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THE SECRETARY OF THE AIR FORCE**

**AIR FORCE TACTICS, TECHNIQUES
AND PROCEDURES 3-42.8**

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Tactical Doctrine

EXPEDITIONARY MEDICAL LOGISTICS (EML) SYSTEM

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(Col Tracy A. Tenney)

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SUMMARY OF CHANGES: This publication has been substantially revised and should be completely reviewed. **NOTE:** Deleted the Blood Support Operations chapter in its entirety (to be included in the revised AFTTP 3-42.711, *Blood Support Operations*).

PURPOSE: The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for medical combat support capability. This document, AFTTP 3-42.8, provides tactics, techniques, and procedures (TTP) for the Expeditionary Medical Logistics (EML) System. Ensure all records created as a result of the processes prescribed in this publication are maintained in accordance with (IAW) AFPD 33-3, *Information Management*, and AFMAN 33-363, *Management of Records*, and disposed of IAW the *Air Force Records Disposition Schedule (RDS)* located at <https://www.my.af.mil/afirms/afirms/afirms/rims.cfm>. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF IMT 847, *Recommendation for Change of Publication*. Route AF IMT 847 through the appropriate chain of command and parent Major Command (MAJCOM).

APPLICATION: This publication applies to all Air Force military and civilian personnel (including Air Force Reserve Command (AFRC) and Air National Guard (ANG) units and members). The doctrine in this document is authoritative but not directive.

SCOPE: This document provides the AFTTP for the EML System. The EML System was designed and is executed to provide global support and sustainment to Air and Space Expeditionary Force (AEF) forces. This AFTTP may be used as a guide for validating future requirements and revisions to appropriate planning and training concepts. Medical Logistics personnel will be deployed to meet specific requirements for various military missions. To meet this requirement, Medical Logistics personnel must have the knowledge and training to successfully sustain a deployed medical force through the full spectrum of military operations. It is imperative that planners and medical personnel understand logistics and distribution processes to meet the deployment and sustainment challenges of AEF forces.

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CHAPTER 1

GENERAL

“Logistics comprises the means and arrangements which work out the plans of strategy and tactics. Strategy decides where to act; logistics brings the troops to this point.”

Jomini, Pr’ecis de l’ Art de la Guerre. 1838

1.1. Mission/Tasks. The Expeditionary Medical Logistics (EML) System provides time-definite resupply of materiel by synchronizing the flow of materiel, information, and funds from initial unit request to delivery. It uses a pull process for resupply and a repair and return process for medical maintenance to minimize inventory (footprint) and airlift requirements. The EML system consists of focused logistics and agile combat support (ACS) concepts, which provide tailored logistics packages to the deployed medical unit by utilizing a predetermined supply chain. Both concepts are required to meet Air and Space Expeditionary Force (AEF) deployment and sustainment challenges. By adopting commercial business practices, the EML system streamlines the requisition process for the deployed medical unit and eliminates or significantly reduces support structures.

1.2. Background. An AEF consists of tailored and rapidly deployable forces – a fundamental shift from the previous philosophy of massive reinforcement of fixed overseas support structures and basing. To support and sustain an AEF and medical forces, the Air Force Surgeon General directed an EML system be developed and executed. The Air Force Medical Operations Agency/Air Force Medical Logistics Office (AFMOA/AFMLO) designed and developed the EML system and Air Force Medical Logistics Global Support Center to provide crucial guidance to medical personnel during all phases of deployment.

1.2.1. ACS is crucial to the Air Force philosophy of power-projection – the deployment of Air Force personnel primarily from the continental United States (CONUS). ACS is the rapid movement of required materiel directly from factory to flight line, providing a reachback sustainment capability for medical and other deployed personnel. This allows for a much smaller logistical footprint in the operating theater. Given the reliance on reachback, the deployment and sustainment challenges are tremendous. Air and sealift may be severely limited.

1.2.2. Reachback is the process of obtaining products, services, and applications, or forces, or equipment, or material from organizations that are not forward-deployed (Joint Publication 3-30, *Command and Control for Joint Air Operations*). Reachback is a critical enabler to EML. After Operation Enduring Freedom, the Deputy Central Command (CENTCOM) Surgeon stated, “Never before has reachback been tested on such a large operational scale...it’s working in principle and in execution...this would not be happening without the great work of our logistics community.”

1.3. Focused Logistics. The primary goal of focused logistics is compression of customer wait time (customers get their materiel faster). To achieve this goal, customers and suppliers must employ effective information management practices and have timely access to reliable and secure telecommunication channels.

1.3.1. Focused logistics is the combination of information and logistics technologies to ensure required materiel arrives at the right time at the right place, every time, no matter where or at what level the conflict. New transportation systems will enable the shift from supply-based systems to manufacturer-direct or prime vendor (PV) delivery. The management of mission and logistics requirements relies on rapid, reliable, and time-definite transportation systems to reduce the need for maintaining excessive on-hand stock.

1.3.2. Focused logistics requires the Services and Combatant Commanders (CCDRs) to reduce forward inventories to a minimal amount (also known as the reduced footprint concept) and relies instead on consistent resupply. The idea of reduced footprint is intended to apply not only to inventory but also to other support systems, such as a hospital. This reliance on transportation and throughput requires careful analysis, confidence on the part of the CCDR, and continued access to ports.

1.4. In-Transit Visibility (ITV). ITV is necessary to ensure smooth flow of supplies and sustainment. Plan to establish ITV procedures and ITV nodes at all ports of embarkation, transit points, and ports of debarkation. Lack of ITV may cause loss of confidence in the supply system and create unnecessary ordering and an unnecessary burden on limited supply lines.

1.5. Threat. Medical logistics capabilities may be impacted by direct threats to the supply line as well as by threats to U.S. forces, installations, and information systems.

1.5.1. Supply Line Disruption. Supply lines may be disrupted by combat-related activities, supply shortages, transportation delays, and the like. It is important to outline the threat to transportation channels used for focused logistics and reachback. Buffer stock placed at locations like Loaner Repair and Return Centers (LRRC) can be used to mitigate these risks.

1.5.2. Targeting of Medical Facilities. Medical facilities are potential targets of terrorist organizations trying to disrupt health service support (HSS) response capabilities.

1.5.3. Medical Threat. The Air Force responds globally to a broad range of situations requiring medical care. Additional materiel requirements may be necessary to support events. The force health protection (FHP) goal is to prevent casualties resulting from the physical and mental stress caused by environmental, occupational, operational, and chemical, biological, radiological, and nuclear (CBRN) warfare threats.

1.5.3.1. Disease and Non-Battle Injury (DNBI). The degree of this threat depends on geographical location, and is determined by endemic disease, climate, and socioeconomic conditions. Preventive medicine teams, theater epidemiology teams, proper waste management, consultation with specialists, availability of advanced treatment modalities and diagnostics, and medical information management systems are required to minimize this threat.

1.5.3.2. Conventional and Exotic/Unconventional Weapons. These weapons carry the potential to inflict injury in various forms. Effective treatment is dependent on rapid access to appropriate medical personnel, appropriate use of equipment and techniques

representative of the current standard of care, possible specialty consultation, access to medical information, ability to rapidly process tests and data, a communication network, and possible air evacuation.

1.5.3.3. Weapons of Mass Destruction (WMD). Nuclear weapons range greatly in size and energy yield. Nuclear capability is possessed by a growing number of countries. Blast and thermal injury will account for most of the casualties, and radiation effects can be significant. The threat results from individual injury and the potential for a very large number of casualties over a very short period of time, which would severely burden the whole medical evacuation and treatment system. These weapons are less discriminating than conventional weapons and will likely result in a large number of casualties.

1.5.4. Information Warfare. Our heavy reliance on information systems makes them attractive targets to potential adversaries. The threats to these systems are worldwide, technically diverse, and growing rapidly. Network Control Center (NCC) Information Assurance (IA) programs provide information systems security support for the deployed medical facility (DMF). The medical facility abides by the Air Force Forces/Air and Space Expeditionary Task Force (AFFOR/AETF) Network Operations and Security Center–Deployed (NOSC-D) and NCC communications design architectures, operational rules of engagement, and Major Command (MAJCOM) preferred product lists to minimize the threat. Protecting data is of vital importance and backup capability must be designed into the information infrastructure, especially in providing medical asset visibility and in facilitating materiel movement.

