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HEALTH SERVICES

EN ROUTE CARE DOCUMENTATION

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This instruction implements Department of the Air Force Policy Directive (DAFPD) 48-1, *Aerospace & Operational Medicine Enterprise (AOME)*; supports DAFPD 10-29, *Worldwide Aeromedical Evacuation Operations*; and establishes, defines, and implements standards of documentation of care in the Air Force (AF) Aeromedical Evacuation (AE) System. This publication applies to all military and civilian personnel of Regular Air Force, Air Force Reserve and Air National Guard. This publication does not apply to United States Space Force. This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by Title 10 United States Code Section (U.S.C.) 9013, Secretary of the Air Force, and Executive Order 9397 (SSN), as amended. The applicable System of Records Notice (SORN) are: F036 AF PC C, Military Personnel Records System; F044 AF TRANSCOM A; and F044 F SG E, Electronic Medical Records System. The applicable SORNs are available at: **https://dpcld.defense.gov/privacy/SORNS.aspx**. Ensure all records generated as a result of processes prescribed in this publication adhere to Air Force Instruction (AFI) 33-322, *Records Management and Information Governance Program*, and are disposed in accordance with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using AF Form 847, *Recommendation for Change of Publication*; route the AF Form 847 through the appropriate chain of command and parent Major Command (MAJCOM). This publication may be supplemented at any level, but all direct supplements must be routed to the OPR of this publication for coordination prior to certification and approval. Compliance with the attachments in this publication is mandatory. 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. The authorities to waive wing/unit

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SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include adjusting individual roles training requirements, utilizing Electronic Health Record (EHR) in training, removing the title "Super User" and changes required by DAFI 33-360, updates to the acronyms, references and attachments.

Chapter 1

OVERVIEW

1.1. Mission Description. AE includes all elements of En Route Care (ERC) providing 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. AE provides time-sensitive movement of casualties to and between medical treatment facilities (MTFs), 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 AECs to support patients requiring more intensive patient care. The goal is to match patient needs with the appropriate skills, knowledge, equipment, and infrastructure to enable safe, effective, and efficient AE. The AE system is a subset of the overall patient movement system. Patient movement begins as soon as a patient receives care, which may be at point of injury. Patient staging provides medical personnel and equipment necessary for 24-hour patient staging operations, patient transportation to and from aircraft, and administrative processes for tracking patients transiting the AE system worldwide.

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

1.3. Applicability. This DAFI applies to all AE unit-assigned or associated ERC personnel, and all Regular Air Force (RegAF), Air Force Reserve Command (AFRC) and Air National Guard (ANG) medical units. Air Mobility Command/Command Surgeon (AMC/SG) does not provide or issue EHR equipment to En Route Patient Staging System (ERPSS) Unit Type Codes (UTC) (including AFRC and ANG Aeromedical Staging Squadron [ASTS]) that do not have live patient movement missions or activities.

1.4. Publication Administration. This DAFI should be available to all RegAF, 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. Air Mobility Command/Command Surgeon (AMC/SG).

2.1.1. Maintains directive guidance for documentation within the AF AE ERC system (paper and EHR).

2.1.2. Sets training and use requirements (EHR and paper) for the United States Air Force (USAF) ERC continuum and AE system (includes MAJCOM level exercises and pre-deployment tasks) as outlined in this DAFI.

2.1.2.1. EHR.

2.1.2.1.1. Elements of this program include: Hardware maintenance (pre and post mission checks; remediating and/or issues); data and/or metrics; logistics; and primary helpdesk support are directly supported by AMC/SG.

2.1.2.1.2. In cooperation with other Manpower Equipment Force Packaging (MEFPAK) and outside organizations, update information for use by personnel in the USAF's AE and ERC system in accordance with requirements outlined in **Attachment 2.**

2.1.2.1.3. Maintains the EHR system consisting of parts as outlined in **Attachment 2.**

2.1.2.1.4. Ensures support helpdesk information is displayed on all desktop configurations.

2.1.2.1.5. Provides initial hardware (laptops, printers, and routers) and refreshes to applicable ERC UTCs in accordance with Defense Health Management Systems guidance.

2.1.2.1.6. Replaces damaged laptops under warranty via equipment refresh of Automated Data Processing Equipment (i.e. laptops, printers) on the normal cycle in accordance with current Defense Health Management Systems guidance).

2.1.2.1.7. Provides software updates, as required, to the unit and EHRDP designated personnel and ensures updates are functional.

2.1.2.1.8. Supports (equipment and training as needed and coordinated) the EHR use in all facets of MAJCOM-level exercises. **Note:** Coordinate support to **sg.sgsi.amc_ehr_training@us.af.mil** and **amc_ae_ehr@us.af.mil**

2.1.2.2. Paper Documentation.

2.1.2.2.1. Sets directive guidance for AF Form 3899-series for documentation, utilization and training requirements.

2.1.2.2.2. Reports and sends questions relating to training and clinical requirements via email: **amc.sgk@us.af.mil** and **amc_ae_ehr@us.af.mil**

2.2. Air Force Operational Medicine Information System (AFOMIS).

2.2.1. Develops and executes training for all Joint Operational Medicine Information Systems in accordance with **Attachment 2.**

2.2.2. AFOMIS maintains secondary helpdesk support for all EHR users to receive immediate assistance for troubleshooting actions. **Note:** Helpdesk contact information is on desktop display of every EHR.

2.3. Patient Staging or Aeromedical Evacuation Squadron (AES) Commander.

2.3.1. Ensures all assigned personnel use this document and receive training for EHR and paper documentation in accordance with duties assigned as outlined in **Chapter 2, Chapter 3** and **Attachment 2. Exception:** The requirements related to EHR are not applicable to assigned personnel to ERPSS UTCs (includes ANG ERPSS and AFRC Aeromedical Staging Squadron [ASTS]) in units without equipment or a real world, live patient movement mission.

2.3.2. Appoints in writing a primary and alternate Electronic Health Record Document Program designated personnel (EHRDP). Maintain current EHRDP appointment letters at the unit level and forwards a copy of current appointment letters to AMC/SG (email **amc_ae_ehr@us.af.mil** and **amc.sgk@us.af.mil**) through their appropriate MAJCOM.

2.3.3. Appoints EHR trainers to train users within the unit.

2.3.4. Ensure replacement costs due to damaged hardware and consumables (such as printing paper, ink cartridges, etc.) are projected in the unit budget.

2.3.5. Ensures assigned personnel complete initial training within one year of assignment to a UTC. This requirement may be accomplished via formal course (Aeromedical Evacuation Patient Staging Course), an exercise, utilizing EHR trainers or deployment and/or operational support. **Note:** Coordinate support to **sg.sgsi.amc_ehr_training@us.af.mil** and **amc_ae_ehr@us.af.mil**

2.3.6. Ensures unit members receive hands-on recurring training at least every 12 months to Subject Knowledge Level B (reference **Attachment 2 Table A2.2**).

2.3.7. Ensures the EHR is utilized within all unit training programs and MAJCOM-sponsored exercises.

2.4. Patient Staging Unit and AES Chief Nurse (CN).

2.4.1. Ensures assigned personnel are able to apply guidelines per **Chapter. 3**, **4** and **5**.

2.4.2. Establishes a peer review program in accordance with AFI 46-101, *Nursing Services and Operations*, for documentation during live patient care. Peer review for privileged providers is in accordance with AFI 44-119, *Medical Quality Operations*. Chief Nurses should review clinical documentation obtained during training events.

2.4.3. Ensure appropriate number and mix of personnel have active Theater Medical Data Store (TMDS) account in order to support mission operations.

2.4.4. Ensures assigned personnel complete and verify data transmission at the end of each shift or mission (not applicable for training).

2.4.5. Reports EHR status for each live patient mission tasked on the EHR Utilization Report (contact AMC SGSI and SGK [**amc_ae_ehr@us.af.mil** and **amc.sgk@us.af.mil**] for questions).

2.4.6. AES Chief Nurses coordinate with Aircrew Training offices to use the EHR in training events (such as Aeromedical Readiness Missions, local exercises, clinical simulation missions, etc.).

