



UNITED STATES TRANSPORTATION COMMAND

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APR 29 2008

MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE
EUROPEAN COMMAND, COMMAND SURGEON
PACIFIC COMMAND, COMMAND SURGEON
SOUTHERN COMMAND, COMMAND SURGEON
NORTHERN COMMAND, COMMAND SURGEON
CENTRAL COMMAND, COMMAND SURGEON
DEP DIRECTOR, TRICARE MANAGEMENT ACTIVITY
GPMRC
TPMRC-E
TPMRC-P
JPMRC

FROM: USTRANSCOM/TCSG

SUBJECT: USTRANSCOM/SG Policy Directive for Inter-theater Patient Movement (PM) to Continental United States (CONUS)

1. USTRANSCOM is committed to providing the highest quality medical care to all personnel moving through the patient movement system. This policy letter addresses inconsistencies identified in the regulation and validation of patient movement requests generated in different theaters. In an effort to standardize the regulation and validation of intertheater patient movement to CONUS medical treatment facilities, the attached policy will become effective 30 days from the date of this letter.

2. If you have any questions, please contact my POC, Lt Col Lisa McKinney, Chief, Global Patient Movement Requirements Center (GPMRC) @ DSN 779-7171.

WILLIAM K. STATZ
COL, MC, USA
Command Surgeon

OPR: GPMRC

Attachments:

- 1) USTRANSCOM/TCSG Policy Directive for Inter-theater Patient Movement (PM) to Continental United States (CONUS)
- 2) List of Special Patient Classifications
- 3) Contractor Information
- 4) Does My In-patient Require an Accepting MD & Algorithm



cc:

HQ AETC/SG

HQ AFRC/SG

HQ ANG/SG

HQ AMC/SG

HQ CENTAF/SG

HQ PACAF/SG

HQ USAFE/SG

USTRANSCOM/TCSG POLICY DIRECTIVE
PATIENT MOVEMENT (PM) TO AND WITHIN THE CONTINENTAL UNITED STATES
(CONUS)

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1. **Purpose:** To establish policy on standards for validation and regulation of Patient Movement Requests (PMRs) to and within the Continental United States.

2. **References:**

2.1. DoDD 6000.12; Health Services Operations and Readiness, 29 Apr 96. (Certified Current as of 24 Nov 2003)

2.2. DoDD 5154.06; Armed Services Medical Regulating Directive, 12 Jan 05.

2.3. DoDI 6000.11; Patient Movement, 9 Sep 98.

2.4. Joint Pub 4-02; Health Services Support, 31 Oct 06.

2.5. AFTTP 3-42.5; Aeromedical Evacuation (AE) – AF Tactics, Techniques, and Procedures, 1 Nov 03.

2.6. AFI 41-307; Aeromedical Evacuation Patient Considerations and Standards of Care, 20 Aug 03, IC1, 10 Aug 07.

2.7. OTSG/MEDCOM Policy Memo (current edition)

2.8. USCENTCOM Guidance on Through Regulation of Patients Outside of Area of Responsibility (AOR), 28 Jun 2005

2.9. USTRANSCOM MEMORANDUM: Level of Care Transfer Requirements for Patient Movement Operations, 5 Apr 2004 (superseded by this policy)

2.10 AMC/SG MEMORANDUM: Reference USTRANSCOM/SG Policy Letter dated 10 Jul 06 “Medication Administration, Self-Medicating Patients and Controlled Substance Accountability within the Patient Movement (PM) System”, 5 Oct 2006

2.11. DEPUTY SECRETARY OF DEFENSE MEMORANDUM, Policy Guidance for Provisions of Medical Care to Department of Defense Civilian Employees Injured or Wounded While Forward Deployed in Support of Hostilities, 24 Sep 2007

3. **Applicability:** This policy applies to all personnel involved in the patient movement process from point of origin through destination.

4. **Policy:**

4.1. In order to safely regulate patients to destination MTFs, it is essential that the PMR accurately reflects the patient’s current condition and provides a succinct care summary to ensure the receiving MTF is prepared and capable to assume care of the patient upon arrival. Additionally, the PMR and AF Form 3899 communicate the care plan and orders to all en-route care providers, including Aeromedical Evacuation crews (AE), Aeromedical Staging Facilities (ASF), Theater Validating Flight Surgeons (TVFS), and Patient Movement Requirements Centers (PMRCs).

4.1.1. Currently, the only authorized system for PMR submission and tracking is the TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES). However, there are several other Electronic Medical Database (EMD) systems being utilized to document patient care for patients originating from the AOR (e.g. Joint Patient Tracking Application [JPTA], Theater Medical Data Server [TMDS], etc.). With the requirement to document patient data separately in each system it is easy to omit important patient information in either system. While it is not the responsibility for PMRCs to track patients utilizing other EMD systems, it is their responsibility to ensure accurate clinical and administrative information is documented in the PMR submitted via TRAC2ES. If information in the PMR conflicts with information found in the EMD, the PMRC shall gain clarification from the referring MTF and ensure proper documentation.

4.1.2. PMRCs shall update PMRs after surgical or invasive (ie insertion of CVP, SWAN, Art line, CT) procedures or after significant changes in clinical condition. The PMR should remain either in a validating or errored state until all clinical information is updated. EXCEPTION: Urgent/Priority patients traveling with Critical Care Air Transport Teams (CCATT) may be validated to expedite movement on a case-by-case basis in coordination with the attending physician and the Theater Validating Flight Surgeon and shall be clearly documented in the PMR.

4.1.3. **PMR Clinical documentation:** Before the PMR can be validated clinically, documentation shall include:

- a. Diagnosis and appropriate medical specialty
- b. An accurate and concise history of the patient's current medical condition, any significant past medical/surgical/psychological history that could be aggravated by PM, and reason for current PM
- c. Date/time of last surgery if applicable
- d. Current vital signs (Attachment 4)
- e. Significant current lab values (Attachment 4)
 - Must have current H/H for all trauma/post-op patients
- f. If ventilated, must have most current ABG results (within 12-24 hours of validation)
- g. Oxygen requirements
- h. Pain management (Attachment 4)
- i. Self medicating patients must be clearly identified
- j. Regional and epidural pain management infusions must be well documented to include medication, location, rate of infusion, pump type, and who is providing oversight of epidural infusion (note: IAW Ref 2.6, patients with an epidural require a medical attendant. If attached to a CCATT stopping at port of entry but patient is going past port, a medical attendant must be assigned to go past port to final destination)

k. Current medications/IVs - shall mirror the 3899 and will include self-administered medication IAW AFI 41-307.

l. **Any procedures/treatments specifically addressed in AFI 41-307 related to patient's diagnosis** (i.e. chest X-ray results at least 24 hours post chest tube removal, post op Hgb)

m. Travel limitations (Stops, RONS, Cabin Altitude Restrictions, etc)

n. Patient equipment (e.g. External fixators, epidural pain pumps, cardiac monitors, chest tube drainage systems, type of wheelchair including dimensions [LxWxH], weight and if it is collapsible, crutches, etc.)

4.1.4. **PMR Administrative documentation:** Before the PMR can be validated administratively, documentation shall include:

a. Complete patient demographics:

- Name, Status, ID, Nationality, Grade, Age, Classification, Precedence, Gender
- CCATT/Specialty Team (if required)
- Special status (if patient meets criteria established in Attachment 1)

b. Unit information (should be complete as possible to include contact information to facilitate notifying unit of delays/changes and to determine appropriate destination treatment facility)

c. Place of Residence

d. Injury Type and Casualty Event (as appropriate)

e. Origination and Destination MTF

f. Ready Date/Time (Attachment 4)

g. Reason Regulated

h. Attending Physician's name and contact information

i. Accepting Physician's name and contact information (as required)

NOTE: Non-contingency patients can only be moved on a non-interference basis. If a non-contingency inpatient is transiting a CONUS ASF that does not have inpatient capability, an interim RON accepting physician must be arranged by the sending MTF and documented in the PMR should no immediate follow-on mission to patient's final destination be available. The accepting RON MD, MTF, patient and family should be made aware that if there are no contingency requirements, the patient/family could have extended stays at the RON location(s). Family/NMAs are responsible for all costs associated with travel/lodging. The sending MTF must clearly convey this to the family/NMA prior to movement and a statement of understanding annotated in the PMR.

j. Insurance information (if applicable)

k. Attendant information if required

l. If patient is a non-uniformed service personnel, document IAW 4.9.

4.1.5. Movement Remarks: The sending MTF shall ensure the receiving facility is aware of all inbound patients (inpatient and outpatient). PMR documentation shall reflect clinical service, name of individual contacted at the receiving facility to confirm capability, capacity and pick-up of the incoming patient and/or family, whether patient is traveling by military or commercial air. **EXCEPTION:** Does not apply to MTFs located in a Joint Operational Area (JOA). JPMRC should assist forward MTFs in coordinating with final destination MTFs for all through regulated patients.

Patients regulated via commercial air/ground shall have ticket number, itinerary (transport origin/destination), and planned departure/arrival date/time (select transport mode: commercial air/ground to access date/time field) documented in the "movement" section of the PMR to ensure receiving facility and patient's command are aware of patient's scheduled arrival, to coordinate patient pick-up. Flight number(s) and name of airline(s) must be documented in the movement remarks for all commercial flights.

4.1.6. Ground transportation coordination and documentation

4.1.6.1. Military Facilities: Ground transportation to and from flight-line by military treatment facilities is the responsibility of the sending and receiving facility. Documentation for patients moved by specialty transport teams (i.e. Burn Team, CCATT, NICU, etc.) shall include the following in the remarks section of the PMR: the preferred ground transport (AMBUS or ambulance), special equipment requirements, O2 requirements, cite numbers for other patients being managed by same specialty transport team, and name/contact information of person notified at receiving facility. Receiving PMRCs shall confirm accuracy of documented ground transportation arrangements prior to PM.

4.1.6.2. Civilian Facilities: When patients are moving to/from a civilian MTF, ground transport arrangements must be documented in the remarks section of the PMR. In addition to the required data fields documentation must include: name of ground transportation provider, 24-hour contact phone number, name of person contacted to confirm ground transportation arrangements, complete address of civilian facility (both sending and receiving as applicable), and admitting/discharge instructions/limitations (i.e. acceptance hours M-F 0800-1600, pt to be direct admit to ward 9C, etc.). PMRCs (both sending and receiving as applicable) shall confirm accuracy of documented ground transportation arrangements prior to PM.

4.1.6.3. Commercial Ticket Program: To ensure patient safety and accountability, patients regulated via commercial air must be ambulatory, require no medical attendant, and must not need assistance with carrying luggage. His/her medical condition must be stable and not anticipated to change during flight and the PMR must contain documentation in accordance with (IAW) 4.1.5. Additionally, the PMR shall contain the name of the individual or unit responsible for receiving the patient. Contact information for the individual/unit must also be included. The patient administration division for the receiving unit shall create an in-transit visibility (ITV) event in TRAC2ES confirming the date and time of patient arrival within 48 hours. They will then notify the destination PMRC to close the PMR. The PMRC shall confirm patient arrival prior to PMR completion.

4.1.7. Enroute documentation

4.1.7.1. Once a PMR is validated, only the PMRC can make changes/updates. To facilitate ongoing communication between en-route care providers when the PMR is in execution state, the TRAC2ES AF Form 3899 Progress Notes shall be used to document any updates or changes in patient status, equipment, medication orders/etc. A/E crews, ASF, TVFS, PMRCs, and transport personnel will then be able to view these updates in TRAC2ES prior to patient arrival. NOTE: These changes will not show up on the PMR Long Form but can be printed as needed and attached to the PMR Long Form for documentation purposes.

4.1.7.2. To ensure patient safety, any changes in patient condition/status that could be aggravated by PM must be evaluated by a VFS to determine if patient is safe to continue movement. The PMRC must be notified of changes. Upon notification, the PMRC shall document the change in condition as well as the name of the evaluating VFS.

4.1.7.3. Progress Notes will not be used to document administrative changes, especially regarding precedence, classification or destination, and shall not be utilized for updates prior to execution.

4.2. Level of Care Transfer Requirements: To safely move patients it is essential to maintain the same level of care from origination to destination. The sending physician is responsible for initial patient assessment and recommending the appropriate level of care for the patient during transport, in addition to precedence, mode (i.e. mil air or commercial) and destination for that patient. The PMRC is the final authority to determine level-of-care required for patient movement.

4.2.1. Trained medical personnel shall transport all patients not eligible for commercial movement. At a minimum, medical personnel must be current in Basic Life Support (BLS).

4.2.2. Any patient requiring en-route or in-flight care shall be transferred to a corresponding level of care. For instance:

4.2.2.1. A critical care patient attended by a CCATT shall be transferred to a comparable or higher level of critical care capability.

4.2.2.2. Patients, who are being treated in an ICU when the PMR is submitted and validated, should receive that standard of care until they reach their destination. The receiving facility must have the capability to maintain that level of care. Exceptions will be reviewed on a case-by-case basis in coordination with attending physician and TVFS and shall be clearly documented in the PMR.

4.2.2.3. A patient requiring cardiac monitoring in-flight requires ACLS trained personnel to transport from the flight line to the MTF (with appropriate monitoring).

4.2.2.4. An ambulatory patient recovering from a surgical procedure with no complications may be transported with BLS capabilities by medical technicians. NOTE: Enlisted personnel may only take control of narcotics, or other controlled medications if they have been trained and appointed by the MTF commander.

4.2.3. A patient validated by a PMRC for commercial passenger PM but moving via AE for convenience may be released to the care of their commanders, families, or other non-medical custodians.

4.2.4. Any service moving unregulated patients through "Other means" should make the appropriate arrangements with the receiving facility to ensure patient safety and the appropriate level of care is met when the patient arrives.

4.3. MTF Flight Surgeon (FS) Responsibilities. At the originating/referring MTF, physicians credentialed to practice flight medicine are responsible for determining whether patients can be moved safely by air transport. If one is not available, the PMRC is available for consultation. Recognize that medical clearance differs from clinical validation (Attachment 4) for movement. Clearance simply states to the PMRC the patient can be moved safely by air. All changes in patient status shall be communicated to the PMRC and TVFS. The FS will determine, after consulting with the referring physician and the PMRC/TVFS, whether to proceed with/postpone PM and/or whether a change in movement precedence is indicated.

4.4. Contingency Regulating:

4.4.1. DoDD 5154.06, paragraph 4.2 – In contingency operations, the Commander, USTRANSCOM, shall have the authority to regulate Uniformed Services patients from the supported combat theater directly into the theater military treatment facilities (MTFs) of the other Geographic Combatant Commands or the CONUS. Such regulation shall be based on the medical capability and bed availability information released by the respective theater TPMRC and/or surgeon or Military Services, for use by USTRANSCOM.

4.4.2. Contingency Regulating is invoked only when conditions exist that preclude using standard procedures. The USTRANSCOM/SG shall make recommendation to the USTRANSCOM/CC as to when, where and for how long contingency regulating should be invoked. (Attachment 4)

4.5. Open Regulation. Open regulation is designed for inpatients IAW section 4.4 above. Open regulation is only authorized for PM from an AOR to the supporting theater of operation (ref 2.8). All inpatients not meeting open regulation criteria shall be regulated to the MTF closest with capability to the patient's unit of assignment unless service specific guidance dictates otherwise. An accepting physician must be identified in the PMR by the sending MTF. The originating PMRC must verify this information prior to PMR validation (Ref 2.7). Unless service specific guidance dictates otherwise, all inpatients, regardless of destination MTF shall have an accepting physician. (See Attachment 3.)

4.6. Outpatient Regulation. Outpatients may be regulated IAW service specific guidance. In the absence of guidance, outpatients should be regulated to the MTF located within the TRICARE area in which the patient is enrolled (typically the MTF closest to their unit of assignment) and has capability to care for the patient's clinical needs. Sending MTFs and PMRCs shall use the TRICARE MTF Locator (<http://www.tricare.mil/mtf/>) to identify and verify medical capability. All of the facilities listed serve Active Duty and family members. This information is subject to change, therefore sending MTFs shall confirm any information presented with the destination MTF before submitting the PMR. The PMRC will also verify this information prior to validation. EXCEPTION: When patients are through regulated from a JOA, the JPMRC will assist the sending MTF in identifying the appropriate destination MTF utilizing the TRICARE MTF Locator.

4.7. Urgent/Priority precedence should not be used for outpatients except on a case-by-case basis. If a determination is made that a patient requires an elevated precedence for movement, an accepting physician must be identified by the sending MTF and verified by the validating PMRC. Arrangements must be made and annotated in the PMR that outpatients will be seen within 24 hours of arrival at destination facility.

4.8. **Attendants.** It is the responsibility of the sending MTF to provide Medical Attendants, if required, from origination to destination. The patient's destination should be determined by clinical needs and destination MTF clinical capability, not the desire to allow attendants to be released sooner. The only exceptions are patients who require a specialty transport team, i.e. CCATT. Patients who are attended by a specialty transport team should be regulated to port of entry due to the patient's acuity; however, if regulated past port of entry, the team is responsible to accompany the patient to the final destination. (Non-medical attendants are also required to travel to the patient's ultimate destination)

4.9. **Non-Uniformed Services Personnel.** All non-uniformed services personnel shall be validated and regulated IAW established policies and guidelines.

4.9.1. **DoD Civilians** – IAW Deputy Secretary of Defense Memorandum (ref 2.11), all DoD Civilians who become ill, contract diseases or are injured or wounded while forward deployed in support of U.S. military forces engaged in hostilities are eligible for medical evacuation and health care treatment and services in MTFs at the same level and scope provided to military personnel. The same system used to track Active Duty patients through the Military Health System shall be used to track DoD civilian employees injured in theater while forward deployed. Deployed civilians who were treated in theater continue to be eligible for treatment in an MTF or may choose a private sector medical facility.

4.9.2. **Contractors** – See Attachment 2; Contractor Information

4.9.3. **Foreign Nationals, Secretarial Designees, and all other special request moves** – Documentation must be made in the administrative remarks and must include Passport information (not needed for CONUS to CONUS moves) or other proof of authorization to enter the US and its territories (for all non-US citizens), name of individual, contact information and agency authorizing movement (i.e. State Dept), and fund cite for financial reimbursement as required. (For DHS administrative requirements please contact "Parolee Branch Information" at Com: (202) 305-2670)

5. **Definitions:** See Attachment 4

6. **Authority and Responsibilities:**

6.1. USTRANSCOM is the DOD's single manager for policy and standardization of procedures and information support systems for global PM. (Ref 2.4)

6.2. The GPMRC is a joint activity reporting directly to the USTRANSCOM. The GPMRC provides medical regulating services, including clinical validation, limited patient in transit visibility and evacuation requirements planning for intertheater PM and intratheater for CONUS. The GPMRC coordinates with supporting resource providers to identify available assets and communicates transport to bed plans to Service components, or other agencies, to execute the mission. (Ref 2.4)

6.3. The Commander, USTRANSCOM, with and through his or her direct reporting unit, the Global Patient Movement Requirements Center (GPMRC), shall have the authority to regulate Uniformed

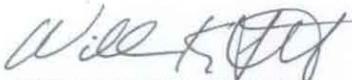
Services patients to and in the CONUS, in peacetime and contingency (both military and civilian) operations. (Ref 2.2)

6.4. The Heads of the DoD Components and the Heads of the Uniformed Services shall provide the USTRANSCOM Surgeon, GPMRC and Combatant Command Theater Patient Movement Requirement Centers (TPMRCs) the information required to support patient movement functions and responsibilities and will ensure the affected components of their respective Components comply with, and provide assistance for, the standardized implementation of policy, procedures, and AIS for patient movement management. (Ref 2.3)

6.5. MTFs are required to update their medical specialty capabilities in TRAC2ES semi-annually (March/Sept) at a minimum and shall monitor TRAC2ES daily to see if any patients have been regulated to their facility. Any changes in medical specialty capability shall be reported to the Service SG by the MTF concerned as they occur. Official notification to GPMRC of capability change shall come from the respective Service SG.

7. Effective Date and Implementation. Implementation date for this policy is 30 days from the date of this letter to allow for adequate dissemination.

APPROVED BY



WILLIAM K. STATZ
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Command Surgeon

OPR: GPMRC

Attachments:

1. List of Special Patient Classifications
2. Contractor Information
3. Does My Inpatient Require an Accepting MD?
4. Definitions

Attachment 1

List of Special Patients

1. Cardiac Patients

- Cardiac monitor for transport
- Implanted defibrillator/pacemaker
- ICU/CCU patient requiring cardiac IV medication drips

2. Blood Disorders Patients

- Anemia (Hgb <7.0) (AE specific)
- Sickle Cell Patients requiring altitude restrictions (AE specific)
- Patients requiring blood/blood products available for transport

3. Communicable Diseases Patients

- TB with <2 weeks treatment with TB meds
- MRSA/VRE (must be briefed to validating surgeon prior to any validation)
- ROC positive patients
- Contaminated patient movements

4. Continuous Intravenous/Intrathecal Medications

- ICU/CCU type IV drips (i.e. Dobutamine, Dopamine, Lidocaine, Nitroglycerin, Fentanyl, Propofol, etc)
- Heparin
- Insulin
- Patients with Epidural
- Patients with Nerve Block

5. Do Not Resuscitate Patients

6. Dialysis Patients

7. ENT/EYE Patients (AE specific)

- Eye injury/surgery with air in orbit requiring an altitude restriction
- Otitis media/barotitis requiring an altitude restriction
- Sinus blocks requiring an altitude restriction

8. OB Patients

- Active labor, medical attendant
- >34 weeks gestation, Airborn Life Support System (ALSS) on standby (AE specific)

9. Orthopedic Patients

- Cervical Spine/ Spinal Precaution Patients
- Stryker Frame/Traction

10. Pediatric Patients

- < 10 lbs requiring ALSS for temperature control
- Requiring attendant due to one-on-one medical nursing care
- Apnea monitor/pulse oximeter/cardiac monitor for transport
- Ventilator supported
- Traveling without parent or legal guardian

11. Respiratory Disorders Patients

- Ventilator patients

12. Specialized Teams Patients

- CCATT or equivalent
- ECMO Team
- Lung Team
- NICU Team

13. Special Operational Restrictions

- Urgent Patients
- Priority Patients
- Altitude restrictions (AE specific)
- Limited RONs
- Limited stops

14. Command Interest

- Any patient O-6 or higher (active duty or retired)
- E-9 depending on position
- Secretarial Designee
- Any other high visibility Patient Movement

Attachment 2

Contractor Information

DoD 4515.13R, Air Transportation Eligibility, Apr 1998

-Other U.S. Government Sponsored Patients. When a Government employee is classified as a patient requiring AE by competent medical authority and authorized Government transportation entitlements according to the JTR, Volume 2 (reference (c)), AE may be provided from overseas to a CONUS hospital or between medical facilities overseas, or in the CONUS. Reimbursement shall be made by the employee's Agency to the AMC at the non-DoD, Government tariff for all AE services provided.

DoDI 6000.11 Patient Movement, Sep 1998

-Beneficiaries of Other U.S. Government Agencies and Other Government-Sponsored Patients. Patients sponsored by a U.S. Government Agency and authorized Government transportation according to the JTR, Volume 2, may be provided patient movement. Reimbursement shall be made by the employee's Agency to USTRANSCOM at the non-DoD, U.S. Government tariff for all patient movement services provided

AE may be provided from overseas to a CONUS hospital or between medical facilities overseas, or in the CONUS. Reimbursement shall be made by the employee's Agency to the AMC at the non-DoD, Government tariff for all AE services provided.

-Reimbursements for Other: U.S. Government Agencies/Government-Sponsored Patients shall be made by the employee's Agency to USTRANSCOM at the non-DoD, U.S. Government tariff.

JP 4-02 Health Service Support

Medical support. The austere environment that contingency contractor personnel may deploy to and operate in, coupled with the potential for limited availability of indigenous medical capabilities in theater, dictates that GCCs through the contract, establish and enforce the requirements for health, dental, and physical standards. Contingency contractor personnel who become unfit to perform their contractor duties in theater through their own actions (e.g., pregnancy, alcohol or drug abuse), should be removed from the theater at the contractor's expense.

(1) During contingency operations in austere and non-permissive environments, contingency contractor personnel may not have access to emergency medical support established by their employer. MTFs within the theater of operations should provide resuscitative care, limited hospitalization for stabilization and short-term medical treatment, with an emphasis on return to duty or placement in the PM system; and assist with PM to a selected civilian facility, in emergencies where loss of life, limb, or eyesight could occur. All costs associated with the treatment and transportation of contingency contractor personnel to the selected civilian facility are reimbursable to the Government and is the responsibility of the contingency contractor personnel, their employer, or their health insurance provider.

(2) Contingency contractor personnel are afforded resuscitative and medical care, when life, limb, or eyesight is jeopardized, and emergency medical and dental care while supporting contingency operations. Emergency medical and dental care include, but are not limited to: refills of prescription or life-dependent drugs (Note: contractor personnel are required to deploy with 180 days of required medication and cannot be assured that their specific medication will be included on the theater pharmaceutical formulary), broken bones, lacerations, broken teeth, or lost fillings.

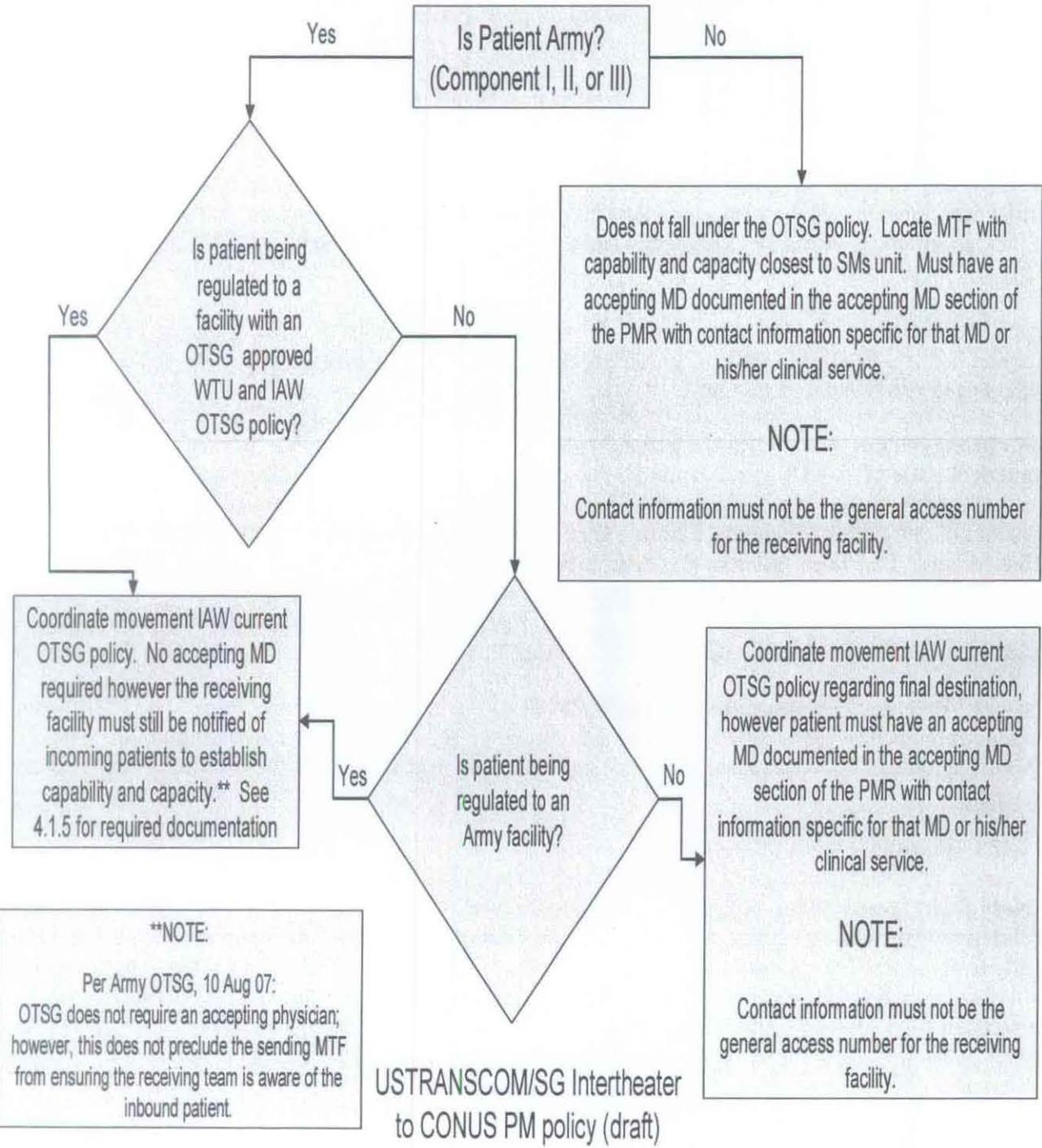
(3) Contingency contractor personnel are not authorized primary and routine medical or dental care unless specifically authorized under the terms of the DoD contract. Primary medical and dental care includes inpatient and outpatient services; non-emergency evacuation; pharmaceutical support; dental services and other medical support as determined by the GCC/CJTF based on recommendations from the JFS and existing capabilities of the forward-deployed MTFs. Contractors must make non-DoD arrangements to obtain all of their chronic prescription therapy.

(4) In instances where contingency contractor personnel require PM for medical reasons from the AOR/JOA to an MTF funded by the Defense Health Program, normal reimbursement policies would apply for services rendered by the facility. Should contingency contractor personnel require PM to CONUS, the sending MTF should assist the contractor personnel in coordinating arrangements for transfer to a civilian facility of their choice.

Attachment 3

DOES MY INPATIENT REQUIRE AN ACCEPTING MD?

NOTE: Categories 1-3 are all inpatient



Attachment 4

Definitions

Contingency - (DoD) A situation requiring military operations in response to natural disasters, terrorists, subversives, or as otherwise directed by appropriate authority to protect US interests. Source: JP 5-0. JP1-02

Current Vital Signs – Within 72 hours of validation for all routine inpatients, within seven days for all outpatients. Urgent/Priority pts must have V/S documented within 12 hours of validation.

Medical Regulating – A process that selects destination medical treatment facilities (MTFs) for Uniformed Services patients being medically evacuated between, into, and out of the different theaters of the geographic Combatant Commands and the Continental United States (CONUS). (Source: Ref. 2.2)

Open Regulation – The process of medically regulating a patient from point of origin directly to a hospital bed in a facility capable of providing the care required. Physicians are required to accept the patients and provide necessary care.

Pain Management – Ascertain the patient's pain level and their acceptable level of pain based on a numerical scale of 0 – 10 with 0 being no pain, 1 being the least and 10 being the worst pain possible. The acceptable level of pain is the level of pain the patient is willing to tolerate. Take into consideration the type of pain medication, time of onset based on route, and duration of known effectiveness. Due to stressors of flight including multiple transfers, aircraft vibration and maneuvering, pain intensity can increase greatly over what the patient is experiencing on the ground. Ensure patient has adequate PRN pain medication listed on the PMR. A pain score of 3 or more usually indicates the need for pain medication. (Ref 2.6)

Patient Movement Requirement Centers (PMRCs) – Global, Theater, and Joint. The PMRC is a joint activity that is responsible for Patient Movement (PM) management and coordination. The PMRC validates PM requests and regulates patients to appropriate MTFs for continued medical care (ref 2.5).

PMR Validation – See Validation

Ready Date/Time – When patient will be ready for transport. This should be the same as the Validation Date/Time as indicated in TRAC2ES or within 72 hours of the Validation Date/Time if not ready to fly at time of validation. If the ready date is in the future, it shall identify the date/time patient will absolutely be ready for PM. NOTE: For Urgent/Priority patients, the time limit established for movement IAW JP 4-02 will be based on the Validation Date/Time or Ready Date/Time, whichever is later.

Current H/H – Within 72 hours of validation, post-operatively or following a blood transfusion, whichever is later.

Current lab values – Significant lab values based on patient condition and MD judgment.

Through Regulation – The process of evacuating patients who do not require additional medical care at other transition points/facilities after departing originating facility and prior to arrival at destination facility. (Ref 2.7)

TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES) – Developed by USTRANSCOM IAW DoDI 6000.11. A single, overall Automated Information System (AIS) that ties together patient accountability from the field, while in transit and at originating, destination, and enroute MTFs. TRAC2ES shall provide limited in transit visibility and medical regulation of patients in both peacetime and contingencies. (Ref. 2.3)

Uniformed Services – The Uniformed Services include the Military Services (refers to the Army, the Navy, the Air Force, the Marine Corps, and the Coast Guard by agreement with the Department of Homeland Security, when it is not operating under the Department of the Navy) and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA) and of the Public Health Service (PHS). Sources: JP1-02/Ref. 2.2

Validated State – The PMR is both clinically and administratively complete and patient is ready to be manifested on a mission.

Validating State – PMR is not validated and cannot be assigned to a mission. Used when most of the clinical and/or administrative information is complete but the PMRC is awaiting final clinical updates, approval for PM from another agency (i.e.: State Dept, Sec Def) or the patient is not yet physically located at an Airfield/MTF where patient can be picked up.

Validation – Procedure used by PMRCs to confirm that all clinical and administrative information is not only error-free, but also accurately reflects the patient's current clinical status and confirms the patient is located at an airfield/MTF where he/she can be picked up for PM at any given time. PM details should be confirmed with the receiving unit before validation occurs.

