JOINT PATIENT MOVEMENT REQUIREMENTS CENTER CONCEPTS OF AEROMEDICAL EVACUATION

Aeromedical Evacuation (AE) requires a team effort with the goal of delivering patients safely and efficiently to the appropriate destination. This paper will introduce essential AE terms, describe functional positions, and delineate the requirements for the referring physician and the Patient Administration Directorate (PAD) to create the Patient Movement Request (PMR). This will enable expeditious validation of patients by the Joint Patient Movement Requirements Center (JPMRC).

Initial Draft by Col Gilbert Hansen, USAF; Edited by: Col Thomas "Ed" Baldwin, USAF; assisted by LTC Diane Boese, US Army; Lt Col Dale Grey, USAF, Lt Col Jimmy Barrow, USAF; Maj Beth Sumner, USAF; and LT Robin Harris, US Navy

TABLE OF CONTENTS

JOINT PATIENT MOVEMENT REQUIREMENTS CENTER CONCEPTS OF AEROMEDICAL EVACUATION

REFERENCES:

AFI 41-301	World Wide AE System
AFI 41-307	AE Patient Considerations
AFI 10-2909	AE Equipment
DODI 6000.11	Patient Movement
AFI 11-2 V3 Chap 3	AE Operations Procedures
JP 4-02	Health Service Support

INTRODUCTION:

Aeromedical Evacuation (AE) requires a team effort with the goal of delivering patients safely and efficiently to the appropriate destination. This paper will introduce essential AE terms, describe functional positions, and delineate the requirements for the referring physician and the Patient Administration Directorate (PAD) to create the Patient Movement Request (PMR). This will enable expeditious validation of patients by the Joint Patient Movement Requirements Center (JPMRC).

TYPES OF PATIENT MOVEMENT:

Casualty evacuation (CASEVAC): a term used by all Services, refers to the unregulated movement of casualties aboard ships, vehicles, or aircraft.

Medical evacuation (MEDEVAC): MEDEVAC traditionally refers to US Army (USA), US Navy (USN), US Marine Corps (USMC), and US Coast Guard PM using predesignated tactical or logistic aircraft, boats, ships, and other watercraft temporarily equipped and staffed with MAs for en route care. MEDEVAC has generally implied the use of rotary wing aircraft with medical attendants (MA).

Aeromedical Evacuation (AE): AE specifically refers to USAF provided fixed-wing movement of regulated casualties using organic and/or contracted mobility airframes with AE aircrew trained explicitly for this mission. The AE system can operate as far forward as fixed-wing aircraft are able to conduct air/land operations.

THE AE CREW:

A basic AE crew is five people: a flight nurse serving as the Medical Crew Director (MCD), a second flight nurse and three AE technicians. A smaller three member Alert Crew has a nurse and two technicians. Alert Crews pick up urgent

or priority patients between planned missions and can care for a maximum of five patients.

TYPES OF AE MISSIONS:

Dedicated AE pilots and aircraft no longer exist in the Air Force. Today the C17, C130, KC135R and occasionally other aircraft are shifted as needed from their regular cargo or refueling missions and scheduled to pick up the AE crew and patients.

Channel Airlift Mission: Common-user airlift service provided on a scheduled basis between two points. There are two types of channel airlift. A *requirements channel* serves two or more points on a scheduled basis depending upon the volume of traffic; a *frequency channel* is timed based and serves two or more points as regular AE missions are not solely for patient movement; floor space may still be utilized for cargo or space-A passengers. These are pre-planned, designated missions and are built into the Air Tasking Order (ATO) and do not interrupt the scheduled flow of cargo. AE missions can and often do cross international boundaries, so there are necessary administrative documents to be cleared before patients can be moved.