2.5. Electronic Health Record Designated Personnel (EHRDP).

2.5.1. Are responsible for maintaining overall situational awareness and supervision of unit personnel's capability for use of the EHR.

2.5.2. Unit training frequency may need to be higher than required in order to support manning changes, equipment availability, deployments, and operations tempo.

2.5.3. Are trained and maintain Subject Knowledge Level D (reference **Attachment 2 Table A2.2**) within 6 months of appointment to the EHRDP (primary and alternate). **Note:** Centralized EHR trainer training may be conducted by AFOMIS. Each unit may send two personnel to receive trainer training and become trainers for their unit, travel is unit funded.

2.5.4. Elevates hardware, software and technical questions and issues to AMC/SG at **amc_ae_ehr@us.af.mil**.

2.5.5. Sends questions relating to training and clinical requirements to AMC/SG via emails: **amc.sgk@us.af.mil** and **amc_ae_ehr@us.af.mil**.

2.5.6. Ensures hardware is maintained in accordance with current guidelines and is fully mission capable to include proper storage and battery maintenance. **Note:** AMC/SG relays current hardware guidelines to EHRDP and units that maintain AE/ERC EHR equipment.

2.5.7. Ensures any medical equipment with communication capability to the EHR is set to Zulu time or Zulu equivalent and Julian date.

2.5.8. Ensures unit members are capable of accessing applicable systems to document patient care and to sign and transmit encounters.

2.5.9. Establishes, resets and, as applicable, synchronizes e-user accounts and passwords.

2.5.10. Establishes and maintains an EHR train the trainer program in accordance with **Attachment 2**.

2.5.10.1. EHR trainers are trained and maintained at a Subject Knowledge Level C (reference **Attachment 2 Table A2.2**).

2.5.10.2. Ensure the unit has adequate EHR trainers to maintain proficiency.

2.5.11. Maintains adequate supply quantities of expendable materials required for EHR documentation to transfer via data disc or printing as required (e.g., data discs, printer paper and printer ink).

2.5.12. Ensure for every live patient movement mission patient data transmission and receipt of records in Theater Medical Data Store (TMDS) has occurred.

2.5.13. Collect and presents metrics (quantitative and/or qualitative) as outlined by the unit's leadership team.

2.5.14. Participates in EHRDP teleconferences (as scheduled, notification is sent via email to unit's designated EHRDP personnel) by AMC/SG.

2.6. Aeromedical Evacuation Crew (AEC).

2.6.1. EHR is the primary and directed documentation method. **Exceptions:** The CN, MCD or AEC may use paper documentation for: missions and/or sorties less than 45 minutes; EHR equipment and/or system fails or malfunctions; or in the judgment of the assigned MCD utilization impedes safe mission execution.

2.6.2. If EHR system fails (live mission or training) or the Medical Crew Director (MCD) determines EHR clinical documentation impedes safe mission operations, the MCD may direct use of paper documentation by AEC and ensure the following:

2.6.2.1. Ensure all patient safety and/or equipment issues are reported (depending on event, both reporting actions may be required).

2.6.2.2. Report to unit's CN (or unit designee) status of EHR equipment and utilization for each live patient mission.

2.7. En Route Critical Care (ERCC) Team.

2.7.1. En Route Critical Care teams utilize EHR system once critical care hardware and/or software components are approved and deployed. **Note:** When ERCC begin utilizing EHR in the AE/ERC system transmitting paper documentation via email is no longer be required.

2.7.2. When completing paper documentation, records are transmitted after patient handoff using the following guidance:

2.7.2.1. All health record documentation transmissions are via an encrypted email sent to **CCATTPilotUnit.59mdw@us.af.mil**.

2.7.2.2. Subject Line: "ATTN: CCATT Process Improvement Program".

2.7.2.3. Messages must include the *Health Insurance Portability and Accountability Act* (HIPAA) statement (reference **paragraph 3.2**). **(T-0).**

2.8. Medical Personnel (Aeromedical Evacuation Crew Member [AECM], ERCC and ERPSS).

2.8.1. All AECMs.

2.8.1.1. Initial EHR training is to the Subject Knowledge Level A (reference **Attachment 2 Table A2.1**) within 6 months of initial AECM qualification or requalification. May be accomplished via formal course (Aeromedical Evacuation Patient Staging Course), exercise, EHR trainers or deployment and/or operational support.

2.8.1.2. Should complete hands-on user training at minimum of every 12-months or more frequently if needed to attain and maintain a Subject Knowledge Level B (reference **Attachment 2, Table A2.1**).

2.8.2. All Patient Staging Personnel (ERCC and ERPSS).

2.8.2.1. Initial training is to the Subject Knowledge Level A (reference to **Attachment 2 Table A2.1** and **Table A2.2**) and within 6 months of being assigned to UTC in a unit with a live patient movement mission.

2.8.2.2. Completes hands-on user training at minimum of every 12-months or more frequently if needed to attain and maintain a Subject Knowledge Level B (reference **Attachment 2, Table A2.2**).

2.8.2.3. Staging management personnel ensures EHR and documentation capabilities on all shifts.

2.8.3. Documents and receives training for paper and EHR documentation in accordance with duties assigned as outlined in **Chapter 2**, **Chapter 3,** and **Attachment 2.**

2.8.4. Uses protocols outlined by EHR training to wirelessly transmit or download encounter files from one EHR system to another.

2.8.5. If wireless transmission is not possible or applicable (location does not have access Armed Forces Health Longitudinal Technology Application-Theater [AHLTA-T]), sending personnel use protocols outlined in EHR manuals (located on EHR desktop or Electronic Flight Bag) to manually copy encounter files to CD so receiving personnel can copy encounter files onto their EHR system. **Note:** Sending personnel confirms patient data is transferred to CD prior to handoff. If unable to transmit data or export and transfer data via CD then final solution is printing copies to provide during handoff.

2.8.6. All documentation not captured electronically is scribed and/or scanned into the permanent EHR as soon as possible. All health care documentation is uploaded and/or physically accompanies the patient during evacuation; and must be handled, maintained and disposed of in accordance with DODM 6025.18, Privacy Act and HIPAA requirements. **(T-0).**

2.8.7. When transferring a patient to any facility without access to AHLTA-T (e.g., a non-DOD medical treatment facility), provide a printed copy of the patient's ERC documentation.

2.8.8. Uses EHR versions of AF Form 3899-series documents and SF 600, *Chronological Record of Medical Care* (available **https://www.gsa.gov/forms-library/chronological-record-medical-care**), in place of paper forms when available.

2.8.9. Non-licensed clinicians document all care they provide for the patient, either electronically (preferred) or on paper. Aeromedical Evacuation Technicians (AET) and Independent Duty Medical Technicians (IDMT) are examples of non-licensed clinicians.

2.8.10. Notes are reviewed and co-signed by a licensed clinician or privileged provider, to verify and validate accuracy of information, within the same shift or mission.

2.8.11. All personnel are responsible to report broken and/or malfunctioning EHR equipment as soon as possible. If away from home station, personnel report critical hardware, software, technical issues to the AFOMIS helpdesk as soon as possible and report via normal channels when return to home station. **Note:** Helpdesk contact information is on desktop display of every EHR.

2.8.12. All hardware, software, or technical issues is reported to AMC/SG **amc_ae_ehr@us.af.mil** and the unit's EHRDP.

2.8.13. All patient safety issues (EHR or paper documentation) are reported to Air Mobility Command, Command Surgeon, En Route Medical Care Division (AMC/SGK) via the Joint Patient Safety Report process (reference DAFI 48-107V1, *En Route Care and Aeromedical Evacuation Medical Operations*, **Chapter 9**).

2.8.14. All paper patient medical documentation is scanned/embedded/transcribed into an AHLTA-T encounter.

2.8.15. Transcribed information includes discharge summaries documented in other EHR patient documentation systems.

2.8.16. Transcription of applicable EHR documentation from systems into the ERC EHR include:

2.8.16.1. Physician orders.

2.8.16.2. Discharge summary.

2.8.16.3. Medications.

2.8.16.4. Treatments.

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

2.8.17. Personnel communicates transcribed information to the evacuation platform during patient handoff.

2.8.18. When patient documentation is transferred via CD, sending staff confirms all patient encounter(s) are exported to a CD and provided to receiving staff prior to transfer of care.