CHAPTER 2

ORGANIZATIONS, ROLES, AND RESPONSIBILITIES

2.1. Air Force Surgeon General (SG). The SG ensures medical units are sourced and supported with deployable medical assets to meet the full spectrum of military operations. The SG also determines EML doctrine and policy and provides the required resources necessary to execute and sustain the EML process, both at the MAJCOM and unit levels.

2.2. Assistant Surgeon General, Health Care Operations. The Assistant Surgeon General, Health Care Operations, provides oversight authority for all aspects of training related to EML to include the incorporation of EML concepts into all applicable Air Force Medical Service (AFMS) education and training courses. The Assistant Surgeon General also coordinates and consolidates Program Objective Memorandum (POM) submissions to support EML execution, training, and war reserve materiel (WRM) requirements.

2.3. Air Force Medical Logistics Division. The Air Force Medical Logistics Division maintains the Air Force Medical Logistics Operations Center (AFMLOC), located at Ft. Detrick, Maryland. The AFMLOC is the center for Air Force medical supply chain management. The Division also maintains three CONUS Consolidated Storage and Deployment Centers (CSDCs) at Port San Antonio, TX, Travis Air Force Base (AFB), CA, and Charleston, SC. The CSDCs provide a full range of medical logistics capabilities, enabling the execution of the EML supply chain.

2.3.1. The AFMLOC coordinates with Total Force (Active Duty, Guard, and Reserve) component medical planners and logisticians of the unified commands to ensure medical requirements are identified in operation plans (OPLANs), exercises, and real-time operations.

2.3.2. The AFMLOC executes, monitors, and reports the supply chain process to the SG as required; validates resource requirements for supply chain nodes and requests manpower assistance as appropriate; and communicates issues, problems, or solutions to the SG, MAJCOMs, AFFOR Surgeon (AFFOR/SG) staff, and Component Numbered Air Force Surgeon (C-NAF/SG) staff.

2.3.3. The AFMLOC develops, publishes, and monitors guidance on supply chain management for MAJCOMs and deployed medical units. Additionally, the AFMLOC obtains and manages the funding stream for shipping costs. Specifically, the AFMLOC maintains information on airflow operations and logistics points of contact (POC).

2.3.4. The AFMLOC is the primary POC for the Combined Air Operations Center (CAOC), the deployed unit, and the sustaining base on materiel and supply chain issues. The AFMLOC will maintain a log with the issues and coordinate resolution with various agencies and commands.

2.3.5. The AFMLOC is responsible for reachback medical logistics in support of the AFFOR/SG and determines the strategy to support the AFFOR/SG medical logistics plan for the Area of Responsibility (AOR).

2.3.6. CSDCs hold consolidation of medical equipment Unit Type Codes (UTCs). CSDCs have the capability to accomplish the full range of maintenance on most medical and non-medical equipment. The CSDCs reduce the risk of loss and non-availability of airlift to opposite coasts. CSDCs can be used as a sustaining base as part of Air Force Global Medical Logistics support.

2.3.7. AFMOA/SGSLW (Port San Antonio, TX) is designated by the Joint Chiefs of Staff as the Theater Lead Agent for Medical Materiel (TLAMM) for Southern Command (SOUTHCOM). A TLAMM serves as a major theater medical distribution node and is the customer interface for medical logistics and supply chain management. A TLAMM is normally responsible for the provision of all core medical logistics functions required to support HSS and FHP operations. These functions include medical supply, medical equipment maintenance, optical fabrication, assembly and fielding of medical assemblages, and management of vaccines, investigational drugs, special equipment, and other medical materiel subject to special interest or control by the Joint Force Surgeon (JFS). See Chapter 7, Integration and Interoperability, of this TTP for more information about the TLAMM and joint interoperability. See JP 4-02, *Health Service Support*, for more information on Health Service Logistic Support (HSLs) in joint operations.

2.4. Air Force Forces Surgeon (AFFOR/SG). The AFFOR/SG is responsible for AFFOR medical logistics in the AOR. The AFFOR/SG (supporting the Component Numbered Air Force [C-NAF], the operational arm of the Air Force in the AOR) identifies requirements for medical logistics manpower augmentation teams to support AFFOR; documents medical logistics manpower augmentation team shortfalls to supporting MAJCOMs; and coordinates logistics support plans with the AFMLOC. When medical logistics elements are assigned in the theater to support supply chain operations, the AFFOR/SG facilitates coordination between the elements and deployed medical personnel. This ensures the deploying element and the local commander have a clear understanding of the responsibilities and duties the element will provide in support of the operation.

2.5. Medical/Operational Planners. Air Force component medical and operational planners verify with the AFMLOC that medical logistics requirements are identified in OPLANs, exercises, and real-time operations (**NOTE:** Under the Air Force Command and Control (C2) Enabling Concept, operational planners reside at C-NAFs.) Some important logistics considerations are local oxygen support capability, local linen support, local hazardous waste disposal, and available power, fuel, and communications capability.

2.6. Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies (MRAs). To maintain the viability and effectiveness of its deployable medical capabilities, the AFMS has assigned MRA responsibilities to three MAJCOMs: Air Combat Command (ACC), Air Mobility Command (AMC), and Air Force Special Operations Command (AFSOC). UTC pilot units work closely with the MRAs to construct and review UTCs, associated mission capability (MISCAP) statements, manpower details, and allowance standards. MRAs request funding for the modernization and sustainment of their UTCs through Line of the Air Force (LAF) and medical programming channels. UTCs are dynamic and are continuously reviewed

and modified. Medical planners should consult with the appropriate MRA to obtain the most current information.

2.6.1. ACC is the MRA for medical ground support personnel and equipment UTCs and medical counter-CBRN (MC-CBRN) allowance standards (AS).

2.6.2. AMC is the MRA for aeromedical evacuation (AE), patient staging, aeromedical enroute care support personnel and equipment UTCs and patient movement items (PMI).

2.6.3. AFSOC is the MRA for special operations medical personnel and equipment UTCs.

2.6.4. Pacific Air Forces (PACAF) and United States Air Forces in Europe (USAFE) may maintain responsibility for theater-unique capabilities with Air Staff approval.

2.6.5. Air National Guard (ANG) will maintain responsibility for ANG capabilities related to Title 32 United States Code (USC) operations. Title 10 USC operations are governed by the active duty MRAs.

2.7. Medical Logistics Personnel. All medical logistics personnel must have the knowledge and training to successfully sustain a deployed medical unit through the full spectrum of military operations.

2.8. Sustaining Base.

2.8.1. The sustaining base is the materiel lifeline of any deployed medical unit. It augments the deployed medical unit's limited logistical capability by assuming the bulk of the supply chain's administrative, sourcing, and tracking functions. The AFFOR/SG, in coordination with the AFMLOC, determines the sustaining base. The sustaining base is typically located within CONUS in close proximity to available commercial materiel resources and can leverage a wider array of transportation options. A sustaining base located outside the continental United States (OCONUS) may be utilized if it increases the expediency of the supply chain and is more cost effective than a CONUS sustaining base.

2.8.2. The sustaining base is normally collocated with a CONUS medical center and has two major advantages: (1) direct access to a large number of suppliers experienced in large-scale logistics support, and (2) in-house providers who can rapidly identify substitutes or alternatives for medical items not readily available.

2.8.3. The sustaining base normally activates an extended workday or on-call operations center to respond to short-notice deployments. Once activated, the sustaining base establishes secure communications with the deployed medical unit and acts as the unit's logistics link through the duration of the deployment or until a theater supply chain is established. As the deployed medical unit's one-stop shop for materiel sustainment and information, the sustaining base will notify the unit of substitutions and fill initial outfitting shortages identified by the deploying unit's home base.

2.8.4. The sustaining base ensures that equipment requirements receive immediate consideration because of the limited inventories of items such as spare parts, tools, and test equipment as well as limited availability of experienced biomedical equipment technicians (BMETs) in deployed medical assemblages. It uses a combination of rapid spare-part procurement, replacement equipment procurement, and (potentially) repairs and returns from a central location.

2.8.5. The sustaining base may activate the Prime Vendor (PV) Air Expeditionary Force (AEF) contract clause and act as the primary conduit of information and guidance for resupply of deployed medical units (PV AEF clauses require vendors to make requested materiel available for transport within 8 hours, 7 days a week).

2.9. Support for Ground Medical Units. Medical materiel personnel (4A1X1) assigned to ground medical UTCs are responsible for managing the supply needs of the DMF. BMET personnel (4A2X1) are responsible for biomedical equipment maintenance and facility management.

2.9.1. UTC FFEP2, Medical EMEDS/AFTH Command and Control (C2), provides the initial medical logistics support for EMEDS facilities.

2.9.2. UTC FFEP3, Medical EMEDS/AFTH 10-Bed Personnel Augmentation, provides additional medical logistics personnel to augment an EMEDS+10 or Air Force Theater Hospital (AFTH).

2.9.3. UTC FFEP4, Medical EMEDS/AFTH 25-Bed Personnel Augmentation provides additional medical logistics personnel to augment an EMEDS+25 or AFTH.

2.10. Support for AE and En-Route Care Units. Medical logistics personnel assigned to AE and en-route care UTCs are tasked with satisfying the medical supply needs of the deployed units.

2.10.1. Medical logistics personnel support the following AE and en-route care UTCs:

- FFQCC, AE Command Squadron
- FFQCM, AE Operations Team Augmentation
- FFQNT, AE Operations Team
- FFQSC, AE Support Cell
- FFVCF, Contingency Aeromedical Staging Facility (CASF) Command Function
- FFVSF, CASF Specialty Function

2.10.2. The 10-bed Mobile Aeromedical Staging Facility (MASF) requires medical supply support to begin seven days after setup.

2.11. Support for Special Operations Units. Theater medical planning guidance generally requires units to deploy with a 30-day package of medical supplies during initial deployment. For AFSOC units, the deployment load will vary based on mission requirements and operational constraints. To determine medical logistic requirements, medical planners must consider the

mission and its duration, the availability of supplies at the mission location, and the availability of alternate medical supply sources in the event the conventional supply system breaks down.

2.11.1. AFSOC medical forces possess limited logistics support capabilities. In many Special Operations Forces (SOF) operations, the short-term, covert, or low-visibility nature of the operation may not allow or require establishment of a resupply mechanism. Consequently, such operations may require particularly careful coordination to ensure resupply when and if necessary. When deployed with AFSOC equipment UTCs, AFSOC medical assets are normally capable of providing medical support to a deployed AFSOC unit for up to 30 days without resupply.

2.11.2. During covert/ clandestine operations, AFSOC medical units deploy with adequate medical supplies and equipment to ensure they have the capability to support operational requirements. When resupply is required, SOF medical planners establish resupply through a variety of mechanisms, which includes support from a host medical treatment facility (MTF), in-country embassy or Military Assistance Group (MILGRP), home station, or main operating base. When deployed in support of a major regional conflict, AFSOC medical logistics support is provided by the conventional HSS system. Prior coordination with the host MTF or Joint Task Force (JTF)/SG will help ensure adequate medical logistics support is available.

2.11.3. SOF medical logistics are normally coordinated through the SOF medical plans officer and are provided by the nearest conventional medical logistics unit if the SOF medics are deployed to a mature theater. If the SOF medics are located in an immature theater, the team will coordinate resupply using local or regional resources when appropriate. Predetermined PMI may need to be placed at forward or intermediate staging bases.

2.11.4. Medical involvement in all phases of mission planning is essential for mission success. AFSOC logisticians, working with line and medical planners, have the requirement base to plan and predict the acquisition and flow of WRM supplies and maintenance that special operations medics require. Their knowledge allows essential strategies to be formulated to ensure adequate equipment and supplies for deployed SOF medical assets. Logistic objectives are to reduce the physical footprint for deployment without degradation of medical capability, maintain portability, and provide a logistics support system to ensure responsive sustainment.

2.12. Augmentation and Sustainment Medical Logistics Support UTCs.

2.12.1. Medical Biomedical Equipment Maintenance Team (FFBMM). FFBMM provides support personnel to augment biomedical equipment maintenance and facility management support to EMEDS DMFs, AFTHs, and other ground medical operations. The team also deploys to PMI Centers and Cells to support AE operations.

2.12.2. Medical Logistics Manpower Augmentation Team (FFLG1). FFLG1 provides medical logistics support personnel to EMEDS DMFs and other facilities. The team may deploy to other logistics nodes, such as distribution hubs and military depots located near aerial ports of embarkation (APOE) or aerial ports of debarkation (APOD), to facilitate the

flow of materiel and information. The team also deploys to PMI Centers and Cells to support AE operations.

2.12.3. Medical Logistics Management Team (FFLGM). FFLGM provides medical logistics support personnel during sustained medical operations. The team deploys to an EMEDS/AFTH where medical logistics is already established.

2.13. Theater Lead Agent for Medical Materiel (TLAMM) Force Module/Operational Capabilities Package (OCP). This medical logistics team provides medical logistics leadership, materiel management, supply distribution, and biomedical equipment maintenance support. The force module consists of one FFLGM, four FFLG1, and one FFBMM UTCs. The team deploys to support the initial transition of an Air Force designated provisional TLAMM from baseline capability to immediate and full operating capacity.

2.14. Other Medical Unit Support. Medical logistics personnel are also assigned to the following medical UTCs:

- FFBD1, Medical Frozen Blood Product Team
- FFBP1, Medical Expeditionary Blood Transshipment Center, Module 1
- FFBP3, Medical Expeditionary Blood Transshipment Center, Module 3
- FFGLB, Medical Patient Decon Team
- FFHA4, Medical CT Scan Team
- FFSGQ, Medical AFFOR Medical Staff, Increment 1

2.15. Non-Medical and Special Operations Unit Support. Medical logistics personnel may support the following expeditionary non-medical and special operations UTCs. Note that medical logistics personnel provide only medical logistics support to these UTCs and function only in non-combatant roles.

- 7PRCS, PR Guardian Angel Combat Support
- 81RSG, STT Medical Supply
- 81SLG, STT Special Tactics Logistics
- 9AAB1, HQS AFFOR QRP
- 9AAB2, HQS AFFOR LRP
- 9AAB3, HQS AFFOR TRP
- 9ACRG, HQS Contingency Response Group HQ
- 9AFWD, HQS COMAFFOR/JFACC Forward Staff
- CT17F, HHQ 17AF AFAFRICA AFFOR Staff
- CT1A5, HHQ AFNORTH AFFOR A-5 Augmentation
- CT1AF, HHQ 1AF HQ AFNORTH AFFOR Core
- FFQE2, Medical SOF CAA Medical Augmentation
- FFQET, Medical SOF IW/SSTR Medical Team Augmentation

2.16. PMI Program. Specific Global Patient Movement Joint Advisory Board (GPMJAB) and Defense Medical Standardization Board (DMSB) approved medical equipment and durable supplies required to support the patient during evacuation are referred to as PMI. Examples of PMI include ventilators, litters, patient monitors, and pulse oximeters. PMI teams are composed

of medical material specialists (FFLG1) and BMETs (FFBMM). Combined, this logistics team provides manpower for operational management of a PMI center. Medical material teams will manage PMI equipment, supplies, accountability/acquisition of required material, and facilitate equipment recycling, scanning, and tracking in the Patient Movement Items Tracking System (PMITS). Equipment repair teams support regional maintenance and repair capability for equipment in PMI centers and/or cells. These teams will provide scheduled preventative maintenance and calibration, repair and maintenance services, and updates to the PMI information system. FFBM1 is the deployable medical calibration and maintenance equipment to perform biomedical maintenance on the deployed PMI. FFQP3 is a notional UTC comprised of PMI that can be tailored to a specific need to include whatever PMI equipment/supplies are necessary for a deployed site. FFQP4 is a deployable PMITS used to track PMI in the deployed area. It consists of a backpack, PMITS laptop, external hard drive, and scanners.

2.16.1. United States Transportation Command (USTRANSCOM) is the PMI system manager (JP 4-02, *Health Service Support*). The Air Force is the PMI program execution agency responsible for resourcing, maintaining, and recycling PMI to support contingency operations for patient movement. Headquarters AMC Surgeon's Office (HQ AMC/SG) is the program management, execution, and action office for the Air Force. All services will fund the original initial quantities of approved PMI in-kind assets. PMI in-kind assets are defined as the exact medical equipment by type and model approved for patient movement. All services will maintain initial quantities of approved PMI in-kind equipment in their medical assemblages, kits/sets/outfits, table of allowance, or AS. This will ensure program standardization and the ability to seamlessly support patient movement. This capability is critical to enabling the PMI system to properly recycle/replace medical equipment in medical assemblages and to ensure their designed operational capability is not diminished due to equipment shortfalls. The Air Force manages patient movement requirements and is responsible for life-cycle management of the equipment assets that reside in the PMI centers. PMI is not intended to supplement service assemblages for use in facilities.

2.16.2. The objective of the PMI program is to sustain patient movement through the AE system without diminishing the capability of forward medical units. The PMI program manages all PMI assets and provides sufficient assets to sustain AE operations or provide for in-kind exchange when PMI accompanies a patient in the AE system. This is done by providing equipment for treatment continuity or by using equipment that is Service-specific and DMSB approved. The PMI system will provide a seamless in-transit patient and/or equipment management process from initial entry to the patient's final destination. The PMITS and PMI will deploy with the AE system, be managed and supplied through the AE system, and collocate with AE intratheater and/or intertheater interfaces to provide initial AE operational capability, sustainment of AE operations, and minimize equipment turnaround time.

2.16.3. Medical logistics personnel manage inventory availability (at PMI centers and cells), asset visibility, and flow of PMI through available transportation methods to meet requirements.

2.16.4. The handling and return of equipment to the originating theater through the AE system requires a reliable supporting logistics infrastructure to ensure that PMIs are available

and serviceable. The plan for a PMI exchange system and the return of evacuation equipment and PMIs to the originating theater should be addressed in the respective theater OPLAN.

2.16.5. PMI Center levels are based on projected casualty flow and time-phased recycling of PMI assets. Timely recycling is essential to maintain and contain our total inventory investment. All services are responsible for tracking and returning PMI assets to the closest PMI Center.

2.16.6. PMI equipment is tested and certified for use on applicable service rotary and fixed-wing aircraft. Service en-route care teams (i.e., Air Force AE Crews and Critical Care Air Transport Teams [CCATT]) will be trained to operate PMI equipment items. An Air Force Form 4033, PMI/AE Certification Label or joint certification label is required to designate airworthiness certification for all PMI equipment. This certification label must be affixed to each piece of PMI certified equipment. Key to successful patient treatment and movement is ensuring medical equipment assets are bar-coded, loaded in PMITS, available for patient treatment, tracked in transit, and recycled to MTFs.

2.16.7. PMI equipment is placed on the patient by the sending MTF. PMI Centers will recycle or replace particular PMI equipment removed from the Service medical facilities to support patient movement events. PMI levels at local MTFs will be determined by local commanders with the minimum prepositioned levels equal to three days of expected worst-case patient flow.

2.17. Expeditionary Combat Support (ECS). ECS for deploying medical units is provided by Air Force, other Department of Defense (DOD) forces, coalition forces, or host nations to ensure medical infrastructure and environment of care requirements are supported. Examples of ECS include local oxygen support capability, local linen support, and local hazardous waste disposal. ECS should be defined in OPLANs, deployment orders, memorandums of understanding, and memorandums of agreement with the various ECS agencies.

CHAPTER 3

OPERATIONS

3.1. Employment.

3.1.1. The AFFOR/SG provides the AFMLOC and deploying medical logistics personnel with information about intratheater airflow and distribution nodes. This information, along with that from AFFOR logistician POCs, ensures the most efficient and effective supply chain is developed for the operation. The AFFOR/SG establishes equipment and supply review policy to aid deployed commanders in validating requirements. This ensures mission requirements can be met and that all activities in the supply chain are focused on procuring and distributing the necessary materiel.

3.1.2. The AFFOR/SG, in coordination with the AFMLOC and sustaining base, identifies the deployment requirements for medical logistics manpower augmentation teams to support the plan. The AFFOR/SG begins the process of requesting the augmentation teams for deployment to the agreed-upon logistics nodes.

3.1.3. The sustaining base and the AFMLOC coordinate with USTRANSCOM and combatant command planners to ensure the most expeditious transportation nodes are used for sustainment. Commercial contract carriers are used to the maximum extent possible. It is essential to minimize the number of nodes through which materiel must transit and eliminate consolidation to reduce delays (see Figure 3-1, Air Force Medical Sustainment Flowchart).

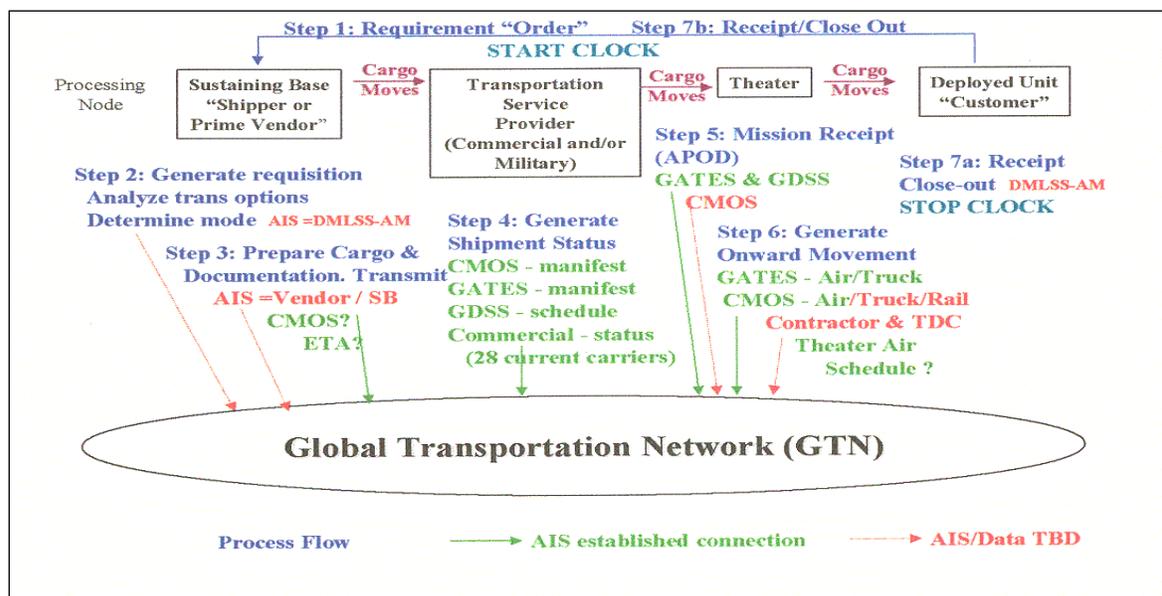


Figure 3-1. Air Force Medical Sustainment Flowchart

3.1.4. The supporting Medical Equipment Repair Center (MERC) and/or PMI Cell acts as a hub for medical equipment repairs and calibrations that cannot be accomplished at the deployed site. AFFOR/SG will coordinate a support agreement between the MERC and PMI

Cell and deployed medical sites that describes what services and equipment the MERC and/or PMI Cell is capable of providing and how the deployed BMET should arrange for this support. If required due to increased workload, a BMET personnel UTC will be requested to augment the MERC and/or PMI Cell. The deployed BMET will determine if the equipment can be repaired, calibrated locally, or if should be replaced.

3.2. Deployment/Redeployment.

3.2.1. Deployed Medical Unit.

3.2.1.1. The deployed medical unit may be multiple UTCs with one or more WRM assemblages that provide medical support in response to war, contingency operations, disaster and humanitarian relief operations, exercises, or any operation that requires the assemblage to be moved from storage to operational use.

3.2.1.2. A deployed medical unit accomplishes unit resupply responsibilities as referenced in applicable Air Force instructions, manuals, and deployment orders/guidance. They coordinate with the AFFOR, AFMLOC, and the sustaining base before deployment to obtain specific instructions during all phases of deployment.

3.2.1.3. Upon arrival in theater, the deployed medical unit initiates communication with the sustaining base and works with deployed communications and systems personnel to secure a permanent communications solution. They notify the sustaining base of issues related to supply maintenance and ensure that resupply requirements are identified and coordinated. It is important to obtain solid shipping addresses, including a commercial address.

3.2.1.4 Resupply requirements are identified to the sustainment base as one of three priorities: urgent (96 hours), immediate (7 days), or routine (30 days). Communications and coordination by the deployed unit with the AFMLOC and sustaining base on materiel and maintenance issues are critical to meet EML time-definite delivery goals.

3.2.1.5. The deployed medical unit appoints a primary POC to communicate various logistics issues with all nodes. The POC updates appropriate contingency and annual training or exercise schedules to ensure EML personnel, equipment, and training are incorporated to meet Concept of Operations (CONOPS) requirements. Deployed personnel identify shortfalls in personnel, equipment, and training, and educate line and medical personnel, especially commanders, on the EML process and capabilities. When required supplies are received, the deployed medical unit notifies either the sustaining base or AFMLOC, or they update the automated information system (AIS) to ensure the transaction is closed within the Global Transportation Network (GTN).

3.2.1.6. Once deployed and mission capable, a unit takes action to ensure logistics support. Logistics personnel must register on Medical Logistics List Servers to receive Quality Assurance/Recall Notices, the online Air Force Medical Logistics Letter, and Medical Equipment Device Alerts. They coordinate with the local Office of Special Investigations (OSI) to validate local vendors outside the pre-approved list and

communicate with other medical units in the area to understand their mission and possible resupply requirements. Coordination with AE units is necessary to establish a process for obtaining PMI in-kind exchange replacements and to establish supply chain synergies. Deployed units should closely coordinate with the AFFOR/SG to ensure requirements beyond the units' AS are reviewed before submission to the sustaining base.

3.2.2. Transportation. Each deployment of a medical assemblage can be unique. Therefore, the transportation scenario will dictate the nodes and methods of moving medical materiel to a deployed medical unit.

3.2.2.1. Materiel and resupply for a deployed medical unit should be transported by the most expedient and reliable lift method. Cargo movement throughout the distribution chain must have 100 percent ITV. Systems must be in place to provide commercial carrier and military transportation system tracking. Lack of ITV can result in delayed and lost shipments, which can negatively impact the mission.

3.2.2.2. Medical logisticians and the transportation community work hand-in-hand to develop executable medical cargo movement plans. Working relationships and agreements should be established to ensure uninterrupted medical cargo movement. Similar contracted or partnership agreements are pursued with commercial transporters to the greatest extent possible.

3.2.3. Redeployment/Reconstitution of Assets. Assets will be shipped to AFMOA/SGSLW (Port San Antonio, TX) for refurbishment, unless otherwise directed. If deployed with the Defense Medical Logistics Standard Support (DMLSS) computer system and a stock record account number, all appropriate transactions (including AS validation) can be processed on site.

3.3. Sustainment.

3.3.1. In a mature theater, there may be a TLAMM element linked to the combatant commands, JTF/SG, AFFOR/SG, deployed medical units, sustaining base, and the AFMLOC. When a TLAMM is established, it will be the deployed unit's primary POC for materiel and equipment support in theater. The sustaining bases will still be available for emergencies and support when the TLAMM is unable to provide support.

3.3.2. The following are the acquisition method strategies, listed in the established priorities for acquisition.

3.3.2.1 The Defense Logistics Agency (DLA) Troop Support PV Program. PV distributed items include Distribution and Pricing Agreement (DAPA) items, Federal Supply Schedule items, PV non-usage items, PV committed volume or Regional Incentive Agreements (RIAs), and PV program electronic commerce (ecommerce) and other electronic tool sources.

3.3.2.2. The DLA Troop Support Electronic Catalog (ECAT).

3.3.2.3. Local Purchase Instruments. Decentralized Blanket Purchase Agreements (DBPAs), Blanket Purchase Agreements (BPAs), and Indefinite Delivery/Indefinite Quantity (ID/IQ) contracts.

3.3.2.4. Other ecommerce and web-based ordering sites. For example, Department of Veterans Affairs (DVA) ordering sites.

3.3.2.5. The DLA Troop Support Depot. Centrally-managed and military/service-unique items.

3.3.2.6. Government purchase cards.

3.4. Materiel Management. Material management requires the ability to organize and provide life-cycle management of medical materiel, including pharmaceuticals, medical supplies, medical assemblages, and medical gases. Each chief of logistics/director of logistics is responsible for all logistics operations in the activity and satellite activities to the extent authorized. These operational responsibilities include:

3.4.1. The acquisition, receipt, storage, issue, movement, maintenance, repair, and accountability of materiel and equipment.

3.4.2. Environmental services management, including housekeeping, textile care services (linen distribution and laundry services), and waste collection and disposal.

3.4.3. Facility management, including real property repair and maintenance, construction and renovations (minor/new), grounds maintenance, physical security, preventive maintenance, energy conservation, facility space utilization, and master planning.

3.4.4. Transportation management, including transportation coordination and justification and management of non-tactical vehicles.

3.4.5. Communications with the information management officer and the plans and operations staff.

3.4.6. Contracting support coordination. The excess materiel management goals are to eliminate excess medical materiel, which is any materiel on hand that is no longer required to satisfy any mission requirement. Also, ensure timely and cost-effective identification of excess materiel and equipment, and aggressively report and advertise excess materiel for possible redistribution of serviceable items to other activities or units.

3.5. Medical Maintenance. All medical equipment must be properly maintained. The oversight responsibility for the safe use of electrical devices in patient care areas is required. Electrical safety inspections of all medical and nonmedical equipment used in patient care areas is mandatory. Testing of isolated power systems and ground fault circuit interrupter (GFCIs) is also required. Electrical safety inspections and testing should be performed in accordance with (IAW) AFI 41-201, *Managing Clinical Engineering Programs*, and AFI 41-203, *Electrical Safety in Medical Treatment Facilities*. BMETs may assist the Chief of the Medical Staff and

others responsible for in-service training by providing user training and education on electrical safety.

3.5.1. Medical maintenance teams will exercise their responsibilities by performing electrical safety inspections, calibration/verification, unscheduled/preventive maintenance, installations/removals, and repairs and modification of biomedical equipment (IAW AFI 41-201). Emphasis is placed upon component-level repairs, replacement of assemblies, modules, and printed circuit boards. They will also maintain and operate a medical equipment repair parts program; technical library with operator and service manuals for individual equipment items; conduct initial inspections for new or transferred equipment; and implement organizational maintenance support for all medical devices used at various locations. BMETs will perform pre-purchase evaluations of medical devices and advise on operational theory, underlying physiological principles, and safe clinical applications of biomedical equipment.

3.5.2. It is imperative that all actions performed by BMETs are documented IAW AFI 41-201. This includes all maintenance actions throughout the life cycle of the medical equipment, such as electrical safety inspections, modifications, calibration/verifications, preventive/unscheduled maintenance, etc. Safety inspections performed in the facility will be accomplished IAW AFI 41-201 and AFI 41-203. Training/in-service training will also be documented upon completion.

3.6. Facility Management. Facility managers maintain the overall safe environment of the entire MTF. Their responsibilities include:

3.6.1. Ensure the identification and correction of electrical safety hazards and coordinate with the base civil engineer (BCE) to ensure inspections of the power distribution and emergency power systems are performed and documented.

3.6.2. Coordinate with BCE to correct power distribution system hazards identified through inspection.

3.6.3. Help perform functional and technical reviews of development documents and drawings.

3.6.4. Identify requirements for medical equipment and furnishings.

3.6.5. Direct acceptance inspections and construction surveillance.

3.6.6. Assist in transitional planning, initial outfitting, and post-occupancy efforts.

3.6.7. Advise on medical facility master planning and life-cycle management.

3.6.8. Conduct facility assessment studies to improve the functional use of existing space.

3.6.9. Perform engineering evaluations of building systems and components.

3.6.10. Provide consultant services for code interpretation and compliance.

3.6.11. Identify facility sustainment, restoration and modernization requirements, and advocate for project funding.

CHAPTER 4

COMMAND AND CONTROL (C2) RELATIONSHIPS

4.1. Command and Control (C2).

4.1.1. Medical operations C2 is defined in warning, execution, and operations orders.

4.1.2. Medical logistics personnel fall under the control of the supported unit. When augmenting an existing medical resource, medical logistics specialists report to the senior ranking medical officer or IAW the established C2 structure.

4.1.3. When employed to augment existing EMEDS/AFTH assets, medical logistics personnel integrate into the supported unit's C2 structure.

4.2. Nodes.

4.2.1. The primary nodes within the EML system include the AFMLOC, the deployed medical unit, and the sustaining base.

4.2.2. Adjunct nodes include PV, JTF/SG, AFFOR/SG, and the TLAMM. Depending on the node and method of transportation employed, the APOE/APOD may become critical adjunct nodes.

4.2.3. Node enabling functions or processes include transportation, AIS technology, worldwide telecommunication capability (including satellite communications [SATCOM]), access to the Internet, logistics manpower augmentation, and the appropriate level of training. All nodes, functions, and processes related to the EML supply chain exist in every phase of a deployment, including post-deployment review and analysis.

CHAPTER 5

INTELLIGENCE

5.1. Health Service Logistics Support (HSLs) Planning. In developing the HSLs estimate and plan, health service personnel obtain updated medical intelligence through standard intelligence sources. By obtaining medical intelligence and studying the medical threat, health service personnel can better predict the types of sustainment medical materiel that will be required for the mission. When this prediction is considered in light of the casualty estimate, theater evacuation policy, and anticipated duration of the operation, the health service logistician can also forecast the expected quantities of materiel items that will be required.

5.2. Medical Intelligence. Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or the AOR. It is any information that is known about a region where USAF assets may deploy or where the USAF may have interest that pertains to an individual's health and welfare, host nation medical threats, and the host nation's medical capability and infrastructure.

5.2.1. The public health officer usually is responsible for gathering and briefing this information.

5.2.2. Until medical information is appropriately processed (ordinarily on the national level by the National Center for Medical Intelligence), it is not considered intelligence.

CHAPTER 6

COMMUNICATIONS/COMPUTER SYSTEMS SUPPORT

6.1. Organic Communications Equipment. Medical logistics support relies heavily on technology to track and maintain supplies. The DMLSS software suite meets these requirements by allowing direct data entry and transmission of orders from remote locations to suppliers.

6.1.1. An effective ITV system is crucial to providing medical logistics support. The GTN provides a means to access transportation and deployment information. PMITS is a commercial off-the-shelf stand-alone system used to track PMI equipment.

6.1.2. All materiel, to include the initial response supplies, sustainment materiel, and medical equipment, is currently managed by one of the following systems:

6.1.2.1. The DMLSS system for EMEDS Health Response Team (HRT), EMEDS+10, EMEDS+25 or larger assemblages.

6.1.2.2. DMLSS Customer Assistance Module (DCAM) for deployed units smaller or below the EMEDS HRT level, AE assemblages, and Special Operations Medical Teams.

6.1.2.3. PMITS for AE deployed units, or a combination of these systems, depending on the size and complexity of medical logistics support required for AE support to the EMEDS/AFTH deployment.

6.2. Communications.

6.2.1. Reliable communications are critical to the entire EML process and begin with proper planning in the pre-deployment phase. Communication requirements must be an integral part of all operation planning documents.

6.2.2. Worldwide telecommunications, including SATCOM and access to the Internet, are essential for establishing and sustaining effective resupply to deployed medical units (see Figure 6-1, Air Force Theater System Connectivity).

6.2.3. The sustaining base and AFMLOC shall ensure that the deploying unit has access to a remote access server (RAS). This will allow the deployed medical units to pass requisitions electronically by SATCOM or by other appropriate means as an interim solution until deployed communications provide the permanent connectivity solution. The sustaining base must establish a deliberate plan to connect the deploying unit with the RAS before actual deployment. This plan must include testing of remote connectivity with the sustaining base before deployment.

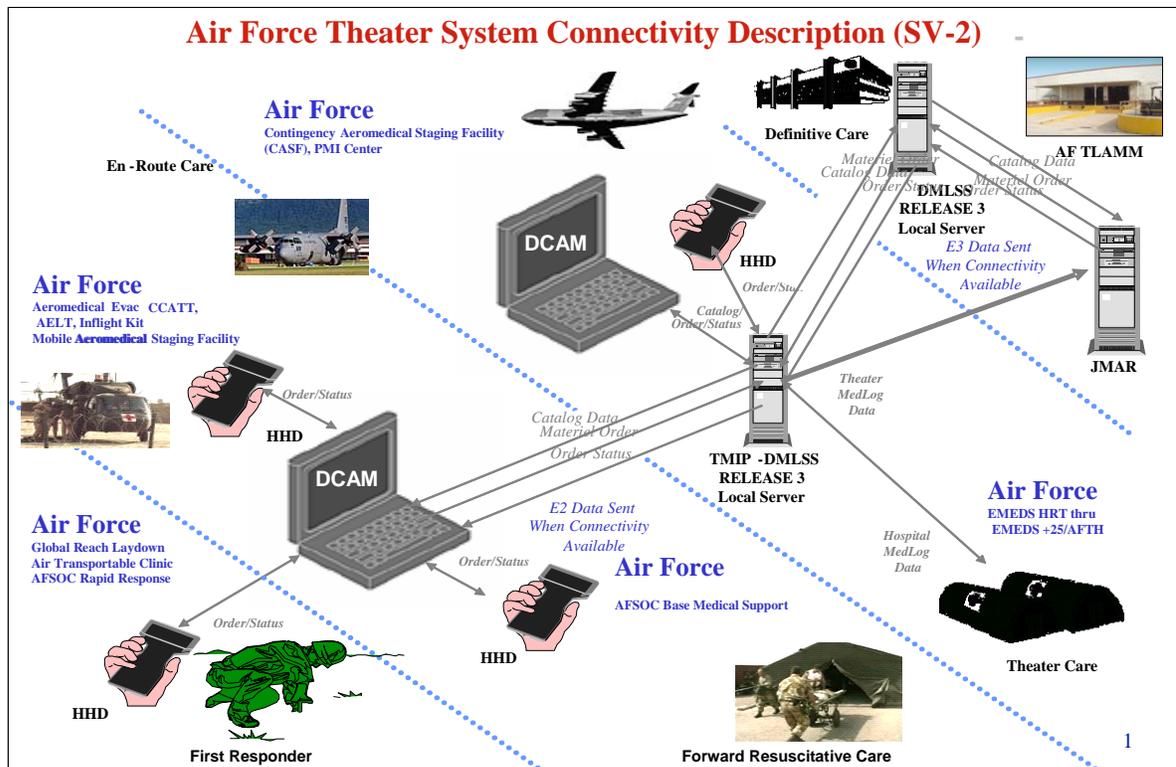


Figure 6-1. Air Force Theater System Connectivity

6.3. Information Management/Technology.

6.3.1. EML information management will be accomplished through the employment of existing information system technologies, DMLSS, and USTRANSCOM GTN.

6.3.2. DMLSS is the primary information management system used by both the sustaining base and the deployed unit (EMEDS HRT or larger) for asset management.

6.3.3. DCAM is the primary AIS used by the deployed medical unit operating below the threshold of an EMEDS HRT.

6.3.4. USTRANSCOM's GTN integrates movement and schedule data from source systems and commercial transportation service providers and feeds this data into supply chain nodes to provide ITV.

6.3.5. Personnel should evaluate and incorporate all technological enhancements into the EML process where beneficial. Data timeliness criteria follows the Under Secretary of Defense (Acquisition, Technology, and Logistics) Implementation Plan for all military and commercial origin, in-transit, and receiving activities to report the arrival and departure of unit strategic and sustainment airlift movements, sustainment sealift movements, and intratheater and CONUS movements.

6.4. Computer Applications.

6.4.1. The Theater Medical Information Program (TMIP) provides the suite of DOD standard applications that support theater HSS operations. These include medical C2, health care delivery, patient tracking, and medical logistics and blood management. TMIP applications are fielded and maintained by each Service.

6.4.2. The DMLSS program provides the DOD standard applications for medical logistics in both institutional and operational environments, integrating national and operational-level business processes, medical information management, and medical information technology. The Medical Logistics Proponent Committee (MLPC), under the direction of the Assistant Secretary of Defense (Health Affairs) (ASD[HA]), is the functional proponent for the DMLSS Program to promote business process innovations that increase the efficiency and effectiveness of medical logistics support of HSS across the full range of military operations. The DMLSS applications that support HSLs are found at all echelons of theater HSS and enable end-to-end management of HSLs processes.

6.4.2.1. DMLSS Release 3.0. Provides medical supply, medical equipment management and maintenance, assembly management, facility management, and customer support functions for theater HSS units.

6.4.2.2. DCAM. Provides a simple, laptop-based tool for customer order management for tactical HSS units. DCAM provides tactical customers with a store and forward capability when communications are not available.

6.4.2.3. Theater Enterprise Wide Logistics System (TEWLS). TEWLS is the DMLSS solution for theater-level distribution of CL VIII supply chain management by a TLAMM. TEWLS integrates CL VIII storage and C-17 HSLs distribution operations in all theater HSLs units under the management of the Medical Logistics Management Center (MLMC), and provides linkage with national-level commercial sources.

6.4.2.4. Joint Medical Asset Repository (JMAR). A Web-based data repository that provides worldwide asset visibility for medical materiel.

6.5. Health Service Logistics Support (HSLs).

6.5.1. HSLs is highly dependent upon reliable and timely data and voice communications to exchange information among customers, HSLs units, commercial suppliers, and transportations systems. Theater HSLs operates primarily in a non-secure environment. Some customers (such as Special Forces) and processes (such as joint movement requests) require access to secure communications. A lack of communications connectivity has been frequently cited in past lessons-learned reports as a major contributing factor when supply chain performance has not met customer requirements.

6.5.2. HSLs planning must address the need for reliable data connectivity for HSLs customers and organizations, especially during the earliest stages of theater operations before

theater communications capabilities are fully mature. HSLs planners must coordinate closely with their J-6 and understand the communications plan for the operation.

6.5.3. HSLs issues that should be considered include:

- 6.5.3.1. HSS customers' ability to communicate requirements and receive status.
- 6.5.3.2. HSLs units' ability to communicate with customers as well as supporting theater and national-level organizations.
- 6.5.3.3. HSLs units' ability to share requirements and movements information with distribution management organizations and provide situational awareness to logistics and/or C2 systems.
- 6.5.3.4. Information security, to include negotiation of firewalls.
- 6.5.3.5. The requirement and/or use of nonstandard communications capabilities, such as SATCOM for HSS/HSLs.
- 6.5.3.6. Training, fielding, and in-theater support for hardware and applications.

6.6. Patient Movement Items Tracking System (PMITS). PMI are tracked using PMITS, which is developed and supported by the DMLSS Program Office. PMITS is a system of systems under DMLSS for non-theater sites and under Theater Medical Information Program-Joint (TMIP-J) for theater sites. Use of PMITS is mandatory for PMI asset visibility and tracking. It allows medical logistics personnel to proactively support deployed organizations. HQ AMC/SGXL is responsible for PMITS operational control, advice, and counsel.

6.6.1. PMITS manages a designated pool of medical equipment to support patients requiring AE. It provides real-time information on the location and operational status of mobile medical equipment. PMITS provides clear visibility on the availability and status of the medical equipment needed to treat patients in-transit. It supports timely recycling of PMI through accurate tracking processes and ensures the right equipment is in place at the right time for aeromedical patient care. By marrying basic inventory tracking with just-in-time logistics, PMITS has substantially decreased inventory costs and improved AE operational readiness, a key element in increasing patient survivability rates. Currently, PMITS supports over 100 sites worldwide.

6.6.2. PMITS uses bar code technology to scan PMI and share PMI data with other authorized users of the system. By using a bar coding system, PMITS links uniquely identified medical equipment with its location and operational status at the point it was scanned. Bar codes will be issued only at PMI centers and designated units or by HQ AMC/SGXL using established bar code guidelines IAW published PMI Bar Coding Methodology & Codes. Users will ensure bar code labels are attached to all PMI equipment assets and loaded in PMITS before use and/or patient movement. The bar code label should include the AMC/SGXL phone number, 1-877-286-1931. If the label is worn or does not have the phone number, contact the nearest PMI center or AMC/SGXL to obtain a new label

immediately. Non-PMI equipment will not be tracked in this system unless coordinated with USTRANSCOM and HQ AMC/SGXL.

CHAPTER 7

INTEGRATION AND INTEROPERABILITY

7.1. Integration with Other Systems/Teams. During contingency operations, the Air Force uses DMLSS to assist in medical materiel management. EMEDS assemblages are equipped with DMLSS, which is part of the TMIP software suite. DMLSS is also capable of stand-alone operation, complete with a finance and procurement source interface. Contingency HSLs operations mirror normal support to peacetime MTFs. Both the EMEDS and the MTF health service personnel have the same health service logistics mission when deployed.

7.1.1. Stored operating supplies may be funded through Air Force Working Capital Fund (AFWCF) assets. As issues are processed, the AFWCF is reimbursed with operation and maintenance (O&M) funds. Air Force assemblages are normally issued up-front using LAF O&M funds to reimburse the AFWCF. When O&M funding is used for operating supplies, no reimbursement by customers is required.

7.1.2. Each assemblage deploys with a set number of days of supplies and will require resupply support before the TLAMM is in place (if designated). AFMLO has the capability to develop Air Force Class VIII sustainment requirements data for specific OPLANs. An EMEDS can be equipped to requisition and receive supplies in a stand-alone mode from its home base, another support base, or other source of supply.

7.1.3. An EMEDS may be designated as a TLAMM for a particular geographic area and a temporary period of time. The designation is specified in the CDR's OPLAN. Transportation and communications augmentation must be provided from within theater to fulfill this mission.

7.2. Interoperability.

7.2.1. Prime Vendors (PVs). The sustaining base requisitions the bulk of the pharmaceutical and medical-surgical supplies needed to support deployed medical units from PVs. AEF requirements are inserted in the PV contracts supporting the sustaining base. Vendor contracts normally contain the requirements to prepare cargo IAW military guidance and requirements. This is especially important for hazardous and refrigerated materiel.

7.2.2. Joint Interoperability. The Air Force fights jointly. In recent years, DOD leadership has reinforced commitment to joint interoperability and joint training in most strategic planning and training documents (see Figure 7-1, Organization for HSLs). In joint operations, the Services must be able to communicate on a continuous basis; this is especially true in the HSLs arena. Interoperability issues must be resolved early on to ensure that timely and effective HSLs can be provided. Interoperability issues include the hardware systems as well as AISs used by each Service.

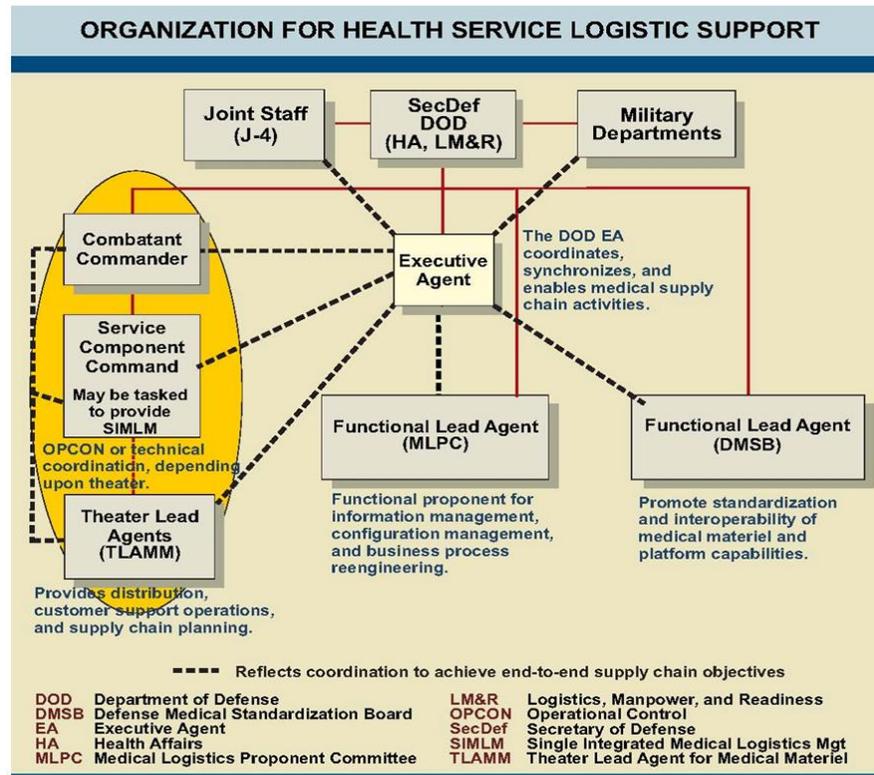


Figure 7-1. Organization for HSL

7.2.3. Defense Logistics Agency (DLA). The Director, DLA is designated the DOD Executive Agent (EA) for medical materiel, pursuant to Department of Defense Directive (DODD) 5101.9, *DOD Executive Agent for Medical Materiel*. The DLA is the major combat support agency that provides worldwide distribution support to the military departments and the combatant commands across the full range of military operations, as well as to other DOD components, Federal agencies, foreign governments, and international organizations. The DLA manages or distributes over 80 percent of the existing stock of defense materiel, including distribution of Service owned stocks and nearly all of the fuel and petroleum products for military use. Consequently, the DLA is one of the largest components in the global distribution network. The DLA is the single DOD POC for the following:

- 7.2.3.1. Synchronize planning and execution of end-to-end medical supply chain activities.
- 7.2.3.2. Improve the identification and coordination of contingency medical materiel requirements.
- 7.2.3.3. Provide financial resources necessary to achieve materiel readiness and end-to-end supply chain operation.
- 7.2.3.4. Establish acquisition programs necessary to ensure availability of medical materiel to meet CCDR requirements.

7.2.3.5. Establish, monitor, and report on medical supply chain performance.

7.2.3.6. Coordinate medical materiel requirements and national-level acquisition programs with other federal agencies, including the DVA, Department of Health and Human Services, and the Department of Homeland Security (DHS).

7.2.4. Theater Lead Agent for Medical Materiel (TLAMM). In a mature theater, there may be a TLAMM element linked to the combatant commands, JTF/SG, AFFOR/SG, deployed medical units, sustaining base, and the AFMLOC. The TLAMM may be jointly staffed to provide customer support and distribution operations. The TLAMM supports the theater medical logistics manager in facilitating materiel movement and in providing medical asset visibility. It is the organization designated to coordinate supply chain management for the entire operating theater or AOR. A TLAMM may be an existing organization that provides routine medical materiel support to theater HSS operations, or it may be an organization that is created as required for a specific OPLAN by deployment of the necessary HSLs capabilities. The TLAMM supports all Service components and designated multinational and/or nongovernmental customers.

7.2.5. Single Integrated Medical Logistics Manager (SIMLM). A SIMLM is established to promote supply chain efficiency and minimize the theater medical logistics footprint. When directed, the SIMLM, in coordination with the JFS, DOD EA, and supporting TLAMM (if designated), will develop an HSLs plan and identify the additional requirements necessary to provide medical logistics support to all designated customers and effectively extend HSLs into the theater in support of forward medical elements. SIMLM responsibility is assigned as required by a CCDR to a Service component command or JTF commander to provide medical logistics support to other Services and designated multinational partners.

CHAPTER 8

TRAINING

8.1. Medical Readiness Training. Medical readiness training for medical logistics personnel is required IAW AFI 41-106, *Unit Level Management of Medical Readiness Programs*. Medical readiness training requirements are divided into four categories: (I) individual training; (II) deployment training; (III) unit training; (IV) integrated training. Additional training may be required to meet theater-specific requirements. These theater-unique training requirements will be identified in deployment reporting instructions or tasking line remarks.

8.2. Mission-Specific Training for Medical Logistics Teams.

8.2.1. MRAs (ACC, AMC, and AFSOC) develop Mission Essential Tasks Lists (METLs) as part of their training management responsibilities. METLs will be developed based on force module packaging or for stand-alone UTCs as determined by the MRA. Mission-specific training should occur at the local level of the base, using team METLs.

8.2.2. The Readiness Skills Verification Program (RSVP) documents an individual's ability to perform specific readiness duties, such as hazardous materials (HAZMAT) handling, forklift operation, and pallet building. RSVP knowledge and performance items, along with associated training sources, are listed on RSVP checklists, which are accessible from Medical Readiness Decision Support System Unit Level Training Readiness Assessment (MRDSS ULTRA). Personnel should document completion of RSV requirements in MRDSS ULTRA IAW the RSVP guidance in AFI 41-106.

8.2.3. Mission-specific training should include, but is not limited to, HAZMAT, cargo preparation, pallet build-up, logistics modules (LOGMODs), vehicle operation, and software products. In some instances, EMEDS training is offered, or specialized experts provide on-site training for information systems. Review of current skill-level core tasks and familiarity in all areas of logistics are integral.

8.2.4. Training exercises should include equipment-specific training and actual procedures, when possible. This measure will help assure that teams are mission capable and ready for integration into the DMF.

CHARLES B. GREEN
Lieutenant General, USAF, MC, CFS
Surgeon General

ATTACHMENT 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

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Forms

AF 4033, PMI/AE Certification Label

Abbreviations and Acronyms

ACC—Air Combat Command
ACS—Agile Combat Support
AE—Aeromedical Evacuation
AEF—Air and Space Expeditionary Force
AETF—Air and Space Expeditionary Task Force
AFB—Air Force Base
AFFOR—Air Force Forces
AFMLO—Air Force Medical Logistics Office
AFMLOC—Air Force Medical Logistics Operations Center
AFMOA—Air Force Medical Operations Agency
AFMS—Air Force Medical Service
AFRC—Air Force Reserve Command
AFSOC—Air Force Special Operations Command
AFTH—Air Force Theater Hospital
AFTTP—Air Force Tactics, Techniques, and Procedures
AFWCF—Air Force Working Capital Fund
AIS—Automated Information System
AMC—Air Mobility Command
ANG—Air National Guard
AOR—Area of Responsibility
APOD—Aerial Port of Debarkation
APOE—Aerial Port of Embarkation
AS—Allowance Standard
ASD(HA)—Assistant Secretary of Defense (Health Affairs)
BCE—Base Civil Engineer
BMET—Biomedical Equipment Technician
BPA—Blanket Purchase Agreement
C2—Command and Control
CAOC—Combined Air Operations Center

CASF—Contingency Aeromedical Staging Facility
CBRN—Chemical, Biological, Radiological, and Nuclear
CCATT—Critical Care Air Transport Team
CCDR—Combatant Commander
CENTCOM—Central Command
C-NAF—Component Numbered Air Force
CONOPS—Concept of Operations
CONUS—Continental United States
CSDC—Consolidated Storage and Deployment Center
DAPA—Distribution and Pricing Agreement
DBPA—Decentralized Blanket Purchase Agreement
DCAM—DMLSS Customer Assistance Module
DHS—Department of Homeland Security
DLA—Defense Logistics Agency
DMF—Deployed Medical Facility
DMLSS—Defense Medical Logistics Standard Support
DMSB—Defense Medical Standardization Board
DNBI—Disease and Non-Battle Injury
DOD—Department of Defense
DODD—Department of Defense Directive
DVA—Department of Veterans Affairs
EA—Executive Agent
ECAT—Electronic Catalog
ECS—Expeditionary Combat Support
EML—Expeditionary Medical Logistics
EMEDS—Expeditionary Medical Support
GFCI—Ground Fault Circuit Interrupter
GPMJAB—Global Patient Movement Joint Advisory Board
GTN—Global Transportation Network
HAZMAT—Hazardous Materials
HQ—Headquarters
HRT—Health Response Team
HSLS—Health Service Logistics Support
HSS—Health Service Support
IA—Information Assurance
IAW—In Accordance With
ID/IQ—Indefinite Delivery/Indefinite Quantity
ITV—In-Transit Visibility
JFS—Joint Force Surgeon
JMAR—Joint Medical Asset Repository
JTF—Joint Task Force
LAF—Line of the Air Force
LOGMOD—Logistics Module
LRRC—Loaner Repair and Return Center
MAJCOM—Major Command
MASF—Mobile Aeromedical Staging Facility
MC-CBRN—Medical Counter-CBRN

MEFPAK—Manpower and Equipment Force Packaging
MERC—Medical Equipment Repair Center
METL—Mission Essential Tasks List
MILGRP—Military Assistance Group
MISCAP—Mission Capability
MLMC—Medical Logistics Management Center
MLPC—Medical Logistics Proponent Committee
MOC—Medical Operations Center
MRA—MEFPAK Responsible Agency
MRDSS ULTRA—Medical Readiness Decision Support System Unit Level Training
Readiness Assessment
MTF—Medical Treatment Facility
NCC—Network Control Center
NOSC-D—Network Operations and Security Center–Deployed
OCP—Operational Capabilities Package
O&M—Operation and Maintenance
OCONUS—Outside the Continental United States
OPLAN—Operation Plan
OPR—Office of Primary Responsibility
OSI—Office of Special Investigations
PACAF—Pacific Air Forces
PMI—Patient Movement Items
PMITS—Patient Movement Items Tracking System
POC—Point of Contact
POM—Program Objective Memorandum
PV—Prime Vendor
RAS—Remote Access Server
RDS—Records Disposition Schedule
RIA—Regional Incentive Agreement
RSVP—Readiness Skills Verification Program
SATCOM—Satellite Communications
SG—Surgeon General, Surgeon
SIMLM—Single Integrated Medical Logistics Manager
SOF—Special Operations Forces
SOUTHCOM—Southern Command
TEWLS—Theater Enterprise Wide Logistics System
TLAMM—Theater Lead Agent for Medical Materiel
TMIP—Theater Medical Information Program
TMIP-J—Theater Medical Information Program-Joint
TTP—Tactics, Techniques, and Procedures
WMD—Weapons of Mass Destruction
WRM—War Reserve Materiel
USAFE—United States Air Forces in Europe
USC—United States Code
USTRANSCOM—United States Transportation Command
UTC—Unit Type Code