Standard Air Routing (STAR) Mission: The intra-theater AE C-130 mission. The majority of patients moved on STAR missions originate and terminate in the same country, simplifying the administrative clearance. STAR missions pick up patients at Forward Operating Bases (FOBs) and drop them off at the "Hub". These hubs are Balad for Iraq and Bagram for Afghanistan. STAR missions are also used to move patients who qualify for the Return to Duty (RTD) program. RTD is a program that allows commanders to keep their personnel by allowing them to have surgery and recover in theater and return to duty in 30 days or less in conjunction with CENTCOM policy. Two facilities are used for this program; Al Udeid in Qatar, and EMF-K at Camp Arifjan in Kuwait. STAR missions can be quite grueling; the C-130 may stop at 4 to 7 FOBs on the way to the Hub performing evasive landing and takeoff profiles. Patients are open regulated to the two hubs, but referring physicians must obtain acceptance from the appropriate specialist at Al Udeid in Qatar, and Expeditionary Medical Facility-Kuwait (EMF-K) at Camp Arifjan prior to AE. This verifies that the correct specialist is available at that location to provide the required care.

CONTINGENCY AEROMEDICAL STAGING FACILITY (CASF):

A Contingency Aeromedical Staging Facility (CASF) is a facility with a mission of holding patients that are cleared for AE and waiting for the aircraft to arrive. A CASF is therefore like a PAX terminal only with beds and medical attendants. CASFs are located at Balad, adjacent to the hospital and at Ali Al Salem, Kuwait; unfortunately, the CASF at Ali Al Salem is a 90-minute ground or 20-minute helicopter ride from the Navy's EMF-K hospital at Camp Arifjan.

DRUGS AND EQUIPMENT:

AE crews are outfitted with flight tested/approved equipment and medication kits comparable in scope and capability to a hospital CRASH CART: oxygen, defibrillator/monitor, suction, IV supplies and ACLS drugs. They also have routine patient care supplies such as gloves, IVs, dressings and bandages and a small medication supply with common drugs such as acetaminophen and phenergan and some controlled medications such as morphine.

AE patients will be issued their own routine medications prior to flight. To simplify record keeping, parenteral narcotics can be dispensed from the AE narcotics box. Morphine and Demerol are available. Medication should be supplied for 1 day for intra-theater and 2 days for inter-theater missions IAW USTRANSCOM policy.

The flight testing process for equipment and medications is extensive and only some equipment used for patients in ground hospitals can be used in flight. It is important for referring physicians, flight surgeons and PADs to be well-versed in the equipment approved for flight by referring to **AFI 10-2909 AE Equipment.** Connectivity and compatibility with standard AE devices as well as power, oxygen, and suction are critical.

Pain and airsickness are common maladies of flight. It is incumbent upon the referring physician, flight surgeon or theater validating flight surgeon to ensure that PRN orders for pain and airsickness are on the 3899. Pre-medication with meclizine 25mg PO 1 hour prior to flight or phenergan 12.5 mg IV or IM during flight works well.

Oxygen is part of the standard AE equipment load and will be provided by the AE crew as ordered on the AF Form 3899. Oxygen orders should be clear and yet flexible enough to allow the AE crew ability to regulate the oxygen to the appropriate needs. For patient's breathing room air, 4 L of oxygen by nasal cannula will normally suffice to replace oxygen at 8000ft cabin altitude. Oxygen prescribing specifics will be covered in a later section.

TRAC2ES AND THE VALIDATION PROCESS:

The TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES) is DoD's system of record for patient movement. No patient is allowed to board an Air Force plane until they are on the Patient Manifest for that flight. They are placed on the manifest by the JPMRC after being validated administratively and clinically through TRAC2ES. There are no exceptions to this policy.

The electronic Patient Movement Request (PMR) and the paper AF Form 3899 are the sole means of communicating patient information to all parties involved in

the movement of patients. PMRs and 3899s are generated at the referring MTF by entering patient information into TRAC2ES. The PMR contains fields for important administrative data as well as clinical data. The 3899 has the referring physician's signature and is the legal document for in-flight care, as well as the patient's medical record.

