BY ORDER OF THE
SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 48-307,
VOLUME 3

12 APRIL 2016

Aerospace Medicine

EN ROUTE CARE DOCUMENTATION

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available on the e-Publishing website at **www.e-Publishing.af.mil** for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: HQ AMC/SGK

Certified by: AF/SG3/5
(Maj Gen Roosevelt Allen Jr.)
Pages: 45

This instruction implements Air Force Policy Directive (AFPD) 10-29, *Worldwide Aeromedical Evacuation Operations* and AFPD 41-2, *Medical Support*. It establishes, defines, and implements standards for health record documentation in the AF Aeromedical Evacuation (AE) System. It applies to all active duty, Air Force Reserve Command (AFRC) and Air National Guard (ANG) personnel assigned to AE units, Critical Care Air Transport Teams (CCATT), En Route Patient Staging Systems (ERPSS), and Specialty Medical En Route Care Transport teams. This publication may be supplemented at any level, but all supplements must be routed to the Office of Primary Responsibility (OPR) listed above for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF 847 from the field through the appropriate functional chain of command to HQ AMC/SGK, Scott AFB IL. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, Table 1.1 for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS). The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

Chapter 1

OVERVIEW/BACKGROUND

1.1. Mission Description. En Route Care (ERC) includes all elements of medical care, support, treatment, staging and transport, from the point at which a request for movement has been received, through the final destination for definitive care. Aeromedical Evacuation (AE) provides time-sensitive ERC of regulated casualties to and between medical treatment facilities (MTF), using organic and/or contracted aircraft with medical aircrew trained explicitly for this mission. AE forces can operate as far forward as aircraft are able to conduct air operations, across the full range of military operations, and in all operating environments. Specialty medical teams may be assigned to work with the AE aircrew to support patients requiring more intensive en route care. The goal is to match patient needs with the appropriate skills, knowledge, equipment, and infrastructure to enable safe, effective, and efficient ERC.

1.2. Purpose. This AFI provides ERC documentation guidelines to promote continuity of care for Department of Defense (DoD) beneficiaries and designees. Information presented in this AFI sets Air Force requirements for health record documentation in the ERC environment, and is not intended to be used as a substitute for sound clinical judgment.

1.3. Applicability. This AFI applies to all AE unit-assigned or associated ERC personnel, and all Active Duty, Air Force Reserve Command (AFRC) and Air National Guard (ANG) medical units.

1.4. Publication Administration. This AFI should be available to all active duty, AFRC and ANG personnel assigned to AE units, Critical Care Air Transport Team(s) (CCATT), ERPSS and Specialty Medical ERC Transport teams.

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. HQ AMC/SG.

2.1.1. Maintains policy support for electronic documentation within the AF AE system.

2.1.2. Sets Electronic Health Record (EHR) training requirements for the AF AE system.

2.1.3. Monitors customer service for the EHR via email: **AMC_AE_EHR@us.af.mil.**

2.1.4. Identifies new software/hardware requirements and communicates new requirements to Theater Medical Information Program-Air Force (TMIP-AF).

2.1.5. Writes and updates TMIP-AF user manuals/guides for use by personnel in the USAF's AE system in accordance with (IAW) requirements outlined in **A2.4**.

2.1.6. Maintains the EHR system consisting of four parts as outlined in **A2.1**.

2.1.7. Will provide initial hardware (laptops, printers, and routers) and refreshes on the normal cycle (4-years).

2.2. HQ AMC/SG. Serves as the waiver authority for the Electronic Health Record Documentation Program (EHRDP).

2.3. TMIP-AF. Develops EHR software and training programs IAW Attachment 2, *En Route Care Electronic Heath Record Hardware / Software / Training Requirements.*

2.4. Patient staging unit and AE Commanders.

2.4.1. Will ensure assigned personnel are using this document to provide initial and recurring training for applicable personnel assigned to units IAW Attachment 2, *En Route Care Electronic Health Record Hardware / Software / Training Requirements.* **(T-1)**.

2.4.2. Will maintain a unit EHRDP. **(T-1)**.

2.4.3. Will appoint an EHRDP officer who is responsible for maintaining overall situational awareness and supervision on elements critical to assuring the unit is capable of capturing EHR information. **(T-1)**. Elements of this program include:

2.4.3.1. Hardware maintenance.

2.4.3.2. Software updates.

2.4.3.3. Training currency.

2.4.3.4. Quality/Metrics.

2.4.3.5. Logistics.

2.4.3.6. Supply.

2.4.4. Will maintain current EHRDP officer appointment letters at the unit level and forward a copy of current EHRDP appointment letters to HQ AMC/SG through their appropriate MAJCOM. **(T-1)**.

2.4.5. May request EHRDP program and/or training waivers from HQ AMC/SG through their appropriate MAJCOM.

2.4.6. Will approve local operating instruction(s) to supplement this guidance or portion of this guidance as necessary to accomplish unit/mission tasks. **(T-1)**.

2.4.7. May appoint instructors who will train users and super users within the unit.

2.4.8. May establish local guidance for pre-flight and post-flight duties and tasks specific to EHR documentation as necessary for mission accomplishment.

2.4.9. Will ensure replacement costs due to damaged hardware and consumables (such as printing paper, ink cartridges, etc…) are projected in the unit budget. **(T-1)**. Damaged laptops under warranty will be handled by AMC SG. HQ AMC/SG will refresh Automated Data Processing Equipment (I.e. laptops, printers, and routers) on the normal cycle (every 4 years).

2.4.10. Will ensure personnel receive EHR user or super user training depending on their assigned duties or responsibilities. **(T-1)**.

2.4.10.1. Initial training will be within one year of assignment to a Unit Type Code (UTC) or one year after basic qualification, whichever is the latter. **(T-1)**.

2.4.10.2. Will ensure unit members receive hands-on familiarization training biennially. **(T-1)**.

2.5. Patient Staging Unit and AE Chief Nurses.

2.5.1. Will ensure Aeromedical Evacuation Crew Members (AECMs) or staging personnel complete and verify data transmission at the end of each shift or mission and report as part of the unit quality assurance program. **(T-1)**.

2.5.2. Will establish a peer review documentation program which examines documentation quality and ensures adherence to standards and scope of practice IAW AFI 46-101, *Nursing Services and Operations*. **(T-1)**. **NOTE**: Peer review for privileged providers will be IAW AFI 44-119, *Medical Quality Operations*.

2.5.3. Will review or delegate the responsibility to review metrics gathered from EHR encounters as part of the unit quality assurance program. **(T-2)**. Metrics will include as a minimum:

2.5.3.1. Validating the number of completed encounters per mission.

2.5.3.2. Compiling usage percentages and utilization rate per crew/unit through the EHRDP appointed personnel.

2.5.3.3. Data gathered from performing peer review on clinical documentation.

2.6. EHRDP Officer and EHRDP appointed personnel will:

2.6.1. Be trained as Super Users. **(T-2).** Centralized Super User training will be conducted by TMIP-AF. Each AES will send two personnel to receive Super User training and become trainers for their unit. **(T-1)**. The centralized Super User training will be locally funded. **(T-1)**.

2.6.2. Elevate hardware and software issues to TMIP-AF program office help desk, or local contract support (where available) within 24 hours. **(T-1)**.

2.6.3. Ensure TMIP-AF support help desk information is placed on hardware desktop in a file labeled "TMIP HELP DESK." **(T-1)**.

2.6.4. Ensure hardware is maintained IAW established guidelines and fully mission capable to include proper storage and battery maintenance. **(T-1)**.

2.6.5. Work with applicable agencies to establish network and terminal connectivity to the EHR database. **(T-1)**.

2.6.6. Develop local operating instruction(s) to supplement this guidance or portion of this guidance as necessary to accomplish unit/mission tasks. **(T-2)**.

2.6.7. Ensure hardware and medical equipment with communication capability to the EHR is set to Zulu time. **(T-1)**.

2.6.8. Ensure the current software is up-to-date prior to each mission (**T-1)**. Armed Forces Health Longitudinal Technology Application Theater (AHLTA-T) software updates originate from the Deployment and Readiness Systems office (D&RS). The updates flow to TMIP-AF Configuration Management Program and then to AMC/SGSI. Minor updates will be provided to the unit EHRDP officer to accomplish. Major updates will be performed by AMC/SGSI staff.

2.6.9. Ensure unit members are capable of accessing applicable systems to document patient care and to sign/transmit encounters. **(T-1)**.

2.6.10. Establish, reset, and synchronize user accounts and passwords as applicable. **(T-1)**.

2.6.11. Be trained to the Super User level within 6 months of appointment to EHRDP supporting role or assignment as the EHRDP officer. **(T-1)**.

2.6.12. Establish and maintain a train the trainer program IAW Attachment 2. **(T-1)**.

2.6.13. Establish and maintain unit policy to ensure appropriate equipment is loaded for each mission to complete electronic documentation to include **(T-1)**:

2.6.13.1. Enter items into the Patient Movement Items Tracking System.

2.6.13.2. Bar-code and track EHR equipment.

2.6.14. Be responsible for malfunctioning hardware equipment reporting and removal/replacement to the unit Information Technology Equipment Custodian. **(T-1)**.

2.6.15. Ensure unit supply maintains adequate quantities of expendable materials required for EHR documentation (e.g. paper/ink). **(T-2)**.

2.6.16. Verify data transmission and receipt of records in the EHR database. **(T-1)**.

2.6.17. Collect and present metrics and/or quality data as outlined by the executive team. **(T-2)**. The executive team is the squadron's senior leadership, such as the Squadron Commander, or Chief Nurse.

2.7. Medical Crew Director (MCD).

2.7.1. Should EHR system failure(s) occur or the MCD determines electronic documentation of clinical care will impede mission times, the MCD will direct the use of paper documentation by AECM and do the following: **(T-1)**

2.7.1.1. Document on TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES) mission coversheet (or AF Form 3829) "EHR not accomplished" **(T-1)**.

2.7.1.2. If the TRAC2ES mission coversheet (or AF Form 3829) cannot be transmitted to the Command and Control (C2) agency post-mission, verbally report electronic documentation was not accomplished **(T-1)**.

2.7.1.3. Ensure the electronic documentation failure is documented on a DD Form 2852 **(T-1)**.

2.7.1.4. Ensure designated unit support personnel are contacted for hardware/software issues encountered during the mission **(T-1)**.

2.8. En Route Critical Care Teams and Special Medical Attendant Teams.

2.8.1. En Route Critical Care Teams and Special Medical Attendant Teams are:

2.8.1.1. Critical Care Air Transport Team (CCATT)

2.8.1.2. Tactical Critical Care Evacuation Team (TCCET)

2.8.1.3. Tactical Critical Care Evacuation Team-Surgical Augmentation (TCCET-SA)

2.8.1.4. Lung Team

2.8.1.5. Burn Team

2.8.1.6. Neonatal Intensive Care Unit Team

2.8.2. En Route Critical Care Teams are exempt from using Armed Forces Health Longitudinal Technology Application – Theater (AHLTA-T) until an approved program is developed. Copies of paper documentation should be transmitted after patient handoff using the following guidance:

2.8.2.1. Transmit encrypted copies of all transport documentation via encrypted email to **CCATTPilotUnit.59mdw@us.af.mil.**

2.8.2.1.1. Subject Line: ATTN: CCATT Process Improvement Program.

2.8.2.1.2. Message will include HIPAA statement as outlined in **3.2.9.1**.

2.8.2.2. If the En Route Critical Care Teams are able to attach clinical documentation to the patient's record in Theater Medical Data Store (TMDS), procedures outlined in **2.7.1.1**. are not required.

