structure or to support rear battle. Both Echelon I and Echelon II CHS may be provided in accordance with geographical areas or sectors suggested by supported units.

The ASMB medical companies establish treatment stations and provide Echelon II CHS (inclusive of dental, laboratory, x-ray, mental health, preventive medicine, and optometry services) over wide geographic areas. Both Echelon I and Echelon II CHS may be provided in accordance with geographical areas or sectors suggested by supported units. The ASMB also provides trauma treatment and MEDEVAC in support of rear operations within the COMMZ. Their mission includes providing medical assessment and medical triage in area damage control operations.

### **MEDICAL LABORATORY SERVICES**

Under the senior medical headquarters, an area medical laboratory (AML) is established in the COMMZ. This high-technology independent laboratory has major operational sections that include anatomic pathology, biochemistry, entomology, epidemiology, microbiology, and veterinary. Its primary role is evaluating the total health environment in the theater, rather than providing individual patient care. This involves an increased role in analyzing and evaluating the effect of NBC agents. The AML is capable of analyzing

patient and animal specimens and samples of food and water. It conducts studies in—

- Aerospace and forensic pathology and toxicology.
- Pest identification and the efficacy of pesticides.
- Frequency and effects of infectious agents and diseases.
- Identification of microorganisms and monitoring of immune response.
- Transmission of zoonotic diseases.

Medical laboratory services are available at all echelons of care—except Echelon I—on an area basis. These services provide subject-matter expertise to commanders regarding risk assessment, preventive measures, and the medical management of illnesses caused by endemic agents and conditions introduced by threat forces. The AML can also serve as the base for research and development efforts.

### **MEDICAL INFORMATION MANAGEMENT**

The proper management of medical information is critical to providing medical support. Decisions such as where to treat casualties and when to evacuate to hospitals depend on knowing what medical resources are available at all times. An effective automated medical management information system provides the capability to track resources, requirements, and patients in support of theater operations. In particular, health service logistics relies heavily on automation, communications-linked medical units, and supporting MEDLOG battalions. Depending on the size of the deployed force, a MEDCOM, medical brigade, or medical group controls medical information management. Arriving with the lead element, units with an automated capability to manage medical information orchestrate both the arrival of medical units in the AO and the interface with other information systems—such as movement and personnel—at all levels.

## **MASS CASUALTIES**

Triage is the evaluation and categorization of patients for treatment and evacuation to

facilitate the efficient use of available resources. Primary considerations for

conducting triage include where it will take place and who is available to do it. When large numbers of patients are immediately located at the incident site, triage is best accomplished at the site. This ensures that priority is appropriately given to those patients requiring immediate evacuation to MTFs.

Medical personnel who are qualified in trauma treatment sort mass casualties. They identify each patient by category, indicating the priority of his treatment and the likelihood of his survival. The four categories are minimal, immediate, delayed, and expectant.

Rapid sorting assures that available treatment is directed first toward those

patients who have the best chance of survival and earliest return to duty. In a rapidly changing battlefield environment, NBC-contaminated patients are separated from uncontaminated patients as the situation dictates. Triage is conducted in the same manner for contaminated and uncontaminated patients; however, the patient and medical treatment personnel are encumbered by mission-oriented protective posture (MOPP) IV. Medical treatment requires more time because of decontamination procedures. FM 3-5, FM 8-10-4, and FM 8-285 discuss the requirement for supported units to provide manpower for patient decontamination.

## HOST NATION

HNS should not be assumed to be immediately available. Therefore, every effort should be made to have HNS agreements in place to accommodate as many requirements as feasible. Attached CA staff augmentation and operational teams provide interface with civil authorities. This interface is coordinated with civilian medical resources (personnel and facilities) for possible treatment of US patients, as well as ensuring a reasonable echelon of care for the local populace. Prenegotiated HNS

agreements can greatly assist in the area of fixed facilities, utilities, maintenance, and patient evacuation and can reduce the manpower requirements in the medical force structure. Maximum use is made of HN transportation resources as they become available, especially rail and waterways. Conversion kits should be procured and monitored to ensure their availability for modifying buses, trains, and barges for patient evacuation.