The PMR Validation Process begins when the referring MTF, typically the Patient Admin Tech (PAD), electronically submits the PMR to the Joint Patient Movement Requirements Center (JPMRC). The PMR is validated by the administrative section and clinical section of JPMRC before forwarding to the Aeromedical Evacuation Control Team (AECT) as a movement requirement. AECT coordinates locally within the Air Operations Center in Qatar (intra-theater) or the Tanker Airlift Control Center (TACC) at Scott AFB (inter-theater) to designate an aircraft to fly the mission and to put an AE crew with it.

Along with JPMRC, GPMRC and TPMRC are the acronyms used for the Joint, Global and Theater Patient Movement Requirement Centers (PMRCs) respectively. JPMRC is located inside the Combined Air Operations Center (CAOC) at Al Udeid Air Base in Qatar with the mission to validate and manage all AE patient movement for the CENTCOM AOR. GPRMC is located at Scott AFB, Illinois with the mission to validate and manage all AE patient movement for the NORTHCOM and SOUTHCOM AORs. GPMRC also integrates medical regulating, evacuation service and centralized command and control for global patient movement. TPMRC-E is located at Ramstein AB, Germany with the mission to validate and manage all AE patient movement for EUCOM and AFRICOM AORs (JPMRC will continue supporting AE operations in HOA for AFRICOM until Oct 09). TPMRC-P is located at Hickam AFB, HI with the mission to validate and manage all AE patient movement for the PACOM AOR. The process of reviewing and validating the PMR at the JPMRC will now be explained.

The Patient Movement Clinical Coordinator (PMCC) is a flight nurse or specially trained enlisted medic in the PMRC that reviews newly submitted PMRs and can validate them under the supervision of the Theater Validating Flight Surgeon (TVFS). All Priority or Urgent patient movements are validated by the TVFS.

The TVFS is the attending physician for all patients during their AE movement. The TVFS must be provided with sufficient clinical information to make informed decisions about time-sensitive patient movement, aircraft requirements such as cabin altitude restrictions, patient medical items (PMI), patient isolation procedures, in-flight medications and oxygen requirements to ensure safe transport. The TVFS is the final authority for patient movement in the AOR. Only after the TVFS validates the PMR does the request become a requirement. AECT receives the requirement, assigns airlift, task AE Crews, and CCATTs as needed.

ADMINISTRATIVE VALIDATION:

The Patient Movement Ops Officer (PMOO) is a patient administration officer or enlisted medical administration technician that reviews the administrative data, and verifies patients are eligible for movement within the AE system. Contractors, Coalition Partners, Foreign Nationals and Civilians require course of action analysis before they can be validated for movement. The administrative data used by the PMOO is just as critical to the validation process as the clinical data, and the process cannot continue if it isn't complete. IAW CENTCOM OPORD and DODI regarding contractors; ID, passport, insurance information and a letter of authorization (LOA) must be provided in order for the PMOO to determine eligibility for AE movement.

PRECEDENCE:

Precedence is the word used in the PMR to describe how quickly a patient should be moved. Precedence is not intended to convey complexity: it is intended to convey the need for a patient to be moved quickly to a higher level of care in order for the patient to receive care not available at the current location and in a timeframe that meets clinical standards. PMRs must accurately reflect any time sensitive elements in order to plan usage of aircraft, and AE Crews.

URGENT is the highest precedence and is used when a patient is temporarily stabilized but needs to be moved to a higher level of care as quickly as possible to save life, limb or eyesight. The goal is to move these patients within 12 hours. The cargo mission will be disrupted to support the AE mission requirement. This process is called In-System Select (ISS).

PRIORITY is the precedence used when a patient is stabilized, but needs to be moved to a higher level of care for a defined clinical reason, and cannot wait for the next scheduled AE mission. The goal is to move these patients within 24 hours. Stabilized mass trauma, open fractures and angina are typically moved as priority patients. Priority bed clearing flights may be arranged if a hospital has a sudden influx and needs to empty beds. ISS is often used for priority patient movements as well.

ROUTINE is the precedence used for stable patients capable of waiting up to 72 hours for evacuation on the next scheduled mission. Routine patients validated for movement must be monitored and if their clinical status or medications change the PMR must be updated.

ATTENDANTS:

Medical attendants are required for patients with a dynamic clinical situation, such as continuous monitoring or intermittent monitoring with adjustments that cannot be anticipated as PRN orders for the AE crew.

SPECIAL TEAMS:

The Critical Care Air Transport Team (CCATT): This team includes a CCATT trained physician, nurse and respiratory technician and is used for patients requiring aggressive fluid resuscitation, ventilator management, or cardiovascular management. Endotracheal intubation is difficult in flight; if intubation is being considered then it should be accomplished before the patient movement begins. **Patients should not be extubated less than four hours before a flight.** If you opt to extubate a patient that has been validated as intubated then you **must** notify JPMRC of the change and the patient status must be updated.

Acute Lung Rescue Team (ALeRT) This Team consists of Joint Service providers to include: Critical Care Surgeon (1-2), Pulmonary/Critical Care Physician (1-2), Critical Care Nurse (1-2), and Respiratory Therapist (1-2). **The team always flies with a CCATT team.** This Specialized team will deploy out of Landstuhl Regional Medical Center (LRMC) to support patients with severe respiratory failure. The ALeRT team brings a variety of ventilator support systems including "Pumpless Extracorpal Lung Assist" with the NovaLung. Indications for alerting the ALeRT are: (1) Acute pulmonary process less than ten days from onset, (2) Oxygen saturation not less than 88% for more than 36 hours, (3) Includes one of the following: (a). Need for URGENT evacuation and not supportable by current transport ventilators. (b). Respiratory Failure in conjunction with intracranial injury.ICP>18 and PCO2 >45. (c). Respiratory acidosis with persistent pH < 7.2.
To activate ALeRT, first complete the PMR, and call JPMRC and discuss the case with the TVFS, then call the LRMC ICU at DSN: 314-486-7141 to discuss the case with The Pulmonologist on duty, he will assist with activation of the team.

EXPEDITING MOVEMENT:

It takes time to identify and generate an Urgent AE mission—usually 2-6 hours from validation. The mission-generation time-clock starts when the patient is validated. Submission of incomplete PMRs and waiting for JPMRC's "error back" message causes more work and doesn't support the validation process. The best way to expedite the validation process is to rapidly collect all necessary data, input the data into the PMR, push send and then call JPMRC to give them a heads-up that an urgent or priority PMR has been submitted. The 24/7 point of contact to assist in expediting patient movement is the Patient Movement Coordinator at JPMRC; DSN 318 436-4417 or 4418.

CLINICAL DESKTOP "CLIFF NOTES" OF AIR EVAC:

To assist PADs and physicians in supplying the necessary administrative and clinical information JPMRC has created the Clinical Desktop. This should be saved on the computer desktop of PADs and clinicians alike. Updated

frequently, this is the “Cliff Notes of AE”. Contact JPMRC for instructions on downloading the Clinical Desktop.

For Example, when you click on Burns:

Burns involving >10% total body surface (TBS) in children and adults over 50 years old and all burns involving >20% TBS, significant burns to the hands, face, genitalia or perineum, 3rd degree burns >5% TBS. Burns with inhalation injury requiring intubation and burns with significant pre-existing medical disorders, multiple trauma associated with burns or with significant electrical injury (including lighting) and chemical burns as follows: White phosphorus burns involving >5% TBS; vesicant gas involving >5% TBS, conjunctivae, or significant injury to airway should be coordinated with Brooke Army Medical Center prior to movement .

CLINICAL DATA:

This PMR Tab is designated for the attending physician’s clinical summary (similar to a Patient Discharge Summary) and is either copied or cut and pasted from the AF 3899 into the PMR by the PAD. This summary will appear in TRAC2ES and is used to clinically validate the patient. It follows the patient through the AE system. The properly signed 3899 is the official medical record referred to by the AE Crew in flight . The attending physician must agree with the diagnosis on the PMR prior to its submission to preclude disconnects that cause delay in validation. Summarize Chief Complaint, HPI, Injuries, surgeries performed and significant lab and radiologic findings. Don’t waste space with superfluous lab results and inconsequential history. This section is used by the TVFS to determine if the patient is safe to fly, precedence, classification, destination, and numbers of stops.

MADPAD—use this as an acronym mnemonic to remember key points, because all patients should have a…
Mechanism: e.g. IED, rollover, GSW, fall
At time: Time of injury or onset of illness, specify L for local or Z for Zulu
Description: of injury/symptoms, and location
Precedence: here is where you provide justification for the precedence.
Alert: put the mental status here; for example: AOx3 or GCS X/15;
Dolor: Latin for pain, put pre-medication and post med pain scales here

The local flight surgeon should add an assessment relative to flight after the attending physician’s note.

HSCAPE—mnemonic acronyms to assure you provide info about the patient from head to toe. The acronym stands for Head, Spine, Chest, Abdomen, Pelvis and Extremities.

Head: Major concerns for AE include pneumocephaly, intracranial hemorrhage or cranial edema from Closed Head Injury, eye injuries, or sinus blockage. If exploration of the head is all negative then state: head cleared clinically and/or by CT.
Spine: If the mechanism of injury could have caused a spine injury, then investigate and mention negative findings: Spine cleared clinically and/or by CT. If not cleared, then note specifically how patient will be transported. If a patient is sedated and the cervical spine cannot be clinically cleared, but a CT scan has been performed, then state that: c-spine cleared by CT but not clinically. Spinal immobilization is an important consideration that must be coordinated with neurosurgery or orthopedics.
Chest: This includes airway from jaw to diaphragm. If not intubated, then state reliability of airway and oxygen requirements. If intubated report vent settings and ABG. **Patients should not be extubated less than four hours before a flight.** Better to keep an improving patient on the ventilator for flight than to extubate and have a crisis in the air. Explore the possibility of pneumothorax or hemothorax and state how cleared i.e. via X-ray or CT. If not cleared, then report the location of the chest tube.
A small pneumothorax not treated will become a large pneumothorax at altitude. **A minimum of 24 hours is required post chest tube removal** with expiratory/lordotic chest x-ray, and the x-ray interpretation documented on the patient's 3899/PMR to have the patient validated for flight. **We would prefer you not pull chest tubes prior to flight in this AOR.**
Abdomen: Again, if mechanism of injury could lead to abdominal trauma, then state how abdominal injury was ruled out, i.e. abdominal exam negative by FAST exam. Comment on any trapped gas. Fix any acute abdomen finds prior to AE.
Pelvis: Simply state if the pelvis is stable or unstable. This is also a place to mention if a Foley is inserted.
Extremity: If there are no extremity wounds then simply note that: ext x 4 NVI; meaning all four extremities are neurovascularly intact. If there are extremity wounds then a statement about compartment syndrome should be included. If there are splints or wraps then a note about how they can be adjusted to accommodate swelling during flight should be included. For example: R-leg open fracture reduced, cleaned and external fixator applied; the calf is supple and not at risk for compartment syndrome. R-arm is in cast that has been bi-valved. L-leg crush wound with tense calf; fasciotomies have been performed. L-arm with circumferential 3-degree burns, escharotomies have been performed. **Remember to maintain an extremity splint/dressing "window" to facilitate neurovascular checks distal to extremity wounds/fractures.**

Labs need to be addressed after MADPAD and HSCAPE. The local Flight Surgeon summary may be accomplished after the initial PMR is submitted, and more recent labs should be included with the time drawn to remove doubt. If the patient was extubated, then note the time and the current O2 supplement and most recent O2Sat. Abbreviate where possible. Example: Out of OR at 1230L,

remains intubated with FIO2 of 40%, Peep 5, Sat 100%, PAO2 131, pH 7.38, CO2 41, BE -4; Hgb 9.5; Na 139, K 4.1, Ca 9.5, BUN 20, Cr 2

The following example shows a good, succinct CLINICAL DATA section write up:

21 y/o M, S/P IED blast, J221:0330L, sustained: FX R tallus and open FX L-tib-fib. Pt requires PRIORITY AE in order to get R-tallus FX pinned in less than 48 hours. Pt is AOx3, pain 7/10 before, 2/10 after meds; O2 sat 96% at RA. Head, spine, chest, abd, and pelvis cleared by CT and clinically. Pt to OR at 0500L where L tib-fib fxs washed and stabilized with external fixators; compartments were addressed with fasciotomy. Compartment syndrome no longer a concern; both extremities NVI. Pt extubated at 0700Z. Two hour post extubation O2 sat 96 % on RA. Pt is hemodynamically stable after 4 units PRBC and FFP; Four Hour Post Op labs: H/H 8.8/28, WBC 12K, Na 134, K 4.4, Cl 109, CO2 22. Foley in place to gravity. IV in L-arm RL @ 150cc/hr.

Short, sweet, and thorough!

MEDICATIONS:

This PMR Tab includes both medication for flight, and patient allergies. Phenergan is the drug of choice for air sickness, and is given IM or IV. **Zofran is great for post-anesthesia, but is not appropriate for AE.** For a PO medication meclizine works well. **WARNING!!** The Allergies section **default is "none"**. This is dangerous because if this is neglected at the PAD office and the PMR is submitted with the default of "Allergies: none" then JPMRC may validate thinking there are no allergies when there are, and could lead to significant risk to the patient in transit.

VITAL SIGNS:

It is important in this PMR Tab to ensure that the Date/Time accurately reflect when the vitals were taken. If the patient has a temp, is there an infection hazard? See the ROC List on the Clinical Desk Top for contagious illnesses to consider on AE flights. If the pulse is >100 is there a reason evident? Is the patient on a monitor? If the respirations are >20 is there a reason evident? CXR? Oxygen desaturation is the most common indicator of trouble on AE flights, any suggestion pre-flight of trouble is a major red flag.
WEIGHT: A regular NATO litter is only certified for up to 250 lbs. For heavier patients, the Army Decon litter is certified up to 350 lbs or the oversized litter (OSL) for patients greater than 350 lbs. **Note: the limiting factor is not only the litter, the cantilever arms on the C-17 are only rated by BOEING at 250 lbs for top position, and 275 lbs for the mid and lower position. The Patient Support Palate (PSP) top position is rated at 220 lbs, and at 320 lbs for mid and lower positions.**

OXYGEN: During the validation process the ground level oxygen prescription is converted into the flight level oxygen prescription. Make certain the ground level prescription that you use for the starting point is current and accurate. This is a common cause for phone calls back to the MTF to inquire about current oxygen requirements.

IAW AFI 41-307 Patients with hemoglobin below 8.0 mg may be transported if the condition is chronic and stable, and not related to bleeding. Patients with a hematocrit below 25% are not airlifted without concurrence of the Validating Flight Surgeon (VFS). Low flow O2 is used continuously on patients with extremely low hemoglobin or hematocrit levels, as in dialysis and chemotherapy patients. An altitude restriction below 5000 feet may be ordered by the VFS.

Guidelines to Determine Oxygen Requirements **PATIENTS CONDITION**	**IN-FLIGHT O2 REQUIREMENTS**
Chronic Low Hgb:	
8.5-10 7.0-8.5 Below 7.0	Oxygen Available Oxygen at 2L for flight AE Validating Flight Surgeon
Post-Op Low Hgb (acute):	
9.0-10 8.0-9.0 Below 8.0	Oxygen Available Oxygen at 2L for flight AE Validating Flight Surgeon

LAB: Hemoglobin of 8 is safe to fly only if it's stable. It can't be assumed to be stable an hour after trauma surgery, so repeats are essential. Any question, transfuse or send blood.

PATIENT MOVEMENT INFORMATION DATA (PMI):

This PMR Tab contains 8 fields to enter PMI equipment. All other equipment information should be entered under **"CLINICAL DATA"** tab**. The Wound VAC must have model/serial number recorded on the PMR**; Foley if applicable; **Chest tubes should have type specified such as Atrium** with suction also specified; Ambit pain pump; cardiac monitor status etc. go here. **It is extremely important to ensure that all equipment is appropriately annotated in the PMR.** Aircraft are restricted in amperage. The AECT can determine ahead of schedule what electrical requirements will be required for the mission if the equipment is completed accurately.

ADMIN REMARKS:

This PMR Tab is where JPMRC usually puts information concerning patient authorization for movement across national boundaries such as passport/visa

info. Also, here is where the TVFS orders are placed specifying: In-flight oxygen, Stops, RONs, Cabin Altitude Restrictions (CAR) and in-flight checks and medicines not already ordered elsewhere. If the PAD runs out of room in the Clinical Data Section then this section can also be used as a continuation section for Clinical Data as necessary.

ERROR BACK:

The TRAC2ES system allows the PMCC to send requests for additional information back to the PAD/MRO before validation. This error-back function unlocks the PMR so that the requesting PAD can modify and update the PMR with the requested information. The PMR shows a status of "Error Back" in TRAC2ES and it is the responsibility of the PAD technician of the requesting facility to answer the question or have the doctor call the TVFS. The validation process is on hold until changes are made. A list of common problems that cause the JPMRC to "error back" PMRs for clarification will now be presented using vignettes.

Example 1: PRIORITY PMR question: A 25 y/o female with a newly discovered breast lump and no other medical condition is submitted as a PRIORITY with no explanation as to the "time-sensitive" nature of the procedure that she was being evacuated to receive. She was an outpatient and should have been submitted as ROUTINE. This person's health will not be adversely affected if AE cannot pick her up for 72 hours. Also, she is clinically stable. Therefore, submitting the PMR as PRIORITY in an attempt to get her out on the next plane only slows down the process because the PMR will need to be "errored back" with a request for the PAD to change the precedence request from PRIORITY to ROUTINE.

Example 2: PRIORITY PMR question: a 50 y/o male with right upper quadrant pain and suspected cholecystitis, no fever, moderate pain controlled on meds is submitted as a priority. This PMR would be "errored back" for clarification. OK, there is a possibility that this person could be either a PRIORITY or a ROUTINE, but more data would back up this request. After error-back for clarification, we learned that this patient has long standing diabetes and is at high risk for gangrene—thus, the PRIORITY is justified. Bottom line, to avoid the error-back, put a clear reason in the PMR why the patient should be PRIORITY. It is not clear until it is written in the PMR.

Example 3: URGENT PMR: A PMR was submitted with the following: 27 y/o male s/p IED; hemodynamically unstable; L BKA, R open tib-fib fx NVI but at risk for compartment syndrome; FAST incomplete due to unstable condition; intubated and exploratory lap in progress; 16 units of PRBC and FFP given so far; will need CCATT. Even though it is clear this patient will need AE and CCATT, JPMRC will not validate a PMR until we have clinical information that the patient is finished with surgery and is in fact stabilized. This case would be in

“error back” status requesting post op vital signs, oxygen requirements, ventilator status, and lab data.

THEATER VALIDATING FLIGHT SURGEON:

An organized approach to validation assures nothing important is missed. Here’s one way to approach the PMR.

1. **PATIENT DEMOGRAPHICS:** Check if you agree with precedence, classification and CCATT. Add patient info to TVFS spreadsheet.

2. **MOVEMENT INFORMATION:** note if BI or DNBI and update spreadsheet.

3. **ADMIN DATA:** Check origin and destination of patient. Remember to think about airfield elevation for patients with gas expansion or oxygenation issues. This data is available at: http://worldaerodata.com/countries/. Also, most intra-theater missions should have the theater hub as the destination rather than LRMC.

4. **CLINICAL DATA:** Read through the section and underline all important negatives or positives. This is the meat of the PMR. If you do not understand what is going on with the patient you must talk to the attending physician. Though the attending physician’s telephone number is supposed to be on the PMR it is almost always wrong, so we make one attempt to call and then “error back” the PMR to the PAD tech and ask them to find the attending and have them call the TVFS.

5. **TVFS Orders:** All TVFS orders need to validate the precedence, classification, CCATT-yes/no status, destination, in-flight oxygen, STOPS, RONS, CAR, monitoring and any additional medicines or instructions.

CONTACT INFORMATION:

The Joint Patient Movement Requirements Center can be contacted at:
DSN: 318-436-4417/4418,
VOSIP: 308-436-3054,
DSN Fax: 318-436-4359
E-mail CAOCJPMC@AUAB.AFCENT.AF.MIL

PATIENT CLASSIFICATION
Date edited: January 2009

The attending physician determines patient classification and are classified in the following manner:

CLASS 1: Neuropsychiatric Patients: Inpatient Status

1A - Severe Psychiatric Litter Patients. Psychiatric patient requiring the use of a restraining apparatus, sedation, and close supervision at all times. Should have a medical attendant.

1B - Psychiatric Patients of Intermediate Severity. Psychiatric patients requiring tranquilizing medication or sedation, not normally requiring the use of a restraining apparatus, but who can react badly to air travel or who may commit acts that could endanger themselves or the safety of the aircraft. Keep restraining apparatus available for use. Should have an attendant.

1C - Psychiatric Walking Patients of Moderate Severity. Psychiatric patients who are cooperative and who have proved reliable under observation. May or not require an attendant for movement.

CLASS 2: Inpatient Litter Patients (Other than Psych)

2A - Immobile Litter Patients. Patients unable to move about on their own volition under any circumstances.

2B - Mobile Litter Patients. Patients able to move about on their own volition in an emergency.

CLASS 3: Inpatient Ambulatory Patients (Other than Psych)

3A - Ambulatory patients, non-psychiatric and non-substance abuse, going for treatment or evaluation.

3B - Recovered ambulatory patient returning to home station.

3C - Ambulatory, drug or alcohol (substance) abuse, going for treatment

CLASS 4: Infant Category

4A - Infant under 3 yrs of age, occupying and aircraft seat, going for treatment.

4B - Infant requiring an incubator, litter type, going for treatment.

4C - Infant under 3 yrs of age, litter type, going for treatment

CLASS 5: Outpatient Category

5A - Ambulatory outpatient, non-psychiatric, non-substance abuse, going for treatment.

5B - Ambulatory outpatient, drug or alcohol (substance) abuse, going for treatment.

5C - Psychiatric outpatient going for treatment.

5D - Outpatient on litter for comfort, going for treatment.

5E - Returning outpatient, on litter for comfort.

5F - Returning outpatient, returning to duty.

CLASS 6: Attendant Category

6A - Medical Attendant: Physician/Nurse/Tech required for specific medical needs based on the patient's condition and treatments required in flight.

6B - Non-Medical Attendant; Family/Unit member for the purpose of providing assistance on an AE mission, based on the following: "IAW DoD 6000.11"