2.9. All clinicians (AECMs, En Route Critical Care Teams, ERPSS), unless otherwise waived or exempt, (for waiver or exemption, contact AMC AE EHR@us. af.mil), will:

2.9.1. Follow system protocols to ensure data is transmitted. **(T-1)**.

2.9.2. Review, sign and co-sign (as required) notes in order to close out an encounter. **(T-1)**.

2.9.3. Use protocols outlined by TMIP-AF to wirelessly transmit or download encounter files from one EHR system to another. **(T-1)**.

2.9.3.1. If wireless transmission or download is not possible, sending ERPSS and AE personnel will use protocols outlined in EHR manuals to manually copy encounter files to portable media so receiving personnel can copy encounter files onto their EHR system. **(T-1)**.

2.9.3.2. Print, scribe and/or scan any health care documentation not recorded in the EHR. **(T-1)**. All health care documentation should be uploaded or physically accompany the patient during evacuation.

2.9.3.3. Print and provide the ERC documentation prior to transferring to a non-DoD medical treatment facility. **(T-1)**.

2.9.3.4. Use EHR versions of AF Form 3899 series documents and SF 600, Health Record – Chronological Record of Medical Care, in place of paper forms when available. **(T-1)**.

2.9.3.5. When internet connectivity cannot be established, data disk creation cannot be accomplished, other technical challenges preclude electronic record transmission or receiving clinicians do not have access to the ERC EHR, clinicians must use printed hard-copy SF 600s, Health Record – Chronological Record of Medical Care. **(T-1)**.

2.9.3.6. When systems and permission allow, non-licensed clinicians should electronically document patient care. Aeromedical Evacuation Technicians and Independent Duty Medical Technicians are examples of non-licensed clinicians.

2.9.3.6.1. Notes will be reviewed and co-signed by a licensed clinician or privileged provider. (**T-1**).

2.9.3.6.2. Notes will be co-signed within the same shift or mission. **(T-1)**.

2.9.3.7. All AE and ERPSS personnel are responsible for reporting broken/malfunctioning EHR hardware to their respective EHRDP Officer as soon as possible. **(T-2)**. If away from home station, clinicians will report software issues to the TMIP-AF help line as soon as possible, and notify the unit EHRDP Officer on return to home station within 24 hours. **(T-1)**.

2.10. AECMs will:

2.10.1. Be trained to the user level within one year after basic qualification. **(T-1)**.

2.10.2. Be identified to train to the super user level within one year after being trained to the user level. **(T-2)**. Mission management is responsible to ensure the crew complement includes super user capability on all operational missions. **(T-1)**. **NOTE**: In order to mitigate any hardware/software problems on operational flights, one or more aeromedical evacuation crew members will have super user training. One or more aeromedical evacuation crew members on Operational Training Missions, Static Training Missions, and Aeromedical Readiness Missions (ARMs) training flights should be a super user to facilitate EHR training and to mitigate any hardware/software problems. User and super user training are not grounding items.

2.10.3. The EHRDP officer or appointed personnel may request an EHR training kit to facilitate training outside of ARMs via email **AMC_AE_EHR@us.af.mil.**

2.11. Patient Staging Personnel will:

2.11.1. Be trained to the user level within one year of assignment to the UTC. **(T-1)**.

2.11.1.1. Identified personnel will be trained to the super user level within one year after being trained to the user level. **(T-2)**.

2.11.1.2. Staging management is responsible to ensure super user capability on all shifts. **(T-2)**.

2.11.2. Scan/embed/transcribe applicable paper records into an AHLTA-T encounter. **(T-1)**.

2.11.2.1. Transcribed information should include discharge summaries documented in other electronic patient documentation systems, such as Essentris.

2.11.2.2. Transcribe applicable electronic documentation from systems into the ERC EHR, including:

2.11.2.2.1. Physician orders.

2.11.2.2.2. Discharge summary.

2.11.2.2.3. Medications.

2.11.2.2.4. Treatments.

2.11.2.2.5. Any other pertinent patient information related to the patient's plan of care.

2.11.2.3. Deliver transcribed information to the evacuation platform and communicate these items during patient handoff. **(T-1)**.

Chapter 3

GENERAL DOCUMENTATION GUIDANCE FOR EN ROUTE CARE

3.1. General Principles. Health record documentation is hand written or electronically generated patient information obtained through a clinical process. Health record documentation is a vital component of safe, ethical and effective clinical practice, regardless of the context of practice or whether the documentation is paper-based or electronic. Health record documentation should reflect the application of clinical knowledge, skills and judgment, as well as the patient's perspective. Health record documentation should establish accountability, promote quality and continuity of clinical care. Health records are legal documents.

3.2. General Considerations.

3.2.1. Documentation provides a chronological record and may be used in court or during an investigation to assist with testimony, reconstruct events, establish times and dates, and to substantiate and/or resolve conflict. Health record documentation should provide specific information (when, where, who, what, how and why) about the planning for and provision of a patient's treatment.

3.2.2. The person reading a health record document assumes the person who is doing the recording provided the care or service to the patient. The provider or clinician who performed or observed the intervention/event with the patient should document the health record information.

3.2.3. Documentation should be completed as soon as possible after care is provided.

3.2.4. Events should be documented in chronological order.

3.2.4.1. When it is not possible to document concurrently or within a reasonable time of the event, a late entry or addendum is required.

3.2.4.2. Late entries for paper and electronic documentation start with the words "Addendum." Include the events, and reference the date and time events actually occurred as well as the date and time the Addendum was prepared.

3.2.5. When two or more licensed clinicians are caring for the same patient, each licensed clinician will document and sign for *their* care provided and/or services rendered. **(T-0)**.

3.2.5.1. Unless otherwise stated in Headquarters Air Force (HAF) policy, when both licensed and non-licensed clinicians are caring for the same patient, a privileged provider or licensed clinician will review and co-sign the non-licensed clinician's documentation. **(T-0)**.

3.2.5.2. The privileged provider or licensed clinician must co-sign within the same shift or mission. **(T-0)**.

3.2.6. Designated recorder. During an emergency situation, it may be necessary to designate a recorder. The designated recorder should:

3.2.6.1. Document chronological events, procedures, interventions, and frequency of care implemented.

3.2.6.2. List all who were present and their designation/qualifications during the emergency, such as Registered Nurse/Physician.

3.2.6.3. The designated recorder will provide the documentation to the person assigned to the patient for review and co-signature or concurrence. **(T-0)**.

3.2.7. All entries on a paper-based system will be documented using black or blue ink. **(T-3)**. Do not use pencil, felt pens or highlighters as the information could be changed and/or does not copy or scan clearly. **(T-3)**.

3.2.8. A single line drawn through any blank or "white space" should be used to maintain sequential documentation and prevent erroneous entries.

3.2.9. Patient Privacy. Regardless of the method used to communicate patient information, all clinicians will adhere to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 standards. **(T-0)**.

3.2.9.1. The following statement will be included within the email or on the facsimile coversheet **(T-0)**:

3.2.9.2. "NOTICE: This document may contain information covered under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made."

3.2.10. Health record documentation should provide comprehensive information concerning the condition of the patient or clinical care provided. Documentation should be clear, complete and accurate to facilitate quality assurance and quality improvement initiatives. Clinical documentation will be specific, using measurable data if possible, and avoid generalizations. **(T-0)**.

3.2.11. All patients will be identified using at least two unique identifiers, e.g., patient's name and date of birth. **(T-0)**.

3.2.12. If pseudonyms and identifiers are used, these identifiers will match the demographics used during clinical documentation. **(T-0)**.

3.2.13. During regulated patient movement, all patients should be identified using the TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES) ID band prior to enplaning.

3.2.14. All time documented in the health record will be in Zulu or Zulu equivalent **(T-1)**. All EHR documentation devices will have their system time set to Zulu or Zulu equivalent **(T-1)**.

3.2.15. When appropriate, health record data will incorporate scalable information, e.g., pain 8/10.

3.2.16. Clinicians will use the DoD and U.S. Department of Veterans Affairs (VA) Pain Rating Scale, **Figure 3.1**, IAW United States Army Institute of Surgical Research (USAISR) Clinical Practice Guidelines for adults. **(T-1)**. Clinicians may continue to use the Wong-Baker FACES Pain Rating scale, Figure 2., for pediatric patients. Clinicians may use the Faces Legs Activity Cry Consolability (FLACC) scale, **Table 3.1**, for patients who are unable to communicate their pain.

Figure 3.1. (DoD / VA Pain Rating Scale) .

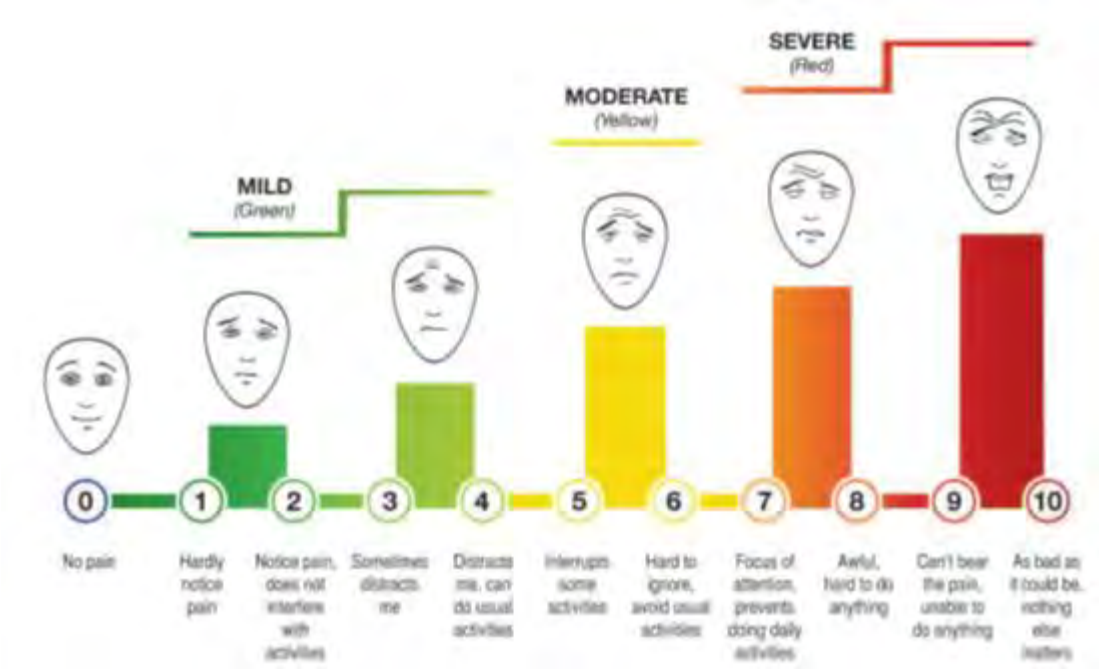
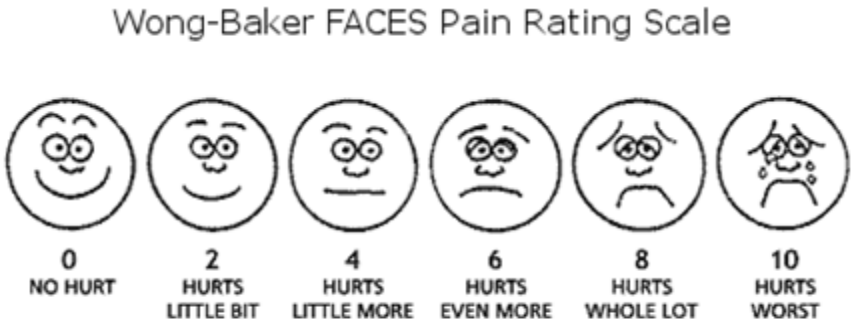


Figure 3.2. (Wong-Baker FACES Pain Rating Scale) .