2.8.19. In accordance with United States Transportation Command (USTRANSCOM) directives staging personnel will utilize TMDS to review en route care data transmitted by the AEC upon aircraft landing for in-bound patients. **(T-0).**

Chapter 3

GENERAL DOCUMENTATION GUIDANCE FOR EN ROUTE CARE

3.1. Overview. Health record documentation is patient information obtained through a clinical process and captured via EHR or paper documentation. Health record documentation is a vital component of safe, ethical and effective clinical practice. Health record documentation should reflect the application of clinical knowledge, skills and judgment, care and treatment for the patient. Health record documentation establishes accountability, promotes quality and ensures continuity of clinical care. All medical documentation (EHR and paper) are legal documents and are part of the patient's permanent health records.

3.2. General Guidelines.

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 health record document assumes the person who is doing the recording provided the care or service to the patient. The privileged provider and/or licensed clinician who performed, directed or observed the intervention and/or event with the patient documents or co-signs the health record information.

3.2.2.1. Non-licensed clinicians document care provided for the patient and the documentation is co-signed by a privileged provider or licensed clinician**.** AET and IDMT are examples of non-licensed clinicians.

3.2.3. Documentation is completed by medical personnel as soon as possible.

3.2.4. Events should be documented in chronological order.

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

3.2.6. Late entries for paper and EHR documentation start with the word "Addendum." Include the following: the event(s), reference the date and time events actually occurred as well as the date and time the Addendum was prepared.

3.2.7. When two or more licensed clinicians are caring for the same patient, each licensed clinician documents and signs individually for their respective care provided and/or services rendered.

3.2.8. When both licensed and non-licensed clinicians are caring for the same patient, a privileged provider or licensed clinician reviews and co-signs the non-licensed clinician's documentation.

3.2.9. The privileged provider or licensed clinician co-signs within the same shift or mission.

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

3.2.10.1. Document chronological events, procedures, interventions, patient response to interventions and frequency of care implemented.

3.2.10.2. List all personnel and their designation/qualifications present during the emergency (for example registered nurse/physician).

3.2.10.3. The designated recorder provide the documentation to the clinician assigned responsibility of patient care for review and/or co-signature.

3.2.11. All entries on paper documentation are documented using black or blue ink.

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

3.2.13. Patient Privacy is protected at all times. Verbal discussion between healthcare workers are communicated in a safe, private area where information is not overheard and patient privacy is maintained.

3.2.13.1. Regardless of the method used to communicate patient information, all healthcare personnel (i.e. privileged providers, licensed clinicians, etc.) must adhere to the DODM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DOD Health Care Programs*. **(T-0).**

3.2.13.2. The following statement is included within the email or on the facsimile coversheet: *"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."* **(T-0).**

3.2.14. Health record documentation should provide comprehensive information concerning the condition of the patient and clinical care provided. Documentation should be clear, complete and accurate to facilitate quality assurance and quality improvement initiatives, while avoiding generalizations. Clinical documentation is specific, using measurable data and incorporating scalable information (e.g., pain 8/10)**.**

3.2.15. All patients are identified using at least two unique identifiers (e.g., patient's name and date of birth).

3.2.15.1. If pseudonyms and identifiers are used, these identifiers match the demographics used during clinical documentation.

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

3.2.16. All dates and times documented in the health record are represented with Julian date (JD001) and in Zulu time (Zulu 0001 or 0001Z) or Zulu equivalent. All EHR documentation devices have the system time set to Julian Date and Zulu or Zulu equivalent.

3.2.17. Healthcare providers will use the pain scales in accordance with DAFI 48-107V1.

3.2.18. Documentation should be objective facts about observations and assessments and should only document conclusions supported by data. Any clinically significant information should be documented with the following:

3.2.18.1. Clear, concise statement of patient status.

3.2.18.2. Assessment data.

3.2.18.3. All ongoing monitoring and patient communication.

3.2.18.4. Any care or interventions provided.

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

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

3.2.18.7. Any plans for follow up.

3.2.18.8. Patient safety events from incidents such as falls, medication errors, clinical emergencies or undesired responses to clinical care are reported by completing a DD Form 2852, *Patient Movement Event/Near Miss Report* or *Joint Patient Safety Report (JPSR) Worksheet* in accordance with DAFI 48-107V1 (please contact AMC/SGK at **amc.sgk@us.af.mil** for most current worksheet). **Note:** Patient safety reporting is a medical quality assurance process used to track and mitigate events that harm or could harm patients in accordance with AFI 44-119. Patient safety event reports are not part of a clinical record; therefore, privileged provider, licensed clinician and/or non-licensed clinician do not include any information in the patient's record and do not reference completion of any safety reports.

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

3.2.20. Paper health record documentation includes a signature and designation of the individual; 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.

3.2.21. Health record documentation reflects a privileged provider, licensed clinician and/or non-licensed clinician has fulfilled his/her duty of care.

3.2.22. EHR documentation is the primary documentation method. The EHR is used unless there is system failure or it is not operationally feasible. **Exceptions:** The CN, MCD or AEC may use paper documentation for: missions and/or sorties that are less than 45 minutes; the EHR equipment and/or system fails or malfunctions; or in the judgment of the assigned MCD utilization will impede safe mission execution.

3.2.22.1. If health record documentation is captured both electronically and on paper, privileged provider, licensed clinician and/or non-licensed clinicians should reference the paper source within the EHR document and cross reference health record information.

3.2.22.2. Example: If an EHR is used to document pain scales and an AF Form 3899I, *Patient Movement Medication Record*, is being used to document pain medication delivery, personnel chart pain scales in the EHR and may add an EHR note stating "see AF Form 3899I for medication delivery times."

3.2.23. Privileged provider, licensed clinician and/or non-licensed clinicians will avoid using problematic abbreviations as detailed in The Joint Commission's official "Do Not Use" list as listed in **Table 3.1** (reference The Joint Commission website for an updated list). **(T-0).**

Table 3.1. Do Not Use Abbreviation List.

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"
*Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. **WARNING:** Is not to be used in medication orders or other medication-related documentation.		

3.2.24. Written calendar dates follow the format DD MMM YYYY.

3.2.25. Errors are corrected as soon as possible. Failing to correct errors properly may be interpreted as falsification of a record.

3.2.25.1. When correcting paper documentation, the original content remains visible so the purpose and content of the correction is clearly understood. When correcting an error make a single line through content, insert "void", annotate with date, time and initials or signature.

3.2.25.2. For errors made in EHR documentation, reference the EHR most current user guide on the EHR computer desktop image. Comments specific to medication administration are final and cannot be modified. Narrative notes should be edited and updated at a later time and should follow guidance for making an Addendum.

3.3. Privileged Provider Orders.

3.3.1. Privileged provider orders are legible when written. All orders are followed by the author's name (printed or typed first name, middle initial, and last name), Julian date, Zulu time and signature.

3.3.2. Privileged providers communicate new orders to clinical staff via the most reliable method.

3.3.3. Unsigned privileged provider orders are not valid orders in the AE system. Orders have either a wet (signature block stamps are highly recommended) or electronic signature. **Exception:** Emergent and/or geographically separated situations reference **paragraph 3.3.2**

3.3.4. In the physical absence of a privileged provider:

3.3.4.1. Ground UTC Registered Nurse (RN) may take verbal orders from privileged providers for emergency cases only.

3.3.4.2. A Flight Nurse (FN) may take telephone orders from a privileged provider at alert time or during mission execution for emergency or routine clinical situations.

3.3.4.3. The entire order will be annotated as Read Back (RB) and verified with the privileged provider prior to the nurse signing the order and proceeding. **(T- 0).**

3.3.4.4. Telephone/verbal orders requires the privileged provider to make an EHR entry stating the date, time, and what the telephone order was once the patient's AE encounter is closed. This entry can be accomplished through TMDS.

3.3.4.5. Telephone/verbal orders are annotated as follows: Julian date, Zulu time, telephone/verbal 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." **Note:** Using signature block stamps are highly recommended and electronic signatures are authorized.

3.3.4.6. Verbal orders and telephone orders must be written into the paper health record and typed into the EHR.

3.3.4.7. Written orders are followed by the author's name (printed or typed first name, middle initial, and last name), Julian date, Zulu time and signature.

3.3.4.8. Orders should, at minimum, include patient's diet, activity, and pertinent medication and treatments as applicable.

3.3.4.9. Paper documentation. If an error is made, single line through content, insert "void", annotate with date, time and initials or signature. Paper orders are not be edited in any other manner.

3.3.4.10. When discontinuing an order, the discontinued order shall be lined through and annotated with "D/C" or "DC", date, time, and initials of person discontinuing or transcribing the order.

3.3.4.11. If the discontinue order was transcribed or transferred to another form, the medication or treatment is lined through and annotated with "DC", "D/C" or "Discontinued", date, time, and initials of person annotating the order. **Note:** The

annotations "D/C" and "DC" are only used as an acronym for discontinue or discontinued.

3.3.4.12. For EHR documentation, discontinue incorrect order and replace with a correct order. **Note:** When using the AHLTA-T, nurses utilize Add Note and type "verbal order" per privileged provider's first name, middle initial, and last name then reference the order as free text. If verbal order is for a medication, document the order in the medication module. Reference the EHR user guide stored on EHR Desktop.

3.3.4.13. Clinical staff reviews paper and/or EHR orders at a minimum once per shift and documents "Orders Reviewed" with date, time and signature on paper progress notes or using Add Note and free text "Orders Reviewed" within an AHLTA-T encounter.

3.3.4.14. Only active privileged provider orders are on the order sheet, patient treatment sheet and/or medication administration records. **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. Early versions of AHLTA-T do not have the ability to annotate when orders are verified, acknowledged and transcribed. Checking an "Orders Reviewed" checkbox within an AHLTA-T alternate input method (AIM) form is also acceptable. The EHR medication administration record module will be open when discontinuing a medication to ensure the discontinued order is annotated in the patient's encounter. **(T-3).** When an EHR order for a medication is submitted, the privileged provider ensures the order is "dispensed" to ensure proper transcription.

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. Privileged providers and/or licensed clinicians note order transcriptions by annotating the date, time, with the words "Noted" or "Transcribed," along with the date, time, printed name and signature of the person transcribing the order.

3.4.3. If a nurse takes a verbal order and transcribes the same order, the nurse includes the words "verbal order" and "transcribed."

3.5. Aircraft Emergency. In the event an aircraft emergency leads to any patient intervention, documentation includes: type of aircraft emergency, cabin altitude pre/post emergency, clinical interventions, and the patient's condition post intervention(s). **Note:** Reference DAFI 48-107V1, for reporting clinical safety events and Air Force Manual (AFMAN 11-2AEV3, *Aeromedical Evacuation (AE) Operations Procedures* to report aircrew operations safety events).

3.6. Focus-Data-Action-Response-Teaching (DART) Charting.

3.6.1. Focus-DART charting is a systematic approach to documentation (paper or EHR), 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. Doing so not only assists with daily planning of interventions and treatment, but also assists the TRANSCOM Patient Movement Requirements Center (TPMRC) with patient movement and evacuation planning.

3.6.1.1. Focus- patient's issue or concern; abnormal or significant negative finding(s).

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

3.6.1.3. A-Action: When applicable, include patient interventions or treatments performed, and/or protocols and procedures initiated. Privileged providers, licensed clinicians and/or non-licensed clinicians should document planned interventions or treatments discussed during plan of care conferences.

3.6.1.4. R-Response: When applicable, includes 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.

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

3.7. Minimum Documentation.

3.7.1. For AECMs, minimum documentation for missions with flight times less than 45 minutes include. **Exception:** Less than minimum documentation are due to mission conditions preventing the ability to meet requirements (i.e. contingency operations).

3.7.2. Documentation of a trip segment as the first clinical entry for each mission.

3.7.2.1. The trip segment includes: date, enplaning station and planned deplaning station. Example: 20130820 Andrews AFB, MD to Scott AFB, IL.

3.7.2.2. On mission legs 45 minutes or less, International Civil Aviation Organization (ICAO) codes for enplaning and deplaning stations may be used. Example: 20130820 KADW KBLV.

3.7.2.3. AECMs should accomplish a trip segment for ERCC patients but are not responsible for clinical documentation.

3.7.3. An assessment of any immediate patient concerns and interventions, and a reassessment of interventions and/or treatments.

3.7.4. Vital signs, oximetry, pain, sedation, and temperature obtained and as indicated by patient diagnoses, assessment findings and privileged provider orders.

3.7.5. Any abnormal findings to include.

3.7.6. Suicidal or homicidal ideations for mental health patients or other diagnoses as applicable.

3.7.7. Assessment of circulation, motor and sensory checks for patients with restraints or other restrictive or constrictive devices.

3.8. Patient Staging Personnel.

3.8.1. Patient staging personnel chart as clinically indicated, upon admission and upon discharge and/or transfer.

3.8.2. Inpatients are charted on at least once per shift, and outpatients will have an entry at least every 24 hours.

3.9. Patient Handoff.

3.9.1. Patient handoff is essential to continuity of care and risk mitigation. Privileged providers, licensed clinicians and/or non-licensed clinicians utilize the Identify, Situation, Background, Assessment and Recommendation (I-SBAR) patient handoff format during patient handoff, as outlined in DAFI 48-107V1.

3.9.2. Patient handoff tools should be given to gaining medical personnel at/during handoff. The I-SBAR forms are not placed in the patient's permanent medical record and are handled and/or destroyed in same manner as a medical record.

3.9.3. AE and ERPSS personnel ensures transmission to TMDS immediately post hand-off. If AE is unable to transmit at hand-off via MiFi, transmission should occur as soon as connectivity is established and is operationally feasible.

Chapter 4

AEROMEDICAL EVACUATION PAPER DOCUMENTATION

4.1. General Principles.

4.1.1. The AF Form 3899-series paper patient record is tailored for each patient based on condition and treatments needed during patient movement. The forms are used to document a patient's care, as applicable, during AE transport when EHR is not utilized (reference **paragraph. 2.6**). Any of the AF Form 3899-series utilized for patient care is scanned in to patient's permanent medical record. All health care documentation is uploaded and/or physically accompanies the patient during evacuation; and must be handled, maintained and disposed of securely in accordance with DODM 6025.18, Privacy Act and HIPAA requirements. **(T-0). Note:** EHR documentation is the primary and directed documentation method and is used with exceptions as outlined in **paragraph 2.6**

4.1.2. Blank 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 AMC/SGK website, please contact via email **amc.sgk@us.af.mil** for current URL. **Note:** The AF Form 3899-series contained within TRAC2ES is not by itself a patient record; until it is officially signed.

4.1.3. When using additional forms from the AF Form 3899 series, recommend annotating on the AF Form 3899: "see also AF Form 3899A-N for additional information.

4.2. AF Form 3899, *Patient Movement Record.*

4.2.1. The AF Form 3899 is used by the TPMRC and Validating Flight Surgeon (VFS) to validate a patient for flight. This form is required for entry into the aeromedical evacuation system. **WARNING:** The 3899, *Patient Movement Record*, is not the same thing as the Patient Movement Request (commonly referred to as the "PMR"), which is what the TRAC2ES system produces based off the approved patient movement request by TPMRC. The TRAC2ES produced PMR is not a medical record.

4.2.2. The referring facility should be aware of available AF Form 3899-series documents and expand the use of these tools as patient needs require. The form should be completed by the originating medical treatment facility and submitted to the TPMRC via TRAC2ES when complete.

4.2.3. AF Form 3899 (front).

4.2.3.1. Section I.

4.2.3.1.1. Documentation uses the last four numbers of the sponsor's social security number (SSN) or the service member's DOD identification number if a patient is a dependent.

4.2.3.1.2. Status: Enter the patient's status (e.g., Service Component-Active, Reserve, National Guard, Retired, Dependent, Civilian, etc.).

4.2.3.1.3. Cite Number: this number once the Patient Movement Request has been submitted in TRAC2ES, this number is provided by the TPMRC.

4.2.3.2. Section II.

4.2.3.2.1. Max # of RONs: Remain overnight (RON) is determined by appropriate TPMRC.

4.2.3.2.2. Altitude restriction: Enter cabin altitude as applicable.

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

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

4.2.3.2.5. Classification: The attending physician, with collaboration with the VFS or TPMRC, determines patient classification (reference patient classifications as outlined in DAFI 48-107V1.).

4.2.3.2.6. Precedence: Urgent (U), Priority (P) or Routine (R) is determined by a privileged provider, as outlined in DAFI 48-107V1.

4.2.3.3. Section III.

4.2.3.3.1. 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.

4.2.3.3.2. Waivers: Enter type of waiver requested.

4.2.3.4. Section IV – Clinical Information.

4.2.3.4.1. A privileged provider provides the clinical information, such as diagnosis and history.

4.2.3.4.2. Diagnosis: Enter diagnosis with International Classification of Diseases code in parenthesis.

4.2.3.4.3. Allergies: Includes food, environmental (including Latex) and/or drug allergies.

4.2.3.4.4. Infection control precautions. Enter standard, contact, airborne, strict airborne, as applicable (reference DAFI 48-107V1).

4.2.3.4.5. Initial appropriate boxes: Mark appropriate boxes and explain any "Yes" in Section V, Clinical History.

4.2.3.4.6. Enter brief clinical history, including procedures and surgeries performed during current hospitalization.

4.2.3.4.7. A flight surgeon or privileged provider, if no flight surgeon is available, should annotate "Patient condition, is stable and cleared for flight" (reference DAFI 48-107V1).

4.2.4. AF Form 3899– *continuation* (back). This page is initiated by a privileged provider and is used to document privileged provider orders only. The form is not used as a continuation form for progress note documentation. The licensed clinician receiving the order documents phone or verbal orders received while en route here.

4.2.4.1. Section I.

4.2.4.1.1. Information matches the front 3899 (front).

4.2.4.2. Section II Medication orders.

4.2.4.2.1. All medications administered to a patient while in the AE system are written as a privileged provider's order. Patient require a Medication Administration Record (MAR), either paper or electronic, unless identified as a self-administered medication (SAM) patient. The SAM patient maintains and takes their own medications and do not require a MAR (AF Form 3899I, *Patient Movement Medication Record* or EHR MAR module). **Exception:** 1) healthcare personnel assesses patient is no longer able to self-medicate safely. 2) Medication prescribed is ordered to be administered from the AE Stock, then a MAR is created. A privileged provider, licensed clinician and/or non-licensed clinician manages changing SAM status in accordance with DAFI 48-107V1.

4.2.4.3. Section III Other orders.

4.2.4.3.1. Enter non-medication orders in this area (e.g., treatments, activity, diet, dressing changes, etc.). **Note:** Use AF Form 3899F, *Patient Movement Physician Order for Behavior Management and Restraints*, for all restraint orders.

4.3. AF Form 3899A, *Patient Movement Record Progress Note* (Front and Back). Privileged providers, licensed clinicians and/or non-licensed clinicians document en route patient care encounters in the AE system, on the AF Form 3899A.

4.3.1. If the patient is a dependent, the sponsor's service number (or SSN if other identifying numbers are not available) is used.

4.3.2. The status of patient will be: AD=Active Duty, NG=National Guard, Res=Reserve, D=Dependent, O=Other.

4.3.3. Each assessment is signed by the caregiver. **Note:** Non-licensed clinicians requires co-signatures by privileged provider and/or licensed clinicians after the last entry indicating acknowledgment and agreement with the preceding entries.

4.3.4. Medical attendants are required to document progress notes on their patients. AECMs assist with the trip segment. After making their entry, the medical attendant prints and signs their full name and follow it with "MA."

4.3.5. Controlled Drug Accountability: Includes the drug name, total number received, and signatures of both the MTF representative and FN.

4.3.5.1. SAM patients do not require a MAR (reference **paragraph 4.2.4.2.1**). Prescribed controlled medications are the personal property of SAM patients. AECMs should not ask outpatients to release their medications, providing outpatients are physically and mentally able to administer and maintain them properly.

4.3.5.2. If a patient is deemed not compliant and/or not competent for SAM, the care team will:

4.3.5.2.1. Personnel notifies the change in SAM status to TPMRC and/or the privileged provider as soon as operationally possible.

4.3.5.2.2. If SAM status is revoked, personnel 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.

4.3.5.2.3. Medical personnel assumes responsibility for administration of the patient's medication.

4.3.5.2.4. Medical personnel initiates or completes DD Form 2852 *or JPSR Worksheet*. (reference DAFI 48-107V1).

4.3.5.3. Controlled medications are listed on the AF Form 3899A in 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 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*. The patient demographic information at the top of the form is completed.

4.4.2. Allergies. Confirm or document allergies to include food, environmental (including Latex) and medication allergies.

4.4.3. Physician Orders/Signature are annotated with Julian date ("JD001"), Zulu time ("Zulu 0001" or "0001Z"), order, print first name, middle initial, and last name followed by provider signature.

4.5. AF Form 3899C, *Patient Movement Physical Assessment*.

4.5.1. The AF Form 3899C is designed for rapid documentation of physical assessment findings of physical assessment findings of patients not under care by an advanced care specialty team.

4.5.2. For patients who are SAM, a privileged provider, licensed clinician and/or non-licensed clinician checks the appropriate boxes on the AF Form 3899C.

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

4.6.1. The AF Form 3899D is used by ERC non-licensed clinicians, licensed clinicians and/or privileged 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 a privileged provider, licensed clinician and/or non-licensed clinician 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* (front and back).

4.7.1. AF Form 3899E is used to record accurate measures of intake and output (I&O) while in the AE system. It is completed by any privileged provider, licensed clinician and/or non-licensed clinician in the AE system.

4.7.2. I&O's are totaled at the end of each mission or shift; the ordering privileged provider determines the parameters, e.g., hours. **Note:** Measurements are in milliliters.

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

4.8.1. The AF Form 3899F is used for patients requiring behavioral management, chemical and/or physical restraints while in the ERC system.

4.8.2. The attending physician orders interventions for behavior management and restraints as necessary for patients in the ERC/AE system using this form.

4.8.3. AF Form 3899G, *Patient Movement Restraint Observation Flowsheet* is used in conjunction with the 3899F to document interventions, observations and assessments.

4.8.4. Orders are valid for a maximum of 24 hours and a privileged provider at RON locations or at a patient's destination reviews the orders. **Note:** 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 overridden by a privileged provider on board the airframe or by the VFS.

4.8.5. An order for restraints is required for 1A or 1B patient classifications. The order specifies 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. If the restraint order is written for restraints to be immediately available at the litter, the MCD contacts the VFS and obtains a restraint order immediately after the patient is restrained.

4.8.6. Restraints as needed (PRN) orders are not allowed and are not used in the ERC/AE system.

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

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

4.9.2. The AF form 3899G is completed by any AECM or medical attendant.

4.9.3. This form is utilized in conjunction with 3899F, *Patient Movement Physician Orders for Behavior Management and Restraints.*

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

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

4.10.2. Privileged provider, licensed clinician and/or non-licensed clinicians utilize this form for any patient with the potential to develop a neurological deficit requiring frequent or repeated assessments.

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

4.11.1. The front of AF Form 3899I is used to document scheduled medications. The back of the form is to document PRN and one-time medications. **Note:** Medical personnel are not required to document medications for patients identified and maintain compliance as self-administering (SAM) patients (exceptions outlined in **paragraph 4.2.4.2.1**).

4.11.2. Privileged providers, licensed clinicians and/or non-licensed clinicians documents medications on the AF Form 3899I or EHR equivalent.

4.11.3. 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".

4.11.4. Enters person's initials, signature, first and last name printed, title, and local unit of assignment and enter initials of privileged provider, licensed clinician and/or non-licensed clinician administering the medication.

4.11.5. Privileged provider Identification includes: initials, signature, first and last name printed, title, and local unit of assignment.

4.11.6. When medication is discontinued, a line is drawn through the medication and write "discontinued" above the line with date, time and initials.

4.11.7. If a medication is held, a circle is drawn around the date/time and document reason on AF Form 3899A, *Patient Movement Progress Note*.

4.11.8. The AF Form 3899I (back), *Patient Movement Medication Record-Single Dose and PRN Medications* is used only to document single dose and/or PRN medications. The healthcare personnel documents the problem and/or complaint for which the PRN or single dose medication us administered.

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

4.12.1. The AF Form 3899J is used by any privileged provider, licensed clinician and/or non-licensed 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 is used by any privileged provider, licensed clinician and/or non-licensed clinician to document a patient's chronological log of events during a cardiac or respiratory arrest.

4.13.2. This form is initiated as soon as possible following the start of a cardiac or respiratory arrest and may be completed by a designated recorder. **Note 1.** If the recorder was a non-licensed clinician a privileged provider or licensed clinician signs to validate the form and content. **Note 2.** If a privileged provider is on board and was involved as part of the Advanced Cardiac Life Support team, the privileged provider signs the form in addition to other required signatures.

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

4.14.1. The AF Form 3899L (front) is used by a clinician in the ERC system to document on a critically ill or injured patient. All applicable pre-mission VS and arterial blood gases (ABG) and applicable post-mission VS and ABG results are annotated on page one.

4.14.2. 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. **Note:** Use other AF Form 3899-series forms as applicable. This is not a

standalone form; rather it should be used as a supplement to the current AF Form 3899-series. Continuing VS should be annotated on the back page.

4.14.3. # CCATT Patients: Enter the total number patients assigned to the transport team.

4.14.4. En Route Time: Enter the total amount of time primary care was rendered to the patient.

4.14.5. Diagnosis: D=Disease, BI=Battle injury, NBI=Non-battle injury.

4.14.6. Max Cabin Altitude: Enter the actual maximum cabin altitude during transport.

4.14.7. Temperature notations are documented in degrees Fahrenheit.

4.14.8. 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 is a number followed by the letter "T".

4.14.9. In the space available for each system, the clinician may add pertinent assessment information that is not otherwise addressed.

4.14.10. Critical Care Transport personnel print full names, rank and Air Force Specialty Codes in the appropriate cell and sign their full name in the cell**.**

4.14.11. Controlled medications received, used, turned-over and/or wasted at the end of a mission are documented by appropriate clinical personnel.

4.14.11.1. A statement is entered in the Flight Notes section or on a SF 600.

4.14.11.2. When the team receives controlled medication for individual patients, document the following: the drug name, total number received, and signatures of both the MTF representative and privileged provider or registered nurse (RN).

4.14.12. Anatomic Man diagram: This diagram is used to document the location of patient injuries, and is used for visual reminder of all injuries.

4.14.13. Physician Orders Block: Annotate new or changed orders for ERC. The privileged provider initials in the first column. The nurse initials in the second column verifying orders were received and annotated.

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

4.15.1. The AF Form 3899M is used by any licensed clinician in the AE system to provide chronological documentation for patients with accompanying patient controlled analgesia (PCA), peripheral nerve block (PNB) and epidural devices.

4.15.2. The form provides a means to document multiple patient care hand-offs and requires both sending and receiving nurse endorsements.

4.15.3. Initial PCA Orders and Pump Set-Up Verification. This section is completed during order verification and PCA pump set up. If an order or program is changed, start a new form.

4.15.4. Order, IV and Pump Verified; Pulse Ox Available: A pulse oximeters available and once orders and pump programming are verified, two licensed clinicians documents verification at designated spots reading RN #1 and RN #2 Signature and Initials.

4.15.5. Patient Handoff – Pump Infusion History Reviewed: Medication volumes and PCA pump history are reviewed and documented during each patient handoff. The PCA/PNB/Epidural infusion history running total is not cleared. The relinquishing nurse will report and document only on the medication administered during their time with the patient (from the previous handoff to the current handoff). The only time total volume remaining is changed is when medication bags are replaced.

4.15.6. Documentation of double-checks are reflected by two signatures on required forms/flow sheets or in the health record.

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

4.16.1. The AF Form 3899N is used to document objective and subjective patient data related to medications flowing through a PCA pump.

4.16.2. Pain reassessment should be accomplished after each intervention.

4.17. AF Form 3829, *Summary of Patients Evacuated by Air* and TRAC2ES *Mission Manifest Report-Cover Sheet.*

4.17.1. Return completed form to the Command and Control (C2) agency upon mission completion (fax, scan or method directed by C2).

4.17.2. The AF Form 3829 is completed by the MCD, when a TRAC2ES generated *Mission Manifest Report-Cover Sheet* (reference **paragraph 4.17.2**) is unavailable. The AF Form 3829 is available on e-Publishing website at **www.e-Publishing.af.mil**.

4.17.2.1. All sections of the form are written legibly in black or blue pen.

4.17.2.2. Identify home station assignments of personnel listed in Flight Crew, Medical Crew and Medical Additional Crew Member and/or trainees sections.

4.17.2.3. Remarks may include: discrepancies, and/or unusual occurrences noted throughout the mission, maximum cabin altitude.

4.17.3. *Mission Manifest Report – Cover Sheet* (printed from TRAC2ES)

4.17.3.1. Annotate the name of the organization providing airlift for the mission and the flight crew (rank and last name of aircraft commander plus number of crewmembers on the flight authorization (i.e. Maj Henry +4).

4.17.3.2. Medical Crew Organization (flight or squadron) assigning AECMs to the mission. Medical Crew: Rank, last name, crew duty position and home unit of assignment of AECMs assigned; list flight instructors and/or evaluators performing instructor and/or evaluator duties for unqualified and/or non-current crew members; augmentees and flight surgeons (authorized to log flight time) accompanying the AEC; and additional Mission Essential Personnel (MEP), and members of the CCATT accompanying the mission; do not include flight surgeons assigned as a medical attendant.

4.17.3.3. When or if changes occur from printed information while AEC is en route, handwrite the changed item(s) as required (patient and attendant numbers; take-off and

landing times; etc). **Note:** AMC/SG no longer requires any additional handwritten information be added to the TRAC2ES *Mission Manifest Report – Cover Sheet*. Leadership at relevant levels may add additional requirements if they determine information is value added for their unit operations, process improvement and/or risk mitigation.

4.17.3.4. Remarks: may include: discrepancies, and/or unusual occurrences noted throughout the mission, maximum cabin altitude.

4.17.3.5. MCD and Authenticating Officer sign and review the form.

4.18. AF Form 3830, *Patient Manifest.*

4.18.1. AF Form 3830 should be utilized when TRAC2ES printed *Patient/Attendee Listing* is not available.

4.18.2. Form provides manifest of 6 patients per page; should complete number of forms required.

4.18.3. All known and applicable information should be legibly documented on form.

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

4.19.1. AF Form 3851 is used by ERC personnel during patient transport to manage baggage for patients and ancillary support members. **Note:** Personnel complete this form when printed documents are not available through TRAC2ES.

4.19.2. This form is completed by the originating MTF, patient staging or AEC (if not completed prior to patients arriving at the aircraft). The MTF or patient staging should photocopy and provide the AEC with enough copies so each offload location and AEC receives one.

4.19.3. AECMs update the form if patients are added or removed from the mission.

4.19.4. One signed copy is given to each en route stop.

4.19.5. One signed copy is filed with mission paperwork.

4.19.6. Use International Civilian Aviation Organization (ICAO) codes for enplane and deplane stations.

4.19.7. Signature of person receiving baggage at offload station: include signature, printed name, rank, and duty phone number.

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

4.20.1. AF Form 3854 is utilized by anyone to transfer the valuables of unconscious and/or incompetent patient from one MTF and/or staging facility to another.

4.20.2. This form should be retained in the patient's medical records. If available this form should be used in conjunction with AF Form 1052, *Envelope/Record of Patient Storing Valuables,* to hold the patient's valuables if possible.

4.20.3. Should 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.

4.20.4. Should list each item, and the quantity, describing each item in general terms. Avoid terms like "gold watch," but rather "yellow band watch" or "ring with clear stone" instead of "diamond ring".

4.20.5. Should list each check number and the issuer separately.

4.20.6. Place a large letter "Z" after the last item is entered so no additional items may be added.

4.20.7. 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."

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

4.21.1. AF Form 3859 is completed by any FN assigned to the mission, or 7-level AET if the crew does not include a FN. The form is used to turn-in unaccompanied narcotics left on the aircraft after the patient has deplaned and given to drug room and/or pharmacy personnel.

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

4.21.3. If positive control of the medication kit has NOT been maintained or if controlled medication is stored at remote location other than a pharmacy (e.g., a nurse's station) or if lock-out tag is compromised, a nurse and another qualified person will count them at change of shift or the beginning/end of every mission and when accessed for patient use and document on AF Form 579, *Controlled Substances Register,* or in automated equipment logs (e.g., Pyxis ® log), as appropriate. **(T-1).**

4.22. AF Form 4449, *En Route Care Equipment Malfunction Report Tag.*

4.22.1. AF Form 4449 is completed when there is failure, malfunction or otherwise inability to utilize equipment. The Form 4449 will be completed fully and attached to the equipment being segregated and turned in for service and/or repair; these actions is in accordance with Ch. 3 of AFMAN 10-2909, *Aeromedical Evacuation (AE) Equipment Standards.*

4.22.2. This product is a physical product maintained by the Warehouse Management System; link to order can be accessed on the Air Force e-Publishing website (**http://www.e-publishing.af.mil**).

4.22.3. Complete Sections I through IV in accordance with guidelines in Chapter 12 of DAFI 48-107V1 and Chapter 3 of AFMAN 10-2909.

4.23. DD Form 2852, *Patient Movement Event/Near Miss Event Report* or *Joint Patient Safety Report Worksheet.*

4.23.1. A DD Form 2852, or *JPSR Worksheet* is completed in accordance with guidelines in DAFI 48-107V1.

4.23.2. The patient safety manager or designee will utilize DD Form 2852 or JPSR Worksheet to enter and submit patient safety event in to the JPSR system.

4.23.3. The patient safety event being reported will not be placed in the permanent medical record.

4.24. Other Forms.

4.24.1. AF Form 3836, *Aeromedical Mission Management* – **Part II**.

4.24.1.1. AF Form 3836 may be used to plan, execute and track a tasked AE operational mission. Form may be completed and stored on paper or electronically.

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

4.24.2.1. AF Form 3838 should be completed and/or maintained with patient as they transit through the AE/ERC system. This form is fully completed and briefed during all hand-offs of patient care.

4.24.3. AF Form 3841, *Certificate Release.*

4.24.3.1. AF Form 3841 is completed and signed if a patient (including medical or non-medical attendant) chooses to be removed from the AE/ERC system. When a patient chooses to exit the AE/ERC system the coordinating TPMRC and VFS are notified and assists with coordination as soon as operationally feasible. The medical personnel completing and processing form maintains the original AF Form 3841 with patient's medical documentation.

4.24.4. AF Form 3889, *AE Mission Manifest Control Log/Report.*

4.24.4.1. AF Form 3889 form may be utilized to plan, execute and track multiple AE operational missions. Form may be completed and stored on paper or electronically.

4.24.5. AF Form 3891, *Patients Reported for Aeromedical Airlift Movement.*

4.24.5.1. AF Form 3891 may be completed to track the number of patients enplaned and deplaned during a mission in the AE/ERC system.

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

4.24.6.1. AF Form 3892 may be utilized by a patient staging and/or holding area to manage and track patient's movement in the AE/ERC system.

4.24.7. AF Form 3894, *Aeromedical Mission Inbound Notification.*

4.24.7.1. AF Form 3894 may be utilized to plan, manage, execute and track multiple AE missions within the same location.

4.24.8. AF Form 1052, *Envelope for Storing Patient's Valuables.*

4.24.8.1. AF Form 1052 is a physical product (envelope) and it may be ordered through the website **https://wmsweb.afncr.af.mil/wms/** (an account and CAC is required for access). This envelope should be used in conjunction with AF Form 3854 and/or DD Form 2005, *Privacy Act Statement – Health Care Records*.

4.24.9. AF Form 1225, *Informed Consent for Blood Transfusion.*

4.24.9.1. AF Form 1225 would be present and completed in preparation or anticipation of a patient requiring a blood transfusion while transiting the AE/ERC system.

4.24.10. DD Form 600, *Patient Evacuation Tag.*

4.24.10.1. DD Form 600 is a physical product (hanging tag for patient property) and it may be ordered through the website **https://forms.documentservices.dla.mil/order/(NSN#:0102LF0006000**).

4.24.10.2. The DD Form 600, should be used to tag and identify patients luggage, property and gear as they transit the AE/ERC system.

4.24.11. DD Form 1380, *Tactical Combat Casualty Care (TCCC) Card.*

4.24.11.1. The DD Form 1380 may be obtained at the DOD Forms Management Program site: **https://www.esd.whs.mil/Directives/forms/**.

4.24.11.2. This form is used in conjunction with TCCC and is not a replacement for a long term medical record. If AE/ERC personnel are provided this card during transfer of patient care a medical record (EHR or paper) is started as soon as operationally feasible and is attached or scanned in to the permanent medical record.

4.24.12. DD Form1502, *Frozen Medical Material Shipment* and DD Form 1502-I, *Chilled Medical Material Shipment.*

4.24.12.1. DD Form 1502 and DD Form 1502-I are utilized when transporting/shipping blood products; these are not items typically completed during patient transport in the AE/ERC system. These documents and materials should be accompanying a patient who has been identified of potentially receiving blood products.

4.24.13. Standard Form 600, *Chronological Record of Medical Care.*

4.24.13.1. SF 600 is a general paper medical documentation form; if completed accompanies other medical documentation and is scanned into the patient's permanent medical record.

Chapter 5

EN ROUTE CARE ELECTRONIC HEALTH RECORD DOCUMENTATION

5.1. General Principles.

5.1.1. EHR documentation is preferred, and should be utilized over paper documentation (Exceptions outlined **paragraph 2.6.2**). The patient's EHR should be tailored for each patient based on condition and treatments, and delivered during patient movement. General documentation guidelines as outlined in **Chapter 3** apply to the EHR.

5.1.2. Privileged providers, licensed clinicians and/or non-licensed clinicians may chart by exception in the EHR system, consistent with applicable standards.

5.1.3. Signature logs are not required for EHRs not containing paper documentation; however, a signature log does accompany the record if the record consists of HER, paper documentation and/or charting.

5.1.4. When documentation is contained in both paper and electronic formats personnel should cross-reference in the other documentation method.

5.2. AHLTA-T Specific Considerations.

5.2.1. AHLTA-T users are responsible for proper utilization of the system to the level of their training proficiency levels based on their assigned roles and responsibilities. **Note:** Reference Roles and Responsibilities, **Chapter 2** for training required and **Attachment 2 Table A2.2** for Proficiency Code Level descriptions.

5.2.2. Entering and reviewing AE EHR information may be done in two ways:

5.2.2.1. Through the creation of an AHLTA-T encounter.

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

5.2.3. Reviewing AE EHR patient information can be done in three ways:

5.2.3.1. Reviewing an AHLTA-T encounter if the information has been transferred from one AHLTA-T system to another.

5.2.3.2. Reviewing a patient's record in TMDS.

5.2.3.3. Reviewing information transferred through the Central Data Repository (CDR) into AHLTA (Garrison). **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.

5.2.4. Patient demographic information and disposition are not altered when patients are already in the Authoritative Data Source (ADS) or information has been transferred on CD. **WARNING**: Do not edit patients already in ADS or on CD; if demographics are incorrect, contact the AFOMIS helpdesk as soon as possible for AFOMIS to make the changes. **Note:** Helpdesk contact information is on desktop display of every EHR.

5.2.5. The encounter should be assigned as "evacuation" for the disposition in an AHLTA-T encounter.

5.2.6. Privileged provider and verbal orders cannot be modified. Discontinue incorrect orders and replace with a correct order, in accordance with **paragraph 3.3** Privileged providers or licensed clinicians entering verbal orders notifies staff when a new order are entered in AHLTA-T. **WARNING**: AHLTA-T does not automatically alert when a new order is written. Medication orders are initiated through the "A/P Medication Module" and all new orders should be immediately relayed to AECMs or clinical staff.

5.2.7. Medication orders can be discontinued via the "A/P module." **Note:** Privileged providers and/or FN with verbal orders may discontinue medication via the "A/P module."

5.2.8. The Medications Module should be used to schedule medications and should be done by the sending MTF or Patient Staging Unit. **Note:** AECMs may need to reschedule or schedule new medications en route. If a medication is missed, licensed clinicians contact the appropriate privileged provider as soon as possible and documents the notification in the record.

5.2.8.1. Verbal medication orders expire in 5 days from the date and time of order entry; the expiration date is input by the medical personnel inputting the information in the EHR. Orders should not expire during patient movement unless the expiration time and date is intentional.

5.2.8.2. Personnel relays all verbal patient orders during patient handoff to the receiving facility. **WARNING:** MTF and patient staging personnel reviews, validates and ensures medication orders do not expire during patient movement.

5.2.8.3. When documenting in chart view and tree view the following applies: **WARNING**: Documenting actions in the "Chart View" can only be done once during the same hour period. Personnel have to navigate to the "tree view" to review and document additional actions and/or comments within the same hour period. **WARNING**: AECMs perform this function upon verbal order from a privileged provider.

5.2.8.3.1. AECMs discontinue medications in accordance with **Attachment 2** and upon verbal order from a privileged provider.

5.2.8.3.2. Cells colored light blue in the "Chart View" have special considerations (reference **paragraph section A2.5.2.16**).

5.2.9. Actions to accomplish EHR documentation for an encounter should be complete in accordance with **Attachment 2**.

DOROTHY HOGG
Lieutenant General, USAF, NC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DODM 6025.18 *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DOD Health Care Programs,*13 March 2019

AFPD 10-29, *Worldwide Aeromedical Evacuation Operations*, 13 February 2019

AFPD 48-1, *Aerospace and Operational Medicine Enterprise*, 7 June 2019

DAFI 33-360, *Publications and Forms Management*, 30 November 2015

DAFI 48-107V1, *En Route Care and Aeromedical Evacuation Medical Operations,* 15 December 2020

AFI 33-322, *Records Management and Information Governance Program,* 23 March 2020

AFI 46-101, *Nursing Services and Operations,* 30 January 2015, certified current 10 April 2020

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

AFMAN 10-2909, *Aeromedical Evacuation Equipment Standards*, 13 March 2019

AFMAN 11-2AEV3, *Aeromedical Evacuation (AE) Operations Procedures*, 19 October 2020

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

Prescribed Forms

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

AF Form 3830, *Patient Manifest*

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 for Patient's Valuables*

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

AF Form 3889, *Aeromedical Evacuation Mission Management Control Log/Report*

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 Physician Orders*

AF Form 3899C, *Patient Movement Physical Assessment*

AF Form 3899D, *Patient Movement Hemodynamic/Respiratory Flowsheet*

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 Flowsheet*

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*

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

AF Form 4449*, En Route Care Equipment Malfunction Report Tagwork*

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

AF Form 1052, *Envelope/Record of Patient Storing Valuables*

AF Form 1225, *Informed Consent for Blood Transfusion*

AF Form 579, *Controlled Substance Register*

DD Form 600, *Patient Evacuation Tag*

DD Form 1380, *Tactical Combat Casualty Care (TCCC) Card*

DD Form 1502, *Frozen Medical Material Shipment*

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

DD Form 2852, *Patient Movement Event/Near Miss Report*

SF 600, *Chronological Record of Medical Care*

Abbreviations and Acronyms

ABG—Arterial Blood Gas

ADS—Authoritative Data Source

AE—Aeromedical Evacuation

AEC—Aeromedical Evacuation Crew

AES—Aeromedical Evacuation Squadron

AECM—Aeromedical Evacuation Crew Member

AET—Aeromedical Evacuation Technician

AF—Air Force

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFPD—Air Force Policy Directive

AFOMIS—Air Force Operational Medical Information System

AFRC—Air Force Reserve Command

AHLTA-T—Armed Forces Health Longitudinal Technology Application-Theater

AIM—Alternative Input Method

AMC—Air Mobility Command

AMC/SG—Air Mobility Command/Command Surgeon

AMC/SGK—Air Mobility Command/En Route Medical Care Division

ANG—Air National Guard

ASTS—Aeromedical Staging Squadron

C2—Command and Control

CCATT—Critical Care Air Transport Team

CDR—Common Data Repository

CN—Chief Nurse

DAFI—Department of the Air Force Instruction

DART—Data-Action-Response-Teaching

DC or D/C—Discontinue

DOD—Department of Defense

EHR—Electronic Health Record

EHRDP—Electronic Health Record Designated Personnel

ERC—En Route Care

ERCC—En Route Critical Care

ERPSS—En Route Patient Staging System

FN—Flight Nurse

GCS—Glasgow Coma Scale

HIPAA—Health Insurance Portability and Accountability Act

ICAO—International Civil Aviation Organization

ID—Identification

IDMT—Independent Duty Medical Technician

I&O—Intake and Output

I-SBAR—Identify, Situation, Background, Assessment and Recommendation

JPSR—Joint Patient Safety Report

MAJCOM—Major Command

MAR—Medication Administration Record

MCD—Medical Crew Director

MEFPAK—Manpower Equipment Force Packaging

MEP—Mission Essential Personnel

MTF—Medical Treatment Facility

OPR—Office of Primary Responsibility

PCA—Patient Controlled Analgesia

PMR—Patient Movement Request

PNB—Peripheral Nerve Block

PRN—As Needed

RB—Read Back

RegAF—Regular Air Force (active Duty)

RN—Registered Nurse

RON—Remain Overnight

SAM—Self-Administered Medication

SORN—System of Record Notice

SSN—Social Security Number

SF—Standard Form

TMDS—Theater Medical Data Store

TRANSCOM—Transportation Command

TPMRC—TRANSCOM Patient Movement Requirements Center

TRAC2ES—TRANSCOM Regulating and Command & Control Evacuation System

USTRANSCOM—United States Transportation Command

UTC—Unit Type Code

VFS—Validating Flight Surgeon

VS—Vital Sign

Terms

Caution—procedures and techniques which could result in damage to equipment if not carefully followed.

Clinician—generalized term, 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 Staging System—denotes the global system versus a singular UTC.

May—used to express an acceptable or suggested means of accomplishment and construed as a non-mandatory provision.

Note—operating procedures, techniques, action, etc., considered essential to emphasize.

Privileged Provider—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—applied to requirements, procedures, techniques, action, etc., which are binding and mandatory.

Should—express a non-mandatory desire or preferred method of accomplishment and 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

ERC EHR HARDWARE, SOFTWARE, AND TRAINING REQUIREMENTS

A2.1. The AE EHR system consists of four parts: Computer hardware, software applications, an expeditionary framework, and a data management infrastructure capable of operating in the en route care environment. **Note:** Coordinate training support to **amc_ae_ehr@us.af.mil** and **sg.sgsi.amc_ehr_training@us.af.mil**.

A2.2. The support contact number, information to update hardware and software is maintained on every AE EHR desktop background screen.

A2.3. Software.

A2.3.1. The current AE EHR system uses the theater configuration of AHLTA (AHLTA-T) to gather data from clinicians. **Note:** AHLTA-T software is a store and forward system. Information generated by one AHLTA-T system is only accessible by another AHLTA-T system if the file(s) created during an encounter is transmitted 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**. **Note:** in accordance with USTRANSCOM directs all privileged providers receiving AE patients to obtain a TMDS account. **(T-0)**

A2.3.2. Software has the capability for gathering comprehensive objective and subjective patient data after an encounter is created.

A2.3.3. The encounter is saved as a file on the local system.

A2.3.4. After the encounter is complete and signed by an authorized clinician, the AE EHR software automatically places the data in queue.

A2.3.5. Once an internet connection is established, data is condensed, encrypted and automatically forwarded to TMDS within 30 minutes.

A2.3.6. Data forwarded to TMDS is batched and sent to the CDR within 24 hours. **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.

A2.4. User manuals are available for use by personnel on the AE/ERC EHR desktop in EHR format; documents include information related to hardware and software and include:

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

A2.4.2. Basic hardware and 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 and/or end of mission data transmission and verification procedