



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TX 78234-6000

MCCS

OTSG/MEDCOM Policy Memo 08-015

Expires 13 May 2010

13 MAY 2008

MEMORANDUM FOR COMMANDERS, MEDCOM Regional Medical Commands

SUBJECT: Patient Movement from Outside Continental United States (OCONUS) and Reception of Warriors in Transition to Military Treatment Facilities (MTFs)

1. References.

a. Department of Defense (DoD) Directive 6000.12, Health Services Operations and Readiness, 20 Jan 98.

b. DoD Instruction 6000.11, Patient Movement, 9 Sep 98.

c. DoDD 5154.6, Armed Services Medical Regulating Directive, 12 Jan 05.

d. Joint Publication 4-02, Health Service Support, 31 Oct 06.

e. Message, HQ, USCENTCOM, CCSG Surgeon, 713:0028 Jun 05, subject: US Central Command (USCENTCOM) Guidance on Through Regulation of Patients Outside of Area of Responsibility (AOR).

f. USTRANSCOM MEMORANDUM: Self-Medicating Patients and Controlled Substance Accountability within the Patient Movement (PM) System, 10 Jul 06.

g. ALARACT Message, 191146Z Apr 03, subject: OIF/OEF Injured Soldier Tracking and Unit Notification.

h. Army Regulation (AR) 40-400, Patient Administration, 6 Feb 08.

i. US Army Medical Command (MEDCOM) Regulation 40-21, Regional Medical Commands and Regional Dental Commands, 22 Oct 99.

j. Air Force Instruction (AFI) 41-307, Aeromedical Evacuation Patient Considerations and Standards of Care. (enclosure contains applicable excerpt.)

k. Memorandum, MEDCOM, DASG-WT, 11 Jan 08, subject: Movement of Soldiers in Transition between Warrior Transition Units (WTUs) and WTUs/Community Based Health Care Organization (CBHCO).

* This policy memorandum supersedes OTSG/MEDCOM Policy 07-041, Subject: Patient Movement from Outside Continental United States (OCONUS) and Reception of Warriors in Transition to Continental United States (CONUS) Military Treatment Facilities (MTFs)

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1. OPORD 08-21, date/time 071100R Feb 08, Soldier Transfer and Regulating Tracking Center.

2. Purpose. To provide guidance on patient movement from all OCONUS locations to destination MTFs.

3. Proponent. The proponent for this policy is the Patient Administration Division (PAD), Health Policy and Services Directorate.

4. Policy.

a. The US Transportation Command (TRANSCOM) Regulating and Command & Control Evacuation System (TRAC2ES) is the official automated information system to medically regulate and track patients requiring patient movement through the US military patient evacuation system. The Joint Patient Tracking Application (JPTA) in conjunction with TRAC2ES provide "total" in-transit visibility of patients from Levels II through V. All originating MTFs or medical activities will create a Patient Movement Request (PMR) in TRAC2ES for Warriors evacuated or moving by other means for medical care. All patient movement will be in coordination with (ICW) the supporting Patient Movement Requirement Center (PMRC). This action will ensure positive control and accountability of Soldiers moving to medical care.

b. Through Regulating of patients (reference 1.e.) will be utilized whenever clinically and administratively appropriate. Through Regulating is the process of evacuating patients who do not require additional medical care at Landstuhl Regional Medical Center (LRMC) or other transition points/activities after departing originating facility and prior to arrival at destination facility.

c. Numerous administrative guidelines shape the Patient Movement process with the intent to evacuate the patient to the right location the first time. A recent assessment points out that MTF Commanders believe they are receiving patients that should be evacuated elsewhere. MTF and WTU Commanders need to be aware that physician-to-physician (attending and accepting) referrals outweigh administrative guidelines and influence the number of patients received over time. MTF/WTU Commanders concerned about the number of patients flowing into their facility/unit should obtain visibility of the number/type of patients accepted for treatment based on physician-to-physician referrals.

d. Patients will be regulated to Walter Reed Army Medical Center (WRAMC) using the same priorities for capability, capacity, and preference delineated for other Army MTFs. Patients will not be referred to WRAMC unless clinically indicated, the Soldier's home and/or unit is under the Health Service Area (HSA) area of responsibility, the Soldier is assigned to Europe-based units or as specifically indicated in this policy.

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e. The attending physician at the originating MTF will only refer to Army MTFs with the capability and capacity to treat the Soldier's medical condition, unless dictated elsewhere in this policy. The attending physician must first consider the destination based on capability and capacity to support the patient's medical needs before deciding to support the patient's location preference. Example: If multiple facilities have the capability and capacity, the facility closest to home (e.g., unit of assignment, Home of Record (HOR), family, etc.) should be selected. If only one facility meets the clinical need, that facility should be the destination Army MTF, despite the Soldier's personal preference.

f. It is imperative that effective communication with the Soldier occurs during the destination selection process. Doing so will greatly enhance the Soldier's acceptance of the decision and minimize conflict or misunderstanding subsequent to the patient's evacuation.

g. When an accepting physician is required for patient movement, the attending physician is responsible for contacting and coordinating with an accepting physician at the destination location. Patient movement support activities such as the Deployed Warrior Medical Management Center (DWMMC), PAD Air Evacuation (AE) personnel or case managers may assist with obtaining an accepting physician's contact information at projected destinations; however, the responsibility remains with the attending physician to coordinate acceptance of the patient.

h. Soldiers of all components requiring inpatient care greater than 30 days or outpatient recovery greater than 60 days will initially move to an Army MTF with capability and capacity closest to the location of patient preference unless otherwise designated in this policy, i.e., Naval Medical Center San Diego (NMCS) for amputees and the Institute for Surgical Research, BAMC, for burns. Soldiers may only select locations with existing personal support structures (e.g., unit of assignment, Home of Record (HOR), family, etc.). Medical capability and capacity of the receiving MTF must be confirmed before patient preference is considered. TRAC2ES will not be used as the sole method of confirming capability or capacity. For example, patient preference is superseded when regulation is required to specific MTFs that have the capability to care for injuries secondary to traumatic amputation or Traumatic Brain Injury (TBI).

(1) Regular Army (RA) (Component I) patients will be regulated to the Army MTF with the appropriate capability and capacity closest to the Soldier's unit of assignment. However, those RA soldiers meeting the greater than (>) 30-day inpatient or >60-day outpatient recovery criteria will be regulated to a medically appropriate Army facility closest to their home or other location with a family support structure.

(2) Army National Guard (Component II) or Army Reserve (Component III) patients will be regulated to the Army MTF with capability and capacity closest to the

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Soldier's home of record or the location where other appropriate NOK or Families reside.

i. All Soldiers who have suffered traumatic amputation(s) will be regulated to a US Military Center of Excellence specializing in amputee care. Amputees from Great Plains Regional Medical Command (GPRMC), Western Regional Medical Command (WRMC), or Pacific Regional Medical Command (PRMC) will be regulated to Brooke Army Medical Center (BAMC), Fort Sam Houston, TX or Naval Medical Center San Diego, CA (Balboa). North Atlantic Regional Medical Command (NARMC) and Southeast Regional Medical Command (SERMC) amputees will be regulated to WRAMC. Patients diagnosed with significant burn trauma will be regulated to the Institute of Surgical Research, BAMC. Patients diagnosed with leishmaniasis will be regulated to BAMC or WRAMC in accordance with clinical practice guidelines.

j. Patients diagnosed with TBI should be regulated to the appropriate MTF per the following guidance:

(1) Penetrating and Severe TBI: All patients with GCS less than (<) 9, penetrating brain injury or predicted need for cerebral angiogram go to NNMC regardless of branch of service. Patients with GCS less than or equal to 9 without penetrating injury should be regulated to WRAMC or NNMCB ICW the attending neurosurgical staff who provide clinical coverage for both hospitals based on intensive care facility and nursing support. Facility determination should be based on branch of service appropriate MTF based on branch of service as long as there is no suspicion for need of arteriogram. Air Force and Army go to WRAMC, Navy and USMC will go to NNMC.

(2) Moderate TBI: Patients whose duty station and/or home is east of the Mississippi will be regulated to WRAMC. Eisenhower Army Medical Center (EAMC) can accept moderate TBI patients in small numbers as long as prior coordination is made in order to confirm current capacity at EAMC and the Augusta VAMC Active Duty Rehabilitation Unit. Patients whose duty station and/or home is west of the Mississippi will be regulated to BAMC.

(3) Mild Symptomatic TBI: Patients with mild symptomatic TBI requiring specialty care will be regulated to Defense Veterans Brain Injury Center (DVBIC) Army sites (WRAMC, BAMC), or other sites (Carl R. Darnall Army Medical Center (CRDAMC), EAMC, Madigan Army Medical Center (MAMC), Tripler Army Medical Center (TAMC), William Beaumont Army Medical Center (WBAMC), Womack Army Medical Center (WAMC), and Evans Army Community Hospital closest to their duty station and/or home. Soldiers who deployed from Alaska can be regulated to 3rd Medical Group, Elmendorf AFB, AK. Validation of TBI sites is ongoing and additional sites will be published in future policy updates.

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(4) Mild, Asymptomatic TBI: Regulate per other medical condition(s).

k. Patients with Behavioral Health (BH) diagnoses will be evacuated IAW reference 1.i. (enclosure contains excerpt of AFI 41-307). The sending MTF will provide an escort, when required, for patients diagnosed with BH conditions. Medical (MA) or Non-Medical Attendants (NMA) provided through the patient's parent unit will continue escort duties until the patient reaches their final CONUS destination. The sending MTF will also ensure that the receiving MTF has identified the same level of care attendant for reception at the destination MTF (reference 1.i.)

l. Regional Commanders will establish and maintain a 24/7 point of contact to identify accepting physicians and verify WTU capability and capacity ICW the receiving MTFs. The RMC 24/7 POC will respond to requesting activities (LRMC DWMMC, other operational OCONUS and CONUS locations) within 24 hours of a request. This new requirement supports expeditiously obtaining the necessary information to move a patient to an appropriate treatment facility. RMCs will ensure units deployed for other than the OIF/OEF missions receive the 24/7 POC information to assist with coordination of Soldier evacuation from elsewhere in the world. Examples of accepting physician requirements include: A patient is from Fort Carson area; Fort Carson does not have supporting specialty and patient must go to BAMC; the attending physician at LRMC must obtain an accepting physician at BAMC. Joint Task Forces (GTMO, Egypt, etc.) not associated with OIF/OEF operations, must have an accepting physician at the destination location. OCONUS activities coordinating Warrior evacuation will make telephonic notifications identified in paragraphs 4.j. (3) and (4).

m. All Warriors are eligible for onward movement or transfer beyond the initial CONUS receiving MTF if medical capability and capacity is available to support their clinical condition. Soldiers may move closer to home after the WTU Commander/Triad accomplishes required assessments and the case management team completes a treatment plan ICW the final destination/treatment facility. Reference 1.k. contains further guidance.

n. Regions and MTF PADs will establish one official AMEDD global email address to support sustainable communication. Recommend coordination with the Outlook System Administrator to establish, publish, and maintain an official AMEDD global email address with associated telephone numbers per facility/RMC/location. Email nomenclature will include: Installation name-Evacuation and Transfer@amedd.army.mil. The email address will need a governing rule that will forward messages to an associated distribution list. The distribution list should include personnel in the MTF and WTU responsible for reception and administrative management. This will help ensure a standardized communication between originating and destination/HQ activities. Regions will consolidate and forward MTF/location email

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addresses and a primary POC responsible for managing the email box to SFC Michael Caldwell, OTSG, Michael.caldwell@amedd.army.mil NLT five days after publication of this policy.

o. Diversion. Once a patient is in transit, the patient's final destination MTF should not be changed unless the patient's medical status changes while enroute. Exceptions to this policy will be coordinated with the Office of The Surgeon General (OTSG), Patient Administration Division (PAD), by calling (703) 681-2718/3014/1833 during duty hours or OTSG OPS21 (703) 681-8052 after duty hours.

p. Sending/receiving MTF and WTU Responsibilities:

(1) LRMC and other OCONUS MTFs will ensure that the appropriate CONUS MTF destination, preferred by the patient, as well as the reason for preference (i.e., home of record, NOK, etc.), is documented in TRAC2ES. PMR created for patients moving by other means will include commercial movement information, PMR commercial ticket number, transport destination, planned departure and arrival date. This does not apply to MTFs located within the CENTCOM Area of Responsibility (AOR).

(2) All MTFs (hospitals and clinics) will monitor TRAC2ES daily at a minimum (7 days a week) for incoming patients. The PAD will provide the inbound/outbound patient manifest to the MTF and WTU Commander, or their designated representatives, and the receiving clinical service as soon as possible to ensure that timely planning for clinical and administrative reception occurs for Warriors arriving by civilian (commercial) or military air. A PMR should be available upon request IAW Protected Health Information (PHI) privacy considerations.

(3) LRMC/DWMMC and all OCONUS medical activities with the responsibility to coordinate patient movement will ensure email notification to the receiving MTF and Region 24/7 point-of-contact prior to patient departure or ASAP thereafter. Leadership will determine when telephonic notification will occur; however, in cases where a Soldier and attending family members are going, by exception, to another Service MTF or directly to the Veterans Administration, telephonic notification to the responsible WTU is mandatory.

(4) CONUS based WTU-to-WTU Soldier transfers require telephonic notification in all cases and is governed by reference 1.k.

(5) The sending MTF will ensure an adequate supply of medications and supplies are provided for patients while in transit IAW reference 1.f.

(6) The sending MTF will ensure a copy of the patient's medical records is

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transmitted to the receiving MTF at time of the patient's departure or a copy is transported with the patient.

(7) LRMC or the initial receiving facility outside the theater of operation will provide Soldiers with the opportunity and ability to make contact with their unit of assignment, home station, Families, or other personal support structure in order to communicate evacuation plans prior to movement to the receiving MTF. This service will be provided by the MTF at no cost to the Soldier.

(8) The sending and receiving MTF and WTU PADs will update patient information in the JPTA to ensure patients can be tracked from point-of-injury to final destination. The Office of the Secretary of Defense (OSD) and AR 40-400 established a requirement to update JPTA on a daily basis and when a patient's status changes (e.g., change of ward, transition from inpatient to outpatient and vice versa).

(9) MTFs will establish local policies for reception and integration of patients evacuated by commercial or military air to their facility. The MTF Reception plan will facilitate medical treatment and management of our returning Wounded Warriors and close a potential gap in the Patient Movement system. The MTF is responsible for developing the policy; however, communication between the MTF, WTU, Rear Detachments, and local supporting agencies is the key to successful reception, integration, and healing.

(10) All Soldiers will be attached to the WTU within 24 hours of arrival. Soldiers regulated to non-Army MTFs as an exception to policy will be attached to an MTF/WTU IAW with reference 1.h.

(11) The PAD will coordinate with the WTU for attachment or assignment orders when patients are evacuated or transferred for further treatment by military or commercial air or ground ambulance, (references 1.j. and 1.k).

(12) The DWMMC for LRMC and WTU for CONUS facilities will initiate a clinical evaluation upon Soldiers arrival. Receiving WTUs will assign a case manager by name for each patient when notified of their pending arrival.

(13) The WTU for outpatients, and/or MTF PAD for inpatients, will notify Commanders (Forward and Rear), installation casualty office, and other agencies as appropriate, within 24 hours of the patient's arrival for Soldiers originating from a Theater of Operations.

(14) The WTU will ensure appropriate lodging is ready for the arriving patient and their Families. This may require external coordination with local rear detachments, garrison, and MWR activities.

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(15) The WTU will ensure a military representative is present at the airport to meet and transport patients to their lodging. The WTU will establish a plan to notify Commanders (Forward and Rear), their Families, installation casualty office, and other agencies as appropriate when the Soldier's arrival or departure date/time changes.

(16) The WTU will coordinate with the installation human resource center and the Soldier's command and control element regarding the publication of attachment or assignment orders for the inbound patient, as required.

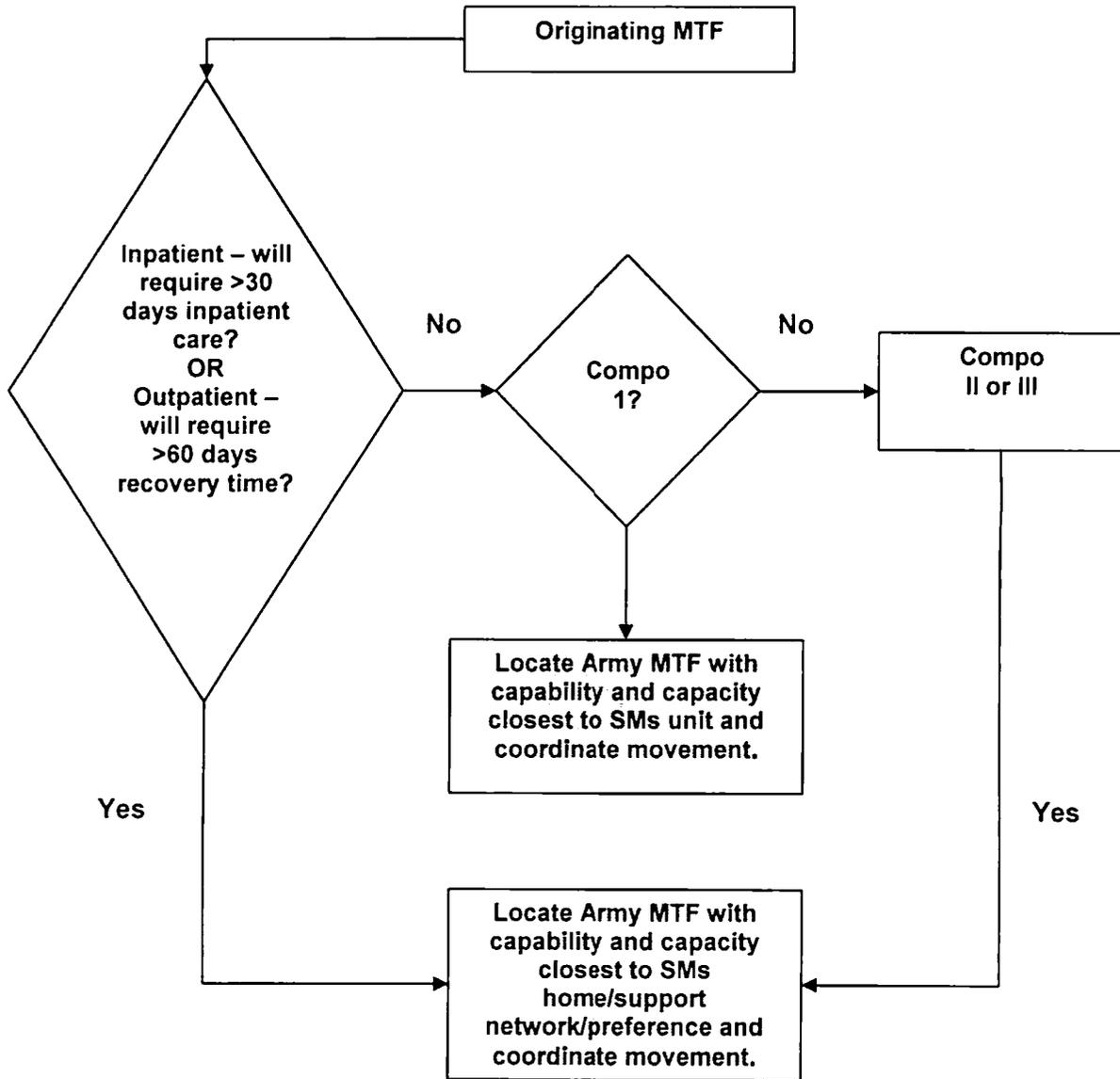
q. Request for exceptions to paragraphs 4.d, i., and j. of this policy will be submitted to the Office of The Surgeon General (OTSG) ATTN: Health Policy and Services, PAD. Requests must succinctly state the reason for the exception and be signed by the originating MTF Commander. The OTSG Chief of Patient Administration will validate the request for exception and forward to Global Patient Movement Requirements Center (GPMRC) for action. GPMRC will attempt to divert the patient as requested, if clinically appropriate and request is received in adequate time to facilitate a mission change.

FOR THE COMMANDER:

Encl


WILLIAM H. THRESHER
Chief of Staff

Warrior in Transition Formula
(Determination of Regulating Destination)
Clinical Capabilities + Capacity + Patient Support System = Patient Movement
Solution



Excerpt

Air Force Instruction (AFI) 41-307 Aeromedical Evacuation Patient Considerations and Standards of Care

Psychiatric Patient AE Classifications

1A: Severe psychiatric litter patients requiring the use of physical restraints, sedation, and close supervision. See AFI 41-307 paragraph **A6.3.1** and **A6.5.2.1.6** for patient preparation and flight support requirements including time-limited restraint guidelines.

1B: Moderately severe psychiatric litter patient requiring tranquilizing medication or sedation for flight. Keep restraints available and secured on the litter or with the MA. See reference I, paragraph **A6.3.2** and **A6.5** for further guidance. **NOTE:** There are no written PRN orders for restraints. Follow paragraph **A6.5**.

1C: Ambulatory psychiatric patient who is cooperative, reliable and not a threat to self or others requiring minimal observation. See reference I, paragraph **A6.3.4**.

3C: Ambulatory drug or alcohol substance abuse inpatient going for treatment dressed in military or civilian clothing.

5B: Outpatient ambulatory, going for treatment of drug, alcohol, or substance abuse.

5C: Outpatient psychiatric patient going for treatment or evaluation.