From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Table 3.1. FLACC Pain Assessment Tool.

FLACC Pain Assessment Tool DATE/TIME						
Face 0 – No particular expression or smile 1 – Occasional grimace or frown, withdrawn, disinterested 2 – Frequent to constant quivering chin, clenched jaw						
Legs 0 – Normal position or relaxed 1 – Uneasy, restless, tense 2 – Kicking, or legs drawn up						
Activity 0 – Lying quietly, normal position, moves easily 1 – Squirming, shifting back and forth, tense 2 – Arched, rigid, or jerking						
Cry 0 – No cry (awake or asleep) 1 – Moans or whimpers; occasional complaint 2 – Crying steadily, screams, or sobs, frequent complaints						
Consolability 0 – Content, relaxed 1 – Reassured by occasional touching, hugging or being talked to, distractible 2 – Difficult to console or comfort						
TOTAL SCORE						

3.2.17.1. How to use the FLACC**.**

3.2.17.1.1. In patients who are awake: Observe for 1 to 5 minutes or longer. Observe legs and body uncovered. Reposition patient or observe for activity. Assess body for tenseness and tone. Initiate consoling interventions if needed.

3.2.17.1.2. In patients who are asleep: Observe for 5 minutes or longer. Observe body and legs uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone. **WARNING**: This scale should not be used on patients undergoing neuromuscular block.

3.2.17.1.3. FACE: Score 0 if the patient has a relaxed face, makes eye contact and shows interest in surroundings. Score 1 if the patient has a worried facial expression, with eyebrows lowered, eyes partially closed, cheeks raised mouth pursed. Score 2 if the patient has deep furrows in the forehead, closed eyes, an open mouth, deep lines around nose and lips.

3.2.17.1.4. LEGS: Score 0 if the muscle tone and motion in the limbs are normal. Score 1 if the patient has increased tone, rigidity, or tension; if there is intermittent flexion or extension of the limbs. Score 2 if the patient has hypertonicity, the legs are pulled tight; there is exaggerated flexion or extension of the limbs, tremors.

3.2.17.1.5. ACTIVITY: Score 0 if the patient moves easily and freely, normal activity or without restrictions. Score 1 if the patient shifts positions, appears hesitant to move, demonstrates guarding, a tense torso, and/or when pressure is applied to a body part. Score 2 if the patient is in a fixed position, rocking; demonstrates side to side head movement or rubbing of a body part.

3.2.17.1.6. CRY: Score 0 if the patient has no cry or moan, awake or asleep. Score 1 if the patient has occasional moans, cries, whimpers, sighs. Score 2 if the patient has frequent or continuous moans, cries, grunts.

3.2.17.1.7. CONSOLABILITY: Score 0 if the patient is calm and does not require consoling. Score 1 if the patient responds to comfort by touching or talking in 30 seconds to 1 minute. Score 2 if the patient requires constant comforting or is inconsolable.

3.2.18. The FLACC pain scale was designed for children between the ages of 2 and 7; however, this pain scale can be used on adults. The FLACC total scores indicate:

3.2.18.1. Zero (0), the patient is relaxed.

3.2.18.2. One to three (1-3), the patient is experiencing mild discomfort.

3.2.18.3. Four to six (4-6), the patient is experiencing moderate discomfort.

3.2.18.4. Seven to ten (7-10), the patient is experiencing severe discomfort.

3.2.19. Clinicians should document objective facts about observations and assessments and should only document conclusions supported by data.

3.2.20. Subjective data from third parties may be included as long as the individual is identified and the statements made are annotated within quotation marks.

3.2.21. Health record notations will include the date, time (Zulu), signature, and designation of the individual. **(T-0)**. Personal initials and signature may be used, if a signature log is used. **NOTE**: A signature log may be located in the medical record and consist of at least one signature clearly related to a printed name and designation of the individual.

3.2.22. Health record documentation reflects a clinician has fulfilled his/her duty of care. Any clinically significant information should be documented such as:

3.2.22.1. Clear, concise statement of patient status.

3.2.22.2. Assessment data.

3.2.22.3. All ongoing monitoring and patient communication.

3.2.22.4. Any care or interventions provided.

3.2.22.5. An evaluation of patient outcomes to include the patient's response.

3.2.22.6. Patient education and assessment of the patient's understanding.

3.2.22.7. Any plans for follow up.

3.2.22.8. Any unanticipated, unexpected or abnormal incidents such as falls, medication errors, clinical emergencies or undesired responses to clinical care. **NOTE**: "Near miss" reporting is a separate process used to track and mitigate patient safety events. Near miss reporting is not part of a clinical record; therefore, clinicians ***will not*** include a DD Form 2852, Aeromedical Evacuation/Near Miss Report, in the patient's record and ***will not*** reference completion of a DD Form 2852 within the patient's record. **(T-0)**.

3.2.23. **Cross referencing health record information.** Health record documentation should be captured electronically when the capability exists. If health record documentation

is captured both electronically and on paper, clinicians should reference the paper source within the electronic document.

3.2.23.1. Example: If an electronic health record is used to document pain scales and an AF Form 3899I, Medication Administration Record, is being used to document pain medication delivery, clinicians will chart pain scales in the electronic health record and may add an electronic note stating "see AF Form 3899I for medication delivery times." **(T-3)**.

3.2.24. Clinicians will avoid using problematic abbreviations as detailed in The Joint Commission's official "Do Not Use" list as listed in **Table 3.2**. (http://www.jointcommission.org/topics/patient_safety.aspx or as updated) **(T-0)**.

Table 3.2. DO NOT USE ABBREVIATION LIST.

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg) Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

3.2.25. Dates will be documented using the following formats, (DD MMM YY or YYYYMMDD). **(T-3)**.

3.2.26. Errors should be corrected as soon as possible. When correcting paper documentation, the original content will remain visible and retrievable so the purpose and content of the correction is clearly understood. **(T-0)**. Failing to correct errors properly may be interpreted as falsification of a record.

3.2.27. For paper documentation, clinicians will cross through the errors with a single line and insert "void" with their initials. **(T-0)**.

3.2.28. For errors made in electronic documentation, refer to the TMIP-AF user guide on the EHR computer desktop image. Comments specific to medication administration are final and cannot be modified. Narrative notes can be edited and updated at a later time.

3.3. Privileged Provider Orders.

3.3.1. Unsigned privileged provider orders are not valid orders in the AE system. Orders will have either a wet or electronic signature. **(T-1)**.

3.3.2. Ground UTC nurses may take verbal orders from privileged providers for emergency cases only.

3.3.3. In the physical absence of a privileged provider, flight nurses may take telephone orders from a privileged provider at alert time or during mission execution for emergency or routine clinical situations. The entire order must be annotated as Read Back (RB) and verified with the privileged provider prior to the nurse signing the order and proceeding. **(T-0)**.

3.3.4. Verbal/Telephone orders will require the privileged provider to make an EHR entry stating the date, time, and what the verbal/telephone order was once the patient's AE encounter is closed. **(T-1)**. This entry can be accomplished through TMDS.

3.3.4.1. Verbal/telephone orders will be annotated as follows **(T-1)**: "date, time (Zulu), verbal/telephone order from (printed first name, middle initial, and last name of privileged provider), printed first name, middle initial, and last name of nurse taking order, rank, signature of nurse."

3.3.4.2. "Verbal order" may be spelled out or abbreviated as "V/O."

3.3.5. Privileged provider orders will be legible. **(T-0)**. All orders will be followed by the author's name (printed or typed first name, middle initial, and last name), date, time (Zulu) and signature. **(T-1).** Electronic signatures are authorized. Using privileged provider signature stamps is highly recommended.

3.3.6. Privileged provider orders should, at minimum, include patient's diet, activity, and pertinent medication and treatments as applicable.

3.3.7. For paper documentation. If an error is made, line through or discontinue the order and annotate with date, time and initials or signature. Paper orders will not be edited in any other manner. **(T-0)**.

3.3.7.1. When discontinuing an order, the discontinued order will be lined through and annotated with "D/C" or "DC", date, time, and initials of person discontinuing or transcribing the order. **(T-0)**.

3.3.7.2. If the discontinue order was transcribed or transferred to another form, the medication or treatment will be lined through and annotated with ("DC", "D/C" or "Discontinued"), date, time, and initials of person annotating the order. **(T-0)**. **NOTE**: The annotations "D/C" and "DC" will only be used as an acronym for discontinue or discontinued. **(T-2)**.

3.3.8. For electronic documentation, discontinue incorrect order and replace with a correct order.

3.3.9. Only active privileged provider orders will be obvious on the order sheet, patient treatment sheet and / or medication administration records. **(T-0)**. **WARNING**: AHLTA-T does not automatically notify staff when a new order is written and needs to be transcribed or scheduled. Likewise, writing or changing a privileged provider order does not mean staff acknowledgement of new or changed orders. Clinicians writing orders will communicate new orders to clinical staff via the most reliable method. **(T-1)**. **WARNING**: Early versions of AHLTA-T do not have the ability to annotate when orders are verified, acknowledged and transcribed. Clinical staff will review ***paper and electronic*** orders at minimum once per shift and should document "Orders Reviewed" with date, time and signature on paper progress notes or document using Add Note and free text "Orders

Reviewed" within an AHLTA-T encounter. **(T-1)**. Checking an "Orders Reviewed" checkbox within an AHLTA-T alternate input method (AIM) form is also acceptable. **WARNING**: The electronic medication administration record module must be open when discontinuing a medication to ensure the discontinued order is annotated in the patient's encounter. **(T-3)**.Refer to TMIP-AF user guide. **WARNING**: When an electronic order for a medication is submitted, the privileged provider must ensure the order is "dispensed" to ensure proper transcription. **(T-1)**. Refer to TMIP-AF user guide. **NOTE:** When using the AHLTA-T, nurses will use Add Note and type "V/O" per privileged provider's first name, middle initial, and last name then reference the order as free text. **(T-1)**. If verbal order is for a medication, document the order in the medication module. Refer to TMIP-AF user guide.

3.4. Order Transcription.

3.4.1. Transcribing an order signifies an order has been reviewed, understood and transferred to nursing patient care forms.

3.4.2. Clinicians will note order transcriptions by annotating the date, time, printing the words "Noted" or "Transcribed," along with the date, time, printed name and signature of the person transcribing the order. **(T-0)**.

3.4.3. If a nurse takes a verbal order and transcribes the same order, the nurse will include the words "V/O and Transcribed." **(T-1)**.

3.5. Trip Segment.

3.5.1. AECMs will document a trip segment as the first clinical entry for each mission. **(T-2)**. The trip segment will include **(T-2)**: date of flight, enplaning station deplaning station. Example: 20130820 Andrews AFB, MD Scott AFB, IL.

3.5.2. On mission legs 45 minutes or less, International Civil Aviation Organization (ICAO) codes for enplaning / deplaning stations may be used. Example: 20130820 KADW KBLV. **(T-3)**.

3.6. Aircraft Emergency. In the event of an aircraft emergency leading to any patient intervention, documentation will include, but is not limited to: type of aircraft emergency, cabin altitude pre/post emergency, clinical interventions, and the patient's condition post intervention(s). **(T-1)**.

3.7. Patient and Attendant Briefings.

3.7.1. **Pre-flight briefings.** AECMs should complete preflight briefings prior to taxi.

3.7.2. Documentation to annotate a pre-flight briefing occurred should be in accordance with (IAW) AFI 11-2AE Vol 3, *Aeromedical Evacuation (AE) Operations Procedures, attachment 2, Aeromedical Evacuation Crew Member Expanded Checklist,* and annotate the patient/attendant's level of understanding. **(T-2)**.

3.8. Focus-DART Charting.

3.8.1. Focus-DART charting is a systematic approach to documentation, using medical terminology to describe the patient's health status, interventions, treatments and patient education. At a minimum, documentation should focus on abnormal findings and significant negative findings. Documentation should include focus, data, action, response and teaching

elements as applicable. Individuals should adopt the principles of focus charting when using electronic media.

3.8.2. Focus: patient's issue or concern; abnormal or significant negative finding(s).

3.8.3. D-Data: When applicable, include subjective and/or objective information related to the stated focus or describing observations at the time of significant events.

3.8.4. A-Action: When applicable, include patient interventions or treatments performed, and/or protocols and procedures initiated.

3.8.4.1. Clinicians should document planned interventions or treatments discussed during plan of care conferences.

3.8.4.2. Doing so not only assists with daily planning of interventions and treatment, but also assists the Patient Movement Requirements Center (PMRC) with evacuation planning.

3.8.5. R-Response: When applicable, include a description of a patient's response to medical and/or nursing care. Response elements could state plan of care outcomes have been attained or are progressing toward attainment.

3.8.6. T-Teaching: When applicable, include a description of patient education performed and an assessment of the patient's understanding.

3.9. Minimum Documentation. For AECMs, minimum documentation for missions with flight times less than 45 minutes will include **(T-1)**:

3.9.1. An assessment of any immediate patient concerns and interventions, and a reassessment of interventions and/or treatments. **(T-1)**.

3.9.2. Vital signs, oximetry, pain, sedation, and temperature as indicated by patient diagnoses/assessment findings/privileged provider orders. **(T-1)**.

3.9.3. Any abnormal respiratory findings to include respiratory adjuncts as indicated. **(T-1)**.

3.9.4. Suicidal or homicidal ideations for psychiatric patients or other diagnoses as applicable. **(T-1).**

3.9.5. Assessment of circulation, motor and sensory checks for patients with restraints or with other restrictive/constrictive devices. **(T-1)**.

3.10. Patient Staging Personnel.

3.10.1. Patient staging personnel will chart as clinically indicated, upon admission and upon discharge/transfer. **(T-1)**.

3.10.2. Inpatients will be charted on at least once per shift, and outpatients will have an entry at least every 24 hours. **(T-1)**.

3.11. Patient Handoff.

3.11.1. Patient handoff is essential to continuity of care and risk mitigation. Clinicians must use the Identify, Situation, Background, Assessment and Recommendation (ISBAR) patient handoff format during patient handoff, as outlined in AFI 48-1XX, vol 1, Aeromedical Evacuation Medical Operations. **(T-2)**.

3.11.2. Patient handoff tools should not be placed in the medical record.

Chapter 4

AEROMEDICAL EVACUATION PAPER DOCUMENTATION

4.1. General Principles:

4.1.1. Patient records are tailored for each patient based on condition and treatments needed during patient movement. The AF Form 3899, Patient Movement Record, will be required for entry into the aeromedical evacuation system. Additional AF Form 3899 series documents will be used to document a patient's care during AE transport. The referring facility should be aware of available AF Form 3899 series documents and expand the use of these tools as patient needs require. When used, the AF Form 3899 series documents become a part of the permanent medical record. **(T-1)**.

4.1.2. Unless otherwise mentioned in this guidance, AF Form 3899 Series forms can be accessed on the Air Force e-Publishing website (**http://www.e-publishing.af.mil**). Form examples can be found at the following website: **https://eis.af.mil/cs/usafae/sg/SG%20Documents/Forms/AllItems.aspx?RootFolder=%2fcs%2fusafae%2fsg%2fSG%20Documents%2fAE%20Clinical%20Documentation%20and%20Forms&FolderCTID=&View=%7b0D340820%2d53DA%2d4B9E%2dA39F%2d9726FEA9B490%7d**. If personnel cannot access the website, please contact HQ AMC/SGK via email **amc.sgk@us.af.mil**, commercial (618) 229-6306 or DSN 312-779-6306.

4.2. AF Form 3899, *Patient Movement Record* (Front and Back).

4.2.1. The AF Form 3899, Patient Movement Record, is the patient movement record (PMR) and is used by the PMRC and Theater validating Flight Surgeon (TVFS) to validate a patient for flight.

4.2.2. The form will be completed by the originating medical treatment facility and submitted to the PMRC via TRAC2ES when complete.

4.2.3. If a patient is a dependent, the last four numbers of the sponsor's social security number (SSN) or the service member's Department of Defense identification number will be used.

4.2.4. Status: Enter the patient's status (e.g., Active Duty, Reserve, National Guard, Retired, Dependent, Civilian etc…).

4.2.5. Cite Number: enter this number once the patient has been submitted in TRAC2ES.

4.2.6. Max # of RONs: RON is remain overnight.

4.2.7. Altitude restriction: Enter cabin altitude as applicable.

4.2.8. Ready date: Enter date patient is ready to travel as coordinated with referring and accepting MTFs.

4.2.9. Number of attendants: Include both medical and non-medical attendants.

4.2.10. Classification: Refer to (Table 3).

4.2.11. Precedence: A privileged provider makes this determination.

4.2.12. Insurance company information is required if the patient is non-military. Document any third party insurance information for all patients to facilitate Third Party Collections.

4.2.13. Waivers: Enter type of waiver requested.

4.2.14. Section IV – Clinical Information. **NOTE 1.** A privileged provider should provide the clinical information, such as diagnosis and history. **NOTE 2.** Diagnosis: enter diagnosis with International Classification of Diseases code in parenthesis. **NOTE 3.** Allergies: Includes food, environmental (including Latex) and/or drug allergies. **NOTE 4.** Infection control precautions: Refer to AFI 48-1XX, V1, *Aeromedical Evacuation Patient Considerations and Standards of Care*. Enter standard, contact, airborne, strict airborne, as applicable. **NOTE 5.** Initial appropriate boxes: Mark appropriate boxes and explain any "Yes" in Section V, Clinical History. **NOTE 6.** Enter brief clinical history, including procedures and surgeries performed during current hospitalization. **NOTE 7.** A flight surgeon or privileged provider, if no flight surgeon is available, should annotate "Patient is stable and cleared for flight."

4.2.15. PMR (continuation). This page should be initiated by a privileged provider and is used to document privileged provider orders only. It will not be used as a continuation form for progress note documentation. Phone or verbal orders received while en route will be documented here by the nurse receiving the order. **(T-2)**. **NOTE 1.** Medication orders: All medications the patient is required to take while in the AE system will be written as a privileged provider's order. **(T-1)**. **NOTE 2.** If a patient is identified as a self-administered medication (SAM) patient, they maintain and take their own medications. The privileged provider's order must list all medications the patient will be taking to include self-administered medications. **(T-1)**. **NOTE 3.** Other orders: Enter non-medication orders in this area (e.g., treatments, activity, diet, dressing changes, etc.). **NOTE 4.** Use AF Form 3899F, Patient *Movement Physician Order for Behavior Management and Restraints*, for all restraint orders.

4.2.15.1. *The attending physician, with collaboration with the VFS or PMRC, determines patient classification. Patients are classified in the following manner:*

Table 4.1. USTRANSCOM PATIENT CLASSIFICATIONS.

CLASS 1	**Neuropsychiatric Patients**
1A	Severe Psychiatric Litter Patients. Psychiatric patient requiring the use of a restraining apparatus, sedation, and close supervision at all times. Will have a medical attendant.
1B	Psychiatric Litter Patients of Intermediate Severity. Psychiatric patients may require tranquilizing or sedating medications to prevent harm to self, aircrew members, or the aircraft. These patients will have a restraint order for applied restraints or restraints immediately available at the litter. Once available restraints are applied to the patient, the MCD will contact the Validating Flight Surgeon for an applied restraint order.
1C	Psychiatric Ambulatory 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 and will require assistance with egress.
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 an 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"

4.3. AF Form 3899A, *Patient Movement Record Progress Note* (Front and Back). AF Form 3899A, Patient Movement Record Progress Note, is used by clinicians to document en route

patient care encounters in the AE system. **NOTE 1.** If the patient is a dependent, the sponsor's SSN or service number will be used. **(T-1)**. **NOTE 2.** Status: AD=Active Duty, NG=National Guard, Res=Reserve, D=Dependent, O=Other. **NOTE 3.** Each assessment must be signed by the caregiver. **(T-1)**. **NOTE 4.** Non-licensed clinicians will require co-signatures by licensed clinicians after the last entry indicating acknowledgment and agreement with the preceding entries. **(T-1)**. **NOTE 5.** Medical attendants will make progress notes on their patients. **(T-1)**. AECMs will assist with the trip segment. **(T-1)**. After making their entry, the medical attendant must print and sign their full name and follow it with "MA." **(T-2)**. **NOTE 6.** Controlled Drug Accountability: Will include the drug name, total number received, and signatures of both the MTF representative and flight nurse. **(T-1)**. **NOTE 7.** Prescribed controlled medications are the personal property of self-administered medication (SAM) outpatients. AECMs should not ask outpatients to release their medications, providing outpatients are physically and mentally able to administer and maintain them properly. **NOTE 8.** For patients who are SAM, clinicians will check the appropriate boxes on the AF Form 3899C, Patient Movement Physician Assessment, list each medication on the AF Form 3899I, Medication Administration Record, and write "SAM" in the boxes next to each medication, or document the following statement on the AF Form 3899A, Patient Movement Record Progress Note, as appropriate. **(T-1)**. "Patient self-medicates, knows how to use and has adequate supply of medications." **NOTE 9.** If a patient is deemed not compliant and/or not competent for SAM, the clinician will **(T-1)**: notify the change in SAM status to the PMRC and/or the privileged provider as soon as possible; document on the AF Form 3899, Patient Movement Record, reason(s) for not being able to continue in SAM status to include the name and count of medications(s) surrendered by the patient; assume responsibility for administration of the patient's medication; initiate DD Form 2852, Aeromedical Evacuation Event/Near Miss Report. Controlled medications should be listed on the AF Form 3899A, Patient Movement Record Progress Note, under the controlled drug accountability section and co-signed by two AECMs or licensed clinicians.

4.4. AF Form 3899B, *Patient Movement Physician Orders*.

4.4.1. AF Form 3899B, Patient Movement Physician Orders, is a continuation form for privileged provider's orders. It is used when there is no more space for orders on AF Form 3899, Patient Movement Record. Complete the patient demographic information at the top of the form. **(T-0)**.

4.4.2. Allergies. Allergies will include food, environmental (including Latex) and/or medication allergies. **(T-0)**.

4.4.3. Physician Orders/Signature. Will annotate date and time (Zulu), order, print first name, middle initial, and last name followed by legal signature. **(T-0)**.

4.5. AF Form 3899C, *Patient Movement Physical Assessment*. The AF Form 3899C, Patient Movement Physical Assessment, is designed for rapid documentation of physical assessment findings on non-Advanced Care Specialty Team patients.

4.6. AF Form 3899D, *Patient Movement Hemodynamic/Respiratory Flowsheet* (Front and Back).

4.6.1. The AF Form 3899D, Patient Movement Hemodynamic/Respiratory Flowsheet, is used by AE and ERPSS clinicians or providers to document vital signs (VS), hemodynamic,

intracranial monitor readings and ventilator settings for patients with invasive monitoring and/or ventilators in the AF AE System.

4.6.2. Any or all of the fields may be used. **NOTE**: If clinicians choose to use this as the source document for VS, recommend annotating "see AF FORM 3899D for VS."

4.7. AF Form 3899E, *Patient Movement Intake/Output*.

4.7.1. AF Form 3899E, Patient Movement Intake/Output, is used to record accurate measures of intake and output (I&O) while in the AE system. It is completed by any clinician in the AE system.

4.7.2. I&O will be totaled at the end of each mission or shift; the ordering privileged provider will determine parameters, e.g., hours. **(T-2)**. Measurements will be in milliliters. **(T-2)**.

4.8. AF Form 3899F, *Patient Movement Physician Orders for Behavior Management and Restraints*.

4.8.1. The AF Form 3899F, Patient Movement Physician Orders for Behavior Management and Restraints, is used for patients requiring chemical and/or physical restraints during evacuation.

4.8.2. The attending physician will order interventions for behavior management and restraints as necessary for patients in the AE system using this form. **(T-2)**. **NOTE 1.** AF Form 3899G, Patient Movement Restraint Observations Flowsheet, will be used in conjunction with this form to document interventions, observations and assessments. **(T-2)**. **NOTE 2.** Orders are valid for a maximum of 24 hours and will be reviewed by a privileged provider at RON locations or at a patient's destination. **(T-0)**. If an order from the sending facility expires during transport, the order remains valid until the patient arrives at either a RON location, the destination facility, or is overridden by a privileged provider on board the airframe or by the TVFS. **NOTE 3.** An order for restraints is required for 1A or 1B patient classifications. The order will specify if the patient is restrained or if the restraints are immediately available at the litter for application if the patient threatens the safety of self, aircrew members, or the aircraft. **(T-1)**. If the restraint order is written for restraints to be immediately available at the litter, the MCD will contact the validating flight surgeon and obtain a restraint order immediately after the patient is restrained. **NOTE 4.** Restraint PRN orders are not allowed. (**T-0)**.

4.9. AF Form 3899G, *Patient Movement Restraint Observation Flowsheet* (Front and Back).

4.9.1. The AF Form 3899G, Patient Movement Restraint Observation Flowsheet, is used to document observations of a patient requiring chemical and/or physical restraints while in the AE system.

4.9.2. It will be completed by any AECM or medical attendant. **(T-2)**.

4.10. AF Form 3899H, *Patient Movement Neurological Assessment*.

4.10.1. The AF Form 3899H, Patient Movement Neurological Assessment, is used to document ongoing neurological assessments for patients in the AE system.

4.10.2. Clinicians are to use this form for any patient with the potential to develop a neurological deficit requiring frequent or repeated assessments. **(T-3)**.

4.11. AF Form 3899I, *Patient Movement Medication Record*.

4.11.1. The AF Form 3899I (Front), Patient Movement Medication Record, is used to document scheduled medications. The reverse of the form is to document as needed (PRN) and one-time medications.

4.11.2. Clinicians will document medications on the AF Form 3899I, Patient Movement Medication Record, or electronic equivalent. **(T-2)**. **NOTE 1.** Use this form for SAM patients as well as clinician administered medications. **NOTE 2.** If additional space is required to document medications, state on the bottom center portion "See Continuation 3899I, attached," and staple together. On the bottom of the center portion of additional 3899Is, write "Continuation 3899I." **NOTE 3.** Initials: Will enter initials of clinician administering the medication. Enter "SAM" in the initial box for medications order by the physician to be self-administered. **(T-1)**. **NOTE 4.** Provider Identification: Will enter clinician's initials, signature, first and last name printed, title, and local unit of assignment. **(T-1)**. **NOTE 5.** When a medication is discontinued,a line will be drawn through the medication and write discontinued above the line with date, time and initials. **(T-1)**. **NOTE 6.** If a medication is held, a circle will be drawn around the date/time and document reason on AF Form 3899A, Patient Movement Progress Note. **(T-1)**. **NOTE 7.** Problem/Complaint (on reverse of form): A reason for administering the PRN or single dose medication will be documented. **(T-1)**.

4.12. AF Form 3899J, *Patient Movement Rhythm/Hemodynamic Strip*.

4.12.1. The AF Form 3899J Patient Movement Rhythm/Hemodynamic Strip, is used by any clinician in the AE system to provide chronological documentation of a patient's cardiac rhythm or hemodynamic rhythms when being continuously monitored.

4.12.2. This form may be used to document rhythm strips during a cardiac or respiratory arrest.

4.13. AF Form 3899K, *Patient Movement / In-Flight Resuscitation Flow Sheet* (front and back).

4.13.1. The AF Form 3899K (front and back), Patient Movement/In-Flight Resuscitation Flow Sheet, is used by any clinician to document a patient's chronological log of events during a cardiac or respiratory arrest.

4.13.2. This form will be initiated as soon as possible following the start of a cardiac or respiratory arrest and may be completed by a designated recorder. **(T-2).** **NOTE 1.** If a nurse was not the recorder, a flight nurse or licensed clinician must sign the form validating its correctness. **(T-1)**. **NOTE 2.** If a privileged provider is on board and was involved as part of the Advanced Cardiac Life Support (ACLS) team, that person will sign the form in addition to other required signatures. **(T-1)**.

4.14. AF Form 3899L, *Patient Movement Record Enroute Critical Care* (front and back).

4.14.1. The AF Form 3899L (front), Patient Movement Record Enroute Critical Care, is used by any clinician in the AE system to document on critically ill or injured patients. AF Form 3899L (back) information is completed at the sending MTF when the team takes responsibility for the patient and concludes when the team provides handoff at the receiving facility.

4.14.2. All applicable pre-mission VS and arterial blood gases (ABG) as well as applicable post-mission VS/ABG results are annotated on page one. Continuing VS should be annotated on the (reverse) page.

4.14.3. Use other 3899 series forms as applicable. This is not a standalone form; rather it should be used as a supplement to the current 3899 package. **NOTE 1.** # CCATT Patients: Enter the total number patients assigned to the transport team. **NOTE 2**. En Route Time: Enter the total amount of time primary care was rendered to the patient. **NOTE 3.** Diagnosis: D=Disease, BI=Battle injury, NBI=Non-battle injury. **NOTE 4.** Max Cabin Altitude: Enter the actual maximum cabin altitude during transport. **NOTE 5.** Temperature notations should be in degrees Fahrenheit. **NOTE 6.** Neurologic: This represents data collected using a Glasgow Coma Scale (GCS). Write the eye movement score next to the "E." Write the motor score next to the "M." Write the verbal score next to the "V" (enter "T" if the patient is intubated or has a tracheostomy). Write the total score next to GCS. If the patient is intubated, the score will be a number followed by the letter "T." **(T-3)**. **NOTE 7.** In the space available for each system, the clinician may add pertinent assessment information that is not otherwise addressed. **NOTE 8.** Critical Care Transport personnel will print full names, rank and Air Force Specialty Codes (AFSCs) in the appropriate cell and sign their full name in the cell below. **(T-1)**. **NOTE 9.** Medications received/wasted/turned-over: At the end of the mission, a list and record controlled medications used and amount wasted will be documented. **(T-1)**. A statement will be entered in the Flight Notes section or on a SF 600, Health Record – Chronological Record of Medical Care, if the team receives controlled medication for individual patients. Include the drug name, total number received, and signatures of both the MTF representative and privileged provider or registered nurse (RN). **NOTE 10.** Anatomic Man diagram: This diagram is used to document the location of patient injuries, and is used for visual reminder of all injuries. **NOTE 11.** Physician Orders Block: Annotate new or changed orders for ERC. The privileged provider will initial in the first column. **(T-2)**. The nurse will initial in the second column verifying orders were received and annotated. **(T-1).**

4.15. AF Form 3899M, *Patient Movement Record PCA/PNB/Epidural Hand-Off Form* (front and back).

4.15.1. The AF Form 3899M (Front), Patient Movement Record PCA/PNB/Epidural Hand-Off Form, is used by any licensed clinician in the AE system to provide chronological documentation for patients with accompanying patient controlled analgesia devices.

4.15.2. The AF Form provides a means to document multiple patient care hand-offs and requires both sending and receiving nurse endorsements. **NOTE 1.** Initial Patient Controlled Analgesia (PCA) Orders and Pump Set-Up Verification. This section is filled out during order verification and PCA pump set up. If an order or program is changed, start a new form. **NOTE 2.** Order/IV/Pump Verified; Pulse Ox Available: A pulse oximeter will be available. Once orders and pump programming are verified, two licensed clinicians will document verification at designated spots reading RN #1 and RN #2 Signature and Initials. **(T-2)**. **NOTE 3.** Patient Handoff – Pump Infusion History Reviewed: Medication volumes and PCA pump history will be reviewed and documented in handoff. A infusion running total will not be cleared. The relinquishing nurse should report and document only on the medication administered during their time with the patient (from the previous handoff to the current handoff).

4.16. AF Form 3899N, *Patient Movement Pain Adjunct Flow Sheet*.

4.16.1. The AF Form 3899N, Patient Movement Pain Adjunct Flow Sheet, is used to document objective and subjective patient data related to medications flowing through a PCA pump. Pain reassessment should be reaccomplished after each intervention.

4.17. AF Form 3829, *Summary of Patients Evacuated by Air*.

4.17.1. The AF Form 3829, Summary of Patients Evacuated by Air, is completed by the MCD, when a TRAC2ES generated coversheet is unavailable, to document AE mission events.

