# Equipment Sourcing for Hospital Units Deployed to Operation Desert Shield

Col Richard I. Donahue, MS*

William H. Howell**

*Operations Desert Shield and Desert Storm required the Army to deploy 35 equipped active and reserve component hospitals in a narrow time window—the largest such deployment since World War II. Equipment for deploying units was shipped from multiple locations to a single staging facility in the theater of operations. This article provides a synopsis of this effort and some observations for future efforts.*

Deployed hospital units were provided equipment through three actions: doctrinal sourcing, packages to fill Deployable Medical Systems (DEPMEDS) equipment shortages and 5-Ton Truck fieldings. Doctrinal sourcing involves the use of home station, primary mobilization (PRIMOB) and prepositioned materiel configured to unit sets (POMCUS) stocks for major equipment and the flow of potency and dated (P&D) materiel. The DEPMEDS shortage packages included materiel fixes and filling shortages not available during initial fieldings. The 5-Ton Truck shipment dealt specifically with units modernized in-theater or equipped from PRIMOB assets.

## Equipment Sourcing

Doctrinal sourcing strategies included shipment of home station equipment. Active component (AC) hospitals that had fielded DEPMEDS equipment deployed their entire Table of Organization and Equipment (TO&E). Active and reserve component POMCUS-equipped hospitals shipped all on-hand other support equipment (OSE) and common table of allowances (CTA) nonmedical items. Reserve PRIMOB-equipped units shipped their minimum essential equipment for training (MEET) sets in addition to the same materiel as POMCUS units.

Another doctrinal sourcing action included POMCUS and PRIMOB equipment sets but in a manner modified from existing operational plans. First, some active component units deployed directly from the US to the theater with their complete home station equipment instead of drawing POMCUS sets. This broke POMCUS unit residual equipment (PURE) relationships and resulted in some reserve units drawing active components POMCUS sets. Secondly, several non-DEPMEDS equipped AC units were provided with DEPMEDS new equipment training (NET) prior to deployment and drew POMCUS sets as their initial "fielding." Also, the hospital troop list was built in stages and was inconsistent with "flagged POMCUS" units; this did not allow the direct relationship between POMCUS sets and unit flags to be maintained. More accurately, POMCUS sets were used as a theater reserve source of equipment for hospitals with the greatest need based on deployment sequence.

Lastly, medical material sets (MMS) are placed into long-term storage (POMCUS and PRIMOB) without any P&D items (those items with a shelf-life of under 60 months). As a result, both the US Army Medical Materiel Center, Europe and the US Army Medical Materiel Agency (USAMMA) were required to build initial P&D packages from owned assets or new procurement through DPSC and push them into the theater.

## Additional DEPMEDS Equipment Packages

In conjunction with unit shipments from home stations and storage depots, equipment packages were assembled and shipped to provide additional hospital capability. Some of these packages provided shortage items while others introduced new and more reliable technology.

Although the sets were functional, the early fielding of DEPMEDS equipment was accomplished with less than a complete package. Since the initial fielding was started in the third quarter of fiscal year 1987, many of the shortage items had been delivered, stored at the Defense Depot Odgen, Utah (DDOU), and made available for shipment to deploying hospitals. An average of three to four military van containers with shortage materiel were sent to each unit. At the same time, recently developed equipment sets, including the Hi-Cap x-ray Apparatus, Lo-Cap x-ray Apparatus (portable), Medical Services Clinic, specialty augmentation sets, Test, Maintenance Diagnostic Equipment (TMDE) and updated laboratory analyzers were completed at DDOU and shipped directly into the theater.

## 5-Ton Trucks

All US active component units equipped with DEPMEDS had 5-Ton Trucks on hand from Tank Automotive Command (TACOM) fieldings. The active and reserve units that drew equip-

**Abbreviations Used**

| | |
|---|---|
| CEGE | Combat Equipment Group, Europe |
| CTA | Common Table of Allowances |
| DCSF | DEPMEDS Consolidated Staging Facility |
| DDOU | Defense Depot, Ogden, Utah |
| DEPMEDS | Deployable Medical Systems |
| MEET | Minimum Essential Equipment for Training |
| MMS | Medical Materiel Sets |
| NET | New Equipment Training |
| OSE | Other Support Equipment |
| P&D | Potency and Dated Materiel |
| POMCUS | Prepositioned Overseas Materiel Configured in Unit Sets |
| PRIMOB | Primary Mobilization Equipment |
| PURE | POMCUS Unit Residual Equipment |
| TACOM | Tank Automotive Command |
| TMDE | Test, Maintenance Diagnostic Equipment |
| TO&E | Table of Organization and Equipment |

*Project Manager, Deployable Medical Systems, HQDA, Office of The Surgeon General, Falls Church, VA 22041-3258.

**Senior Logistics Management Specialist, Deployable Medical Systems, Office of The Surgeon General, Falls Church, VA 22041-3258.

ment from POMCUS were able to get trucks from US Army, Europe. If the designated POMCUS sets did not have trucks, the Combat Equipment Group, Europe (CEGE) cross-levelled trucks to meet the authorizations. PRIMOB equipped units were not afforded this opportunity to obtain trucks, and they deployed with only their home station authorization of four each. Compounding this situation, five active component units were modernized after deployment, well ahead of their scheduled fielding dates.

In order to meet the PRIMOB and modernization requirements, TACOM directed shipment of trucks from the production contract. These trucks were given priority shipment (medical equipment designation), which gave them access to the first available surface transportation to the theater. Deprocessing and issues were made to the gaining unit in theater.

## Fielding Process

As noted above, there were multiple shipments required to equip each hospital. Because of this complex process, the Project Manager, DEPMEDS, in conjunction with OTSG and USAMMA, deployed a fielding team to assist receiving units in obtaining their equipment. This team organized the DCSF and monitored shipping data, consolidated arriving shipments, deprocessed equipment, issued sets, provided NET as required and advised personnel on the initial set-up and operation of the hospitals. By the start of the ground offensive, the DCSF team had modernized five hospitals and processed equipment for the remaining 30 hospital units.

## Observations for the Future

The first and foremost principle learned from this operation was the need for flexibility. Regardless of operational plan sourcing and POMCUS/PRIMOB unit flags, hospitals will be designated for deployment based on a wide range of factors. These may have little to do with their actual equipping status but rather such categories as personnel fill, training, experience or deployment timeframes. Therefore, the logistics system must react quickly to find the most feasible method to meet equipment requirements. As a result, established PURE, POMCUS and PRIMOB relationships can be quickly broken and equipment sourcing will be determined by the deployment timeframe, readiness of sets and equipment location. The bottom line is, however, that the PRIMOB/POMCUS concept works and provides flexibility to source large deployments such as Operations Desert Shield/Storm.

In most instances, the equipment shipments were classified as open cargo shipments and were not identified by a unit location number. This had two major repercussions. First, priority of transportation is normally given to unit shipments rather than commodity (medical) shipments. Without the gaining command's (Central Command/Army Central Command) guidance and influence, hospital shipments could have easily been the last into the theater. The priority was obtained during Desert Shield, however, and so the required delivery dates were met. Secondly, the commodity cargo status made it more difficult to maintain the visibility of the equipment while it was in transit from the storage site or home station. Materiel was scattered among multiple ships, and the exact items on each ship were not readily identifiable. This made the early deployment of a team for the DCSF critical for monitoring and consolidating all shipments. It is highly unlikely that the unit could have achieved full consolidation within a timely manner—if at all—without this assistance.

Movement of hospital units from the port facility to the staging areas near unit deployment sites was often completed using host nation support vehicles. This is a factor that must be considered whenever hospitals deploy. Army resourcing does not provide for 100% mobility in hospital units, and dependent upon the theater, there may be other than military line hauls available for units to use whenever possible. Otherwise, units will be completely dependent upon overtaxed military transportation and will be competing for priority. If units are not able to keep up with their supported division/corps forces, the evacuation line will be lengthened and casualties will increase. It is therefore imperative that unit commanders proactively seek out all transportation assets. ●