Medical Supply Requisition in the Decisive Action Fight

■ By Capt. Matthew L. Tillman

As our Army enters decisive action operations, many lessons need to be relearned by Soldiers who developed their skills in the recent conflicts. One such lesson is class VIII (medical materiel) requisition and distribution.

Brigade combat teams (BCTs) have managed class VIII as a line item requisition process. Units stocked up on supplies at operating bases and then requisitioned replacements. At the BCT level, the formal stock is held at the brigade medical supply office (BMSO), but in most locations, even medical platoons carry excess stock.

Using the Defense Medical Logistics Standard Support Customer Assistance Module (DCAM), units managed these stocks with automated reorder points and inventory management tools. The BMSO also used DCAM to manage the BCT's line item requisitions. DCAM, however, required space and reliable Internet connectivity.

As the Army again fights on the move and combat trains, field trains, and brigade support areas replace logistics nodes on forward operating bases, BCTs will need to relook at how they requisition class VIII. Forward support companies will eventually establish their very small aperture terminals to requisition repair parts, but medical logisticians cannot wait until their supported units require resupply to begin requisition.

The BMSO can partially solve this problem by articulating a well-rehearsed communications plan that includes primary, alternate, contingency, and emergency means for units to requisition class VIII. Units should continue to push for DCAM use in decisive action operations because of its inventory management tools. Blue Force Tracker will be needed to fill the gaps because of the distances that will be covered. As a contingency, emergency requisitions should be submitted by radio or, as a last resort, by paper requisition on supply backhaul.

Because the Army has become comfortable with excess stocks, which are hard if not impossible to move in decisive action operations, the BCT must scrutinize the BMSO authorized stockage list (ASL).

Field Manual 4–02.1, Army Medical Logistics, authorizes the BMSO to stock 100 to 300 lines to be "managed as a safety level and released to support the brigade when routine replenishment operations do not meet mission requirements."

Although the ASL is still used in current theaters, the BMSO will need to carefully tailor the number of lines carried to meet increased demand during early-entry operations and ensure that the amount does not become unmovable. (The current modified table of organization and equipment authorizes the BMSO only two cargo medium tactical vehicles and no specialized containers.)

An ASL review board is the key to successfully determining the right number and type of critical items. This review board is similar to those conducted by maintainers to determine which repair parts to stock in the BCT. The BMSO should start this process using historical demand data and then allow the clinicians of the BCT to review, make suggestions, and then formalize the ASL by having the BCT surgeon and the brigade support battalion commander officially authorize the list.

Field Manual 4–02.1 states, "The BMSO, upon arrival into the theater, will be resupplied by medical resupply sets or preconfigured push-packages until line item requisitioning is established." Likewise, the BMSO should plan to push preconfigured packages to supported battalions based on time and patient estimates generated as part of mission analysis and staff estimates. During operations, those planned pushes should be validated based on disease and nonbattle injury reporting for "sick call" medical supply and battle injury rates for trauma medical materiel.

The BCT should also coordinate with its supporting medical logistics company to make sure that external push-packages are relevant to supported units and every attempt is made to push supplies before they are required.

BCT class VIII requisition has come a long way, but some of the lessons learned will not apply as we transition into decisive action and early-entry operations where a mature theater medical supply infrastructure does not exist. Planners will need to anticipate requirements and manage stocks based on consumption that validates staff estimates.

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