4.17.2. The following guidance is used to complete the form: **NOTE 1.** Complete the form in block print. **NOTE 2.** Aircraft Organization: Document the name of the organization providing airlift for the mission. **NOTE 3.** Medical Crew Organization: Organization (flight or squadron) assigning AECMs to the mission. **NOTE 4.** Manifest Number: Not normally used. **NOTE 5.** Trip Identifier: Mission number from the Global Decision Support System (GDSS). Type Mission: U=Urgent, P=Priority, R=Routine; when flying "special" patients annotate an "S" to the right of the "R." A special patient is defined as a routine patient who may require special expertise, nursing care, equipment, routing or procedures en route. The PMRC identifies these patients and coordinates issues with the originating and destination MTFs. **NOTE 6.** Total Manifested: Enter the total number of patients and attendants manifested for the entire mission (litter – ambulatory + attendants). **NOTE 7.** Flight Crew: Rank and last name of aircraft commander plus the remaining number of crewmembers on the flight authorization (e.g. Maj Henry +4). **NOTE 8.** Medical Crew: Rank, last name, crew duty position and home unit of assignment of qualified and current AECMs assigned to primary AE crew (crew duty position and home unit of assignment will match the information on AFTO Form 781, *ARMS Aircrew/Mission Flight Data Document*). Also list flight instructors who are performing instructor duties for unqualified/non-current crew members, flight examiners administering check rides to unqualified AECMs, augmentees and flight surgeons (authorized to log flight time) accompanying the AE crew. **NOTE 9.** Additional Medical Crew Member/Trainees: Enter rank, last name, crew duty position and unit of assignment for unqualified/non-current AECMs, mission clinical coordinator (MCC), Mission Essential Personnel (MEP), evaluators administering checkrides to qualified crew members and members of the CCATT accompanying the mission. **NOTE 10.** Do not include flight surgeons assigned as a medical attendant. **NOTE 11.** If an individual listed will not be staying with the AE crew until the end of the mission, indicate where the individual will enplane and deplane using ICAO codes. **NOTE 12.** Itinerary: Enter ICAO code for each station in order of proposed itinerary from origin to destination. **NOTE 13.** Enplaned: Use the format Litter – Ambulatory + Attendant to indicate patients enplaned at each station. Use "ORIG" at the first location to indicate mission origination. **NOTE 14.** Deplaned: Use the format Litter – Ambulatory + Attendant to indicate patients deplaned at each station. Use "TERM" at the last stop to indicate termination of mission. **NOTE 15.** On Board: Use the format Litter – Ambulatory + Attendant to indicate total number on board for each segment of the mission. **NOTE 16.** Make pen and ink changes to the itinerary and patient load as they occur during the mission. **NOTE 17.** Remarks: Comments will include, but are not limited to: discrepancies and/or unusual occurrences (i.e. insufficient patient preparation, mission delays, safety risks, problems with passengers, mechanical discrepancies, etc.) noted

throughout the mission, the impact, actions taken and recommendations for follow-up (as applicable). Comments on all urgent, priority, very seriously ill (VSI), seriously ill (SI), "special patients" and patients initiated on oxygen in flight (not ordered by a physician) are mandatory. Information will include enplaning/deplaning ICAO codes, patient cite number, diagnosis, classification, movement precedence, nursing assessment, and treatment administered in-flight and applicable vital signs. Special comments should include but are not limited to: maximum cabin altitude if a patient encountered cardiac or respiratory difficulties, other evidence of decompression sickness, or whenever cabin altitude exceeded 10,000 feet; the number of patients affected by an unscheduled RON, include the location, date, and the degree of services required; any in-flight emergency, either medical or aircraft; details of births or deaths which occurred either in-flight or on the flight line, enter date and Zulu time, station and persons involved; patients with altitude restrictions; any additional persons on board, i.e. flight surgeons, mission essential personnel, medical attendants. Oxygen management documentation includes: total patient oxygen requirement, total pre-mission portable therapeutic liquid oxygen (PTLOX) / therapeutic oxygen level; mid-mission PTLOX/therapeutic oxygen level; post-mission PTLOX/therapeutic oxygen level; maximum cabin altitude during mission. **NOTE 18.** Authenticating Officer reviews the form for completion and signs the form. **NOTE 19**. Fax the form to the C2 agency upon mission completion. **NOTE 20.** The AFTO 781, ARMS Aircrew/Mission Flight Data Document, contains duplicative information mentioned on this form. AECMs may write "see AFTO 781" on the manifest and fax a copy of the AFTO 781 to the C2 agency at the end of the mission.

4.18. AF Form 3851, *Patient Baggage Data*.

4.18.1. AF Form 3851, Patient Baggage Data, is used by ERC members during patient transport to effectively manage baggage for patients and ancillary support members.

4.18.2. This form will be completed by the originating MTF, patient staging or AE crew (if not completed prior to patients arriving at the aircraft) **(T-3)**. The MTF or patient staging should photocopy and provide the AE crew with enough copies so each offload location and AE crew receives one.

4.18.3. AECM will update the form if patients are added or removed from the mission. **(T-3)** **NOTE 1.** One signed copy is given to each en route stop. **NOTE 2.** One signed copy is filed with mission paperwork. **NOTE 3.** Use ICAO codes for onload and offload stations. **NOTE 4.** Signature of person receiving baggage at offload station: include signature, printed name, rank, and duty phone number.

4.19. AF Form 3854, *Receipt for Patient's Valuables*.

4.19.1. AF Form 3854, Receipt for Patient's Valuables, is completed by anyone to transfer the valuables of unconscious/incompetent patient from one MTF/staging facility to another.

4.19.2. This form should be retained in the patient's medical records. **NOTE 1.** Complete four copies, one to be filed with the mission paperwork, one copy sent with the patient's medical record and the last two copies are given to the MTF, or patient staging representative accepting custody of the valuables. **NOTE 2.** List Items Below. List each item, and the quantity. Describe each item in general terms. Avoid terms like "gold watch," but rather "yellow band watch" or "ring with clear stone" instead of "diamond ring."

List each check number and the issuer separately. Place a large letter "Z" through this section after the last item is entered so no additional items may be added. **NOTE 3.** Signature of hospital representative and unit assigned. Clearly print the name and rank of the individual at the receiving MTF or patient staging facility who takes possession of the patient's valuables. That individual then signs the form and certifies receipt of the valuables by writing the following statement in the block: "In Receipt of the Valuables Listed Above."

4.20. AF Form 3859, Turn-In of Unaccompanied Narcotics.

4.20.1. AF Form 3859, Turn-In of Unaccompanied Narcotics, is completed by any flight nurse assigned to the mission, or 7-level AECM if the crew does not include a FN, and used to turn-in unaccompanied narcotics, left on the aircraft after the patient has deplaned, to drug room/pharmacy personnel.

4.20.2. If multiple narcotics or different forms of a narcotic are to be turned in, use a separate AF Form 3859 for each.

4.21. DD Form 2852, *Patient Movement Event/Near Miss Report* (front and back).

4.21.1. Refer to the Department of Defense Instruction Patient Movement, DoDI 6000.11.

4.21.2. The patient safety manager or designee will utilize TRAC2ES to enter a submitted DDF 2852, Pt Movement/Near Miss Report.

4.21.3. The DD Form 2852, Patient Movement Event/Near Miss Report, ***WILL NOT*** be placed in the permanent medical record (refer to NOTE under 3.2.16.8.)

Chapter 5

EN ROUTE CARE ELECTRONIC HEALTH RECORD DOCUMENTATION

5.1. General Principles.

5.1.1. The patient EHR should be tailored for each patient based on condition and treatments needed and delivered during patient movement. General guidelines as outlined in **Chapter 3** apply to the electronic health record.

5.1.2. Clinicians and privileged providers may chart by exception in the EHR system, consistent with applicable standards.

5.1.3. Signature logs are not required for EHRs that do not contain paper documentation; however, a signature log will accompany the record if the record consists of electronic and paper documentation/charting. **(T-2)**. See 3.2.15.

5.1.4. When documentation is contained in both paper and electronic health records. The paper document should be referenced in the EHR.

5.2. AHLTA-T Specific Considerations.

5.2.1. AHLTA-T users and super users will be responsible for proper utilization of the system to the level of their training proficiency levels. **(T-2)**. See **Attachment 2** for training requirements and proficiency codes.

5.2.2. Entering and Reviewing AE EHR Information.

5.2.2.1. Entering patient data into the ERC EHR can be done in two ways:

5.2.2.1.1. Either through the creation of an AHLTA-T encounter or

5.2.2.1.2. Embedding scanned paper documentation in an AHLTA-T encounter or TMDS record.

5.2.2.2. Reviewing AE electronic patient information can be done in three ways. By reviewing an AHLTA-T encounter if the information has been transferred from one AHLTA-T system to another. By reviewing a patient's record in TMDS. By reviewing information transferred through the common data registry (CDR) into AHLTA (Garrison).

5.2.2.3. See NOTES under **A2.3.2** and **A2.3.3.1.3**.

5.2.3. Patient demographic information and disposition.

5.2.3.1. Do not alter patient demographics when patients are already in the Authoritative Data Source (ADS) or information has been transferred on portable media. If demographics are incorrect, contact the TMIP-AF help desk ASAP. TMIP-AF will make the changes. See WARNING under **A2.5.2.10.2.4**.

5.2.3.2. Recommend assigning the disposition in an AHLTA-T encounter to "evacuation." See NOTE under **A2.5.2.11.4**.

5.2.4. Privileged Provider and Verbal Orders.

5.2.4.1. Privileged provider orders cannot be modified. Discontinue incorrect orders and replace with a correct order. See **3.3.7**.

5.2.4.2. Special WARNINGS and NOTES are applicable when entering and discontinuing patient orders in the EHR. See **3.3.7.2**. for details.

5.2.4.3. Privileged providers or clinicians entering verbal orders must notify staff when a new order is entered in AHLTA-T. **(T-1)**. AHLTA-T does not automatically alert clinicians when a new order is written. See WARNING under **A2.5.2.11.6.3**.

5.2.4.4. Medication orders can be discontinued via the "A/P module." See NOTE under **A2.5.2.11.6.4**.

5.2.5. Medications Module.

5.2.5.1. Scheduling of medications should be done by the sending MTF or Patient Staging Unit. See NOTE under **A2.5.2.11.6.8**.

5.2.5.2. If a medication is missed, clinicians will contact the appropriate privileged provider as soon as possible and document the notification in the record. **(T-0)**. See WARNING under **A2.5.2.11.6.10**.

5.2.5.3. Verbal medication order expiration dates will be set to expire 5 days from the time of order entry. **(T-1)**. Orders should not expire during patient movement unless the expiration time and date is intentional. See WARNINGs under **A2.5.2.11.6.11**.

5.2.5.4. See WARNING under **A2.5.2.11.6.12** when documenting in chart view and tree view.

5.2.5.5. AECMs will discontinue medications IAW A2.5.2.11.6.12. only upon verbal order from a privileged provider. **(T-0)**.

5.2.5.6. Cells colored LIGHT BLUE in the "Chart View" have special considerations. See Section **A2.5.2.11.6.13** for details.

5.2.6. Documenting an encounter.

5.2.6.1. Clinicians should document encounters in accordance with training outlined in **A2.5.2.12**.

MARK A. EDIGER
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

AFI 44-119, *Medical Quality Operations*, 16 August 2011

Hockenberry, M. & Wilson, D., *Wong's Essentials of Pediatric Nursing*, 2 October 2014

Jacques, E., *FLACC Scale – Pain Assessment Tool*, 30 April 2014

Maji, A., *Nurses Notes: DART Format*, 5 May 2014

AFI 33-360, *Publications and Forms Management*, 25 September 2013

Health Insurance Portability and Accountability Act

DoD 6025.18-R, DoD Health Information Privacy Regulation

Prescribed Forms

AF Form 3829, *Summary of Patients Evacuated by Air*

AF Form 3830, *Patient Manifest*

AF Form 3835, *Aeromedical Mission Management Part 1*

AF Form 3836, *Aeromedical Evacuation Manifest Part 2*

AF Form 3838, *Do Not Resuscitate (DNR) Certification for Aeromedical Evacuation*

AF Form 3841, *Certification of Release*

AF Form 3851, *Patient Baggage Data*

AF Form 3854, *Receipt of Valuables*

AF Form 3859, *Turn-In of Unaccompanied Narcotics*

AF Form 3860, *Aeromedical Patient Record Data*

AF Form 3891, *Patients Report for Aeromedical Airlift Movement*

AF Form 3892, *Patients Holding for Aeromedical Airlift Movement*

AF Form 3894, *Aeromedical Mission Inbound Notification*

AF Form 3899, *Patient Movement Record*

AF Form 3899A, *Patient Movement Record Progress Note*

AF Form 3899B, *Patient Movement Record Physician Orders*

AF Form 3899C, *Patient Movement Record Physical Assessment*

AF Form 3899D, *Patient Movement Record Hemodynamic/Respiratory Flow sheet*

AF Form 3899E, *Patient Movement Intake/Output*

AF Form 3899F, *Patient Movement Physician Orders for Behavior Management and Restraints*

AF Form 3899G, *Patient Movement Restraint Observation Flow sheet*

AF Form 3899H, *Patient Movement Neurological Assessment*

AF Form 3899I, *Patient Movement Medication Record*

AF Form 3899J, *Patient Movement Rhythm/Hemodynamic Strip*

AF Form 3899K, *Patient Movement In-Flight Resuscitation Flow sheet*

AF Form 3899L, *Patient Movement Record Enroute Critical Care*

AF Form 3899M, *Patient Movement Record PCA/PNB/Epidural Hand-Off Form*

AF Form 3899N, *Patient Movement Pain Adjunct Flow sheet*

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

AF Form 1053, *Record of Patient Storing Valuables*

AF Form 1225, *Informed Consent for Blood Transfusion*

AF Form 3066, *Doctor's Orders*

AF Form 579, *Controlled Substance Register*

DD Form 602, *Patient Evacuation Tag*

DD Form 1380, *US Field Medical Card*

DD Form 1502, *Frozen Medical Material Shipment*

DD Form 1502-I, *Chilled Medical Material Shipment*

DD Form 2239, Consent *for Medical Care and Transportation*

DD Form 2852, *Aeromedical Evacuation Event/Near Miss Report*

SF 514, *Blood Administration*

SF 518, *Blood or Blood Component Transfusion Record*

SF 600, *Health Record - Chronological Record of Medical Care*

Abbreviations and Acronyms

ABG—Arterial Blood Gas

ACLS—Advanced Cardiac Life Support

ADS—Authoritative Data Source

AE—Aeromedical Evacuation

AES—Aeromedical Evacuation Squadron

AECM—Aeromedical Evacuation Crew Member

AFRC—Air Force Reserve Command

AFSC—Air Force Specialty Code

AHLTA-T—Armed Forces Health Longitudinal Technology Application Theater

AIM—Alternative Input Method

ANG—Air National Guard

C2—Command and Control

CCATT—Critical Care Air Transport Team

CDR—Common Data Registry

CMC—Crew Management Cell

DoD—Department of Defense

DSN—Defense Switching Network

EHR—Electronic Health Record

EHRDP—Electronic Health Record Document Program

ERC—En Route Care

ERPSS—En Route Patient Staging System

FLACC—Faces Legs Activity Cry Consolability

GCS—Glasgow Coma Scale

HAF—Headquarters Air Force

HIPAA—Health Insurance Portability and Accountability Act

I&O—Intake and Output

IAW—In Accordance With

ISBAR—Identify, Situation, Background, Assessment and Recommendation

MAR—Medication Administration Module

MCC—Mission Clinical Coordinator

MCD—Medical Crew Director

MEP—Mission Essential Personnel

MTF—Medical Treatment Facility

PCA—Patient Controlled Analgesia

PMR—Patient Movement Record

PMRC—Patient Movement Requirements Center

PRN—As Needed

PTLOX—Portable Therapeutic Liquid Oxygen

RN—Registered Nurse

RON—Remain Overnight

SAM—Self-Administered Medication

SI—Seriously Ill

SSN—Social Security Number

TMDS—Theater Medical Data Store

TMIP-AF—Theater Medical Information Program - Air Force

TRAC2ES—TRANSCOM Regulating and Command & Control Evacuation System

TVFS—Theater Validating Flight Surgeon

UTC—Unit Type Code

VA—U.S. Department of Veterans Affairs

VS—Vital Signs

VSI—Very Seriously Ill

Terms

CAUTION—Procedures and techniques which could result in damage to equipment if not carefully followed.

Clinician—is defined as a physician, nurse, medical technician, or other qualified person who is involved in the treatment and observation of living patients, as distinguished from one engaged in research.

En Route Patient Stage—is a specific UTC staging facility.

En Route Patient Staging System—denotes the global system.

MAY —Used to express an acceptable or suggested means of accomplishment and shall be construed as a non-mandatory provision.

NOTE—Indicates operating procedures, techniques, etc., which are considered essential to emphasize.

Privileged Provider—is a clinician who has been given independent authority by their medical treatment facility or medical unit to begin, alter, or end a plan of treatment for a patient.

SHALL, WILL, and MUST—Used to express requirements that are binding and mandatory.

SHOULD—Used to express a non-mandatory desire or preferred method of accomplishment and shall be construed as a non-mandatory provision.

WARNING—Procedures and techniques which could result in personal injury or loss of life if not carefully followed.

Attachment 2

EN ROUTE CARE ELECTRONIC HEALTH RECORD HARDWARE/SOFTWARE/TRAINING REQUIREMENTS

A2.1. The AE EHR system will consist of four parts: Computer hardware, software applications, an expeditionary framework, and a data management infrastructure capable of operating in the en route care environment. **(T-1)**.

A2.2. The support contact number/information to update hardware/software will be maintained on every AE EHR opening screen. **(T-1)**.

A2.3. Software Development.

A2.3.1. The intuitiveness of software design will be a high priority during software design and testing in order to minimize user training requirements. **(T-1)**.

A2.3.2. The current AE EHR system uses the theater configuration of AHLTA-T to gather data from clinicians. **NOTE**: AHLTA-T software is a store and forward system. Information generated by one AHLTA-T system can only be accessed by another AHLTA-T system if the file(s) created during an encounter is moved along with the patient flow through the AE system. Encounters may be reviewed after obtaining a TMDS account via this link: **https://tmds.tmip.osd.mil/portal**.

A2.3.3. Software will have the capability for gathering comprehensive objective and subjective patient data after an encounter is created. **(T-1)**.

A2.3.3.1. The encounter will be saved as a file on the local system. **(T-1)**.

A2.3.3.1.1. Once the encounter is signed by an authorized clinician, AE EHR software will automatically place the data in queue. **(T-1)**.

A2.3.3.1.2. Once an internet connection is established, data will be condensed, encrypted and automatically forwarded to TMDS within 30 minutes. **(T-1)**.

A2.3.3.1.3. Data forwarded to TMDS will be batched and sent to the CDR within 24 hours. **(T-1)**. **NOTE**: Due to the delay in data flow from TMDS to the CDR, receiving clinicians should use a current instance of AHLTA-T or TMDS to review patient care encounters recorded in the expeditionary and/or ERC environment.

A2.3.3.1.4. Data will be digitized with the ability to be visually interpreted by clinicians, sorted, and queried for metrics, quality analysis, process improvement and research. **(T-1)**.

A2.3.4. Software programs will be developed for the unique ERC environment. Environmental factors include: **(T-1)**.

A2.3.4.1. Lack of continuous en route connectivity and limited bandwidth.

A2.3.4.2. Requiring a system capable of gathering, storing, and forwarding patient information to another instance of AHTLA-T, TMDS and the CDR when external connectivity can be established.

A2.4. Updated hardware and software user manuals will be available for use by personnel in the AE system and will include at a minimum: **(T-2)**.

A2.4.1. Step by step instructions for software use.

A2.4.2. Basic hardware/software troubleshooting.

A2.4.3. Hardware guides will include:

A2.4.3.1. Purpose.

A2.4.3.2. Parts.

A2.4.3.3. Pre-flight and function checks.

A2.4.3.4. Performance.

A2.4.3.5. Power.

A2.4.3.6. Setup requirements, placement and securing recommendations.

A2.4.4. Protocols for end of shift / end of mission data transmission and verification procedures.

A2.4.5. User manuals will be available in electronic format prior to fielding any new hardware or software. Manuals will be placed on each user desktop image.

A2.5. ERC EHR Training Requirements.

A2.5.1. ERC EHR training programs will train "Users" and "Super Users" to proficiency levels as referenced in Table A2.1, Proficiency Code Key. **(T-2)**.Proficiency codes are listed on the end of each training line item.

A2.5.1.2. A "Super User" will be trained in administrative functions to include but not limited to creating user accounts; establishing, resetting, and unlocking account passwords; and assigning system roles and privileges. **(T-1)**.

A2.5.2. ERC EHR training will include: **(T-2)**.

Table A2.1. Proficiency Code Key (IAW CFETP 4N0X1).

Proficiency Code Key		
	Scale Value	Definition: The individual
Task Performance Levels	1	**IS EXTREMELY LIMITED** (Can do simple parts of the task. Needs to be told or shown how to do most of the task.)
	2	**IS PARTIALLY PROFICIENT** (Can do most parts of the task. Needs only help on hardest parts.)
	3	**IS COMPETENT** (Can do all parts of the task. Needs only a spot check of completed
	4	**IS HIGHLY PROFICIENT** (Can do the complete task quickly and accurately. Can
Task Knowledge Levels	a	**KNOWS NOMENCLATURE** (Can name parts, tools, and simple facts about the task.)
	b	**KNOWS PROCEDURES** (Can determine step by step procedures for doing the task.)
	c	**KNOWS OPERATING PRINCIPLES** (Can identify why and when the task must
	d	**KNOWS ADVANCED THEORY** (Can predict, isolate, and resolve problems about the
Subject Knowledge Levels	A	**KNOWS FACTS** (Can identify basic facts and terms about the subject.)
	B	**KNOWS PRINCIPLES** (Can identify relationship of basic facts and state general
	C	**KNOWS ANALYSIS** (Can analyze facts and principles and draw conclusions about the
	D	**KNOWS EVALUATION** (Can evaluate conditions and make proper decisions about
Explanations: A **task knowledg**e scale value may be used alone or with a **task performance scale value** to define a level of knowledge for a specific task. (Examples: a and 1a, b and 2b, or c and 3c) A **subject knowledge scale value** is always used alone to define a level of knowledge for a subject not directly related to any specific task, or for a subject common to several tasks. - This mark is used alone instead of a scale value to show that no proficiency training is provided in the course or CDC.		

A2.5.2.1. Training a user to capture EHR information using AHLTA-T. (3b)

A2.5.2.2. Training a user to properly enter data into fields. (3b)

A2.5.2.3. Providing users with an overview of TMIP, the expeditionary framework and how information flows from the user through the system and to other members of the AE system (including encounter attachments). (B)

A2.5.2.4. Providing users with an explanation of what types of facilities are capable of viewing EHR information and which are not. (B)

A2.5.2.5. Providing an explanation of when printing is necessary within the AE system. (B)

A2.5.2.6. Training applicable users to log into client and remote connectivity to server, which also includes: (3b)

A2.5.2.6.1. Logging into hardware/software. (3b)

A2.5.2.6.2. Verifying connection(s) to server. (3b)

A2.5.2.7. Training AECMs to accomplish Common Access Card sign-on and password reset. (3b)

A2.5.2.8. Training users to log into AHLTA-T which includes: (3b)

A2.5.2.8.1. The ability for a user to accomplish access to hardware, software and electronically sign/co-sign documentation. (3b)

A2.5.2.8.2. AECMs will be trained to create user accounts, set up password(s), reset password(s), assign appropriate roles and privileges and unlock accounts. **(T-1)**. In addition, AECMs will be trained to set up hardware to include connections to printers, routers, and wireless internet access devices. (3b) **(T-1)**.

A2.5.2.9. AECMs and super users will be trained to perform preflight procedures which include **(T-1)**:

A2.5.2.9.1. Hardware preflight. (4c)

A2.5.2.9.1.1. Ensuring kit contents match inventory checklist. (4c)

A2.5.2.9.1.2. Ensuring wireless router connections function appropriately. (4c)

A2.5.2.9.1.3. Ensuring calibration of touch screen(s). (4c)

A2.5.2.9.1.4. Where applicable, verifying MiFi connection to internet. (4c)

A2.5.2.9.2. Software preflight. (4c)

A2.5.2.9.3. Function checks. (4c)

A2.5.2.9.4. Operational preflight. (4c)

A2.5.2.10. Training will include three scenarios covering procedures for patients arriving with data on portable media; patients arriving without portable media but are registered in the ADS, and patients arriving with neither portable media, nor are registered in ADS. Training scenarios will include starting a new encounter, and documenting an encounter. Training will include any **WARNINGS**, **CAUTIONS** or **NOTES**. **WARNINGS, CAUTIONS** and **NOTES** will be trained to the ***proficiency code D*** level. **(T-2)**.

A2.5.2.10.1. Patients arriving with information on portable media.

A2.5.2.10.1.1. Users will understand the purpose of the data manager and where information is stored on the hardware device. (3b)

A2.5.2.10.1.2. Users will demonstrate how to import patient data from portable media. (3b)

A2.5.2.10.1.3. Users will demonstrate how to export data to portable media. (3b)

A2.5.2.10.1.4. Users will demonstrate how to review patient documents from previous encounters. (3b)

A2.5.2.10.2. Patients arriving without portable media but are registered in ADS.

A2.5.2.10.2.1. Users will demonstrate how to search for a patient (last name plus social security number). (3b)

A2.5.2.10.2.2. Users will demonstrate the ability to verify ADS. (3b)

A2.5.2.10.2.3. Users will demonstrate the ability to add a new patient. (3b)

A2.5.2.10.2.4. Users will demonstrate the ability to edit demographics. (3b) **WARNING**: Do not edit patients already in ADS or on portable media.

A2.5.2.10.3. Patients arriving with *neither* portable media, *nor* are found registered in ADS.

A2.5.2.10.3.1. Users will demonstrate how to add a new patient. (3b)

A2.5.2.10.3.2. Users will demonstrate how to enter demographics. (3b)

A2.5.2.11. Training a user to start a new encounter. (3b) **(T-2)**.

A2.5.2.11.1. Users will demonstrate the ability to register a patient. (3b)

A2.5.2.11.2. Users will demonstrate the ability to review previous encounters. (3b)

A2.5.2.11.3. Users will demonstrate the ability to review previous documents. (3b)

A2.5.2.11.4. Users will demonstrate the ability to enter a disposition from the PMR. (3b) **NOTE**: In most cases, the disposition should be "evacuation".

A2.5.2.11.5. Clinicians will demonstrate the ability to load and use templates for documentation. (3b)

A2.5.2.11.6. Clinicians will demonstrate the ability to use the Medication Administration Record (MAR) Module which includes:

A2.5.2.11.6.1. Demonstrating the ability to use "tree view." (3b)

A2.5.2.11.6.2. Demonstrating the ability to use "chart view." (3b)

A2.5.2.11.6.3. Demonstrating the ability to reconcile medications in the medication module utilizing the "A/P module." (3b) **WARNING**: Medication orders are initiated through the "A/P Medication Module." AHLTA-T does not have a mechanism to automatically alert clinicians when new orders are entered, therefore any new order must be immediately relayed to AECMs or clinical staff.

A2.5.2.11.6.4. Privileged providers and flight nurses will demonstrate how to discontinue medications via the MAR Module and "A/P medication module." (3b) **NOTE:** Licensed providers and flight nurses with verbal orders may discontinue medication via the "A/P module."

A2.5.2.11.6.5. Demonstrating use of the expanded "SIG module" to reconcile new medications. (3b)

A2.5.2.11.6.6. Demonstrating how to document medication administration. (3b)

A2.5.2.11.6.7. Demonstrating how to sort continuous infusions, scheduled medications and PRN medications. (3b)

A2.5.2.11.6.8. Demonstrating how to schedule re-occurring and one time use medications using the "Chart View." (3b) **NOTE**: Scheduling of medications should be completed by the MTF or patient staging personnel, however AECMs may need to reschedule or schedule new medications en route.

A2.5.2.11.6.9. Demonstrating how to document actual time medication administered. (3b)

A2.5.2.11.6.10. Demonstrating how to document missed medications. (3b) **WARNING**: If a medication is missed, clinicians will contact the appropriate privileged provider as soon as possible.

A2.5.2.11.6.11. Demonstrating how to document verbal medication orders by entering the privileged provider's name, rank and contact number in the MAR Module comment box. (3b) **WARNING**: All verbal medication orders will be set to expire 5 days from the time the orders were entered. All verbal patient orders will be relayed during patient handoff to the receiving facility. **WARNING**: MTF and patient staging personnel will review, validate and ensure medication orders will not expire during patient movement.

A2.5.2.11.6.12. Privileged providers and AECMs will demonstrate how to discontinue medication and verify a "discontinue medication note" is added to the encounter summary. (3b) **WARNING**: Documenting actions in the "Chart View" can only be done once during the same hour period. Clinicians must navigate to the "tree view" to review and document additional actions and/or comments within the same hour period. **WARNING**: AECMs will perform this function upon verbal order from a privileged provider.

A2.5.2.11.6.13. Clinicians will understand all and/or comments are final once the "verify" box is checked and the "OK" button is clicked. (3c) **WARNING**: Cells colored LIGHT BLUE in the "Chart View" indicate more than one comment or action within the hour were documented. **NOTE**: Another comment is required to correct any previous comment or action errors.

A2.5.2.11.6.14. Demonstrating the ability to navigate to "tree view" to view all comments made within the same hour period. (3b)

A2.5.2.12. Clinicians will demonstrate the ability to document an encounter which includes: **(T-2)**.

A2.5.2.12.1. Demonstrating how to open and use AIM forms for documenting patient assessment and free text information. (3b) **NOTE**: AIM forms should be used to document pre-flight or in-flight assessments.

A2.5.2.12.2. Demonstrating how to use the "add note" function, including:

A2.5.2.12.2.1. Copying and pasting routine statements. (3b)

A2.5.2.12.2.2. Loading notes from overlays and templates. (3b)

A2.5.2.12.2.3. AECMs will demonstrate how to document a trip segment. (3b)

A2.5.2.12.2.4. Demonstrating how to document patient briefings. (3b)

A2.5.2.12.2.5. Demonstrating how to free text notes. (3b)

A2.5.2.12.2.6. Demonstrating how to attach documents or images. (3b) **NOTE**: Information normally contained in a progress note should be documented using "Add Note" as a free text initiative.

A2.5.2.13. Users will demonstrate how to print SF 600, Health Record – Chronological Record of Medical Care, which includes how to automatically and manually set a document up for printing. (3b) **(T-2)**.

A2.5.2.14. Users will demonstrate the data transfer process. (3b) **(T-2)**.

A2.5.2.15. Users will demonstrate post mission or post patient transfer procedures. (3b) **(T-2)**.

A2.5.3. Super User Training. Super user training will include user training plus additional training which includes:

A2.5.3.1. Giving a user the additional ability to perform administrative functions such as setting up accounts, basic system troubleshooting and resetting user passwords. (4c)

A2.5.3.2. Demonstrating how to complete hardware and software updates. (4c)

A2.5.3.3. How to troubleshoot basic problems. (4c)

A2.5.3.4. How to accomplish system maintenance. (4c)

A2.5.3.5. How to load EHR software images. (4c)

A2.5.3.6. How to set up hardware to include connections to printers, routers, and wireless internet access devices. (4c)

A2.5.3.7. How to create a user account, set up a password, reset passwords, assign appropriate roles and privileges, and unlock accounts. (4c)

A2.5.3.8. Setting up hardware / software to allow multiple users to log into the same hardware device in an operational and teaching setting. (4c)

A2.5.3.9. Demonstrating how to set up Common Access Card sign-on (4c)

A2.5.3.10. Demonstrating how to create a user account. (4c)

A2.5.3.11. Demonstrating how to unlock and reset passwords. (4c)

A2.5.4. "Train the trainer" EHR training programs will include: **(T-2)**.

A2.5.4.1. A comprehensive program so unit member(s) will be able to train users and super users in a group setting. Users will be trained to their applicable proficiency codes as outlined in section A2.5 of this attachment. **(T-2).**

A2.5.4.2. A training syllabus and training verification procedures tailored for personnel assigned to Aeromedical Evacuation units and personnel assigned to patient staging units. **(T-2)**.

A2.6. Advanced Care Transport Team EHR requirements. Advanced care transport teams have the basic requirements listed in this attachment with additional requirements not yet available in the current EHR system.

A2.6.1. Additional requirements include:

A2.6.1.1. Ability to quickly document invasive and non-invasive hemodynamic data.

A2.6.1.2. Ability to quickly document invasive and non-invasive neurological patient data.

A2.6.1.3. Ability to quickly document data from patients receiving advanced airway management and/or have complex pulmonary diagnoses.

A2.6.1.4. Ability to monitor patient status and document while being buckled in seat.

A2.6.1.5. Ability for the EHR to provide hands free documentation while treating acute clinical conditions.

A2.6.1.6. Ability to accurately monitor patient fluids and fluid balance.

A2.6.1.7. Ability to automatically extract data from patient devices and populate the EHR after quick review by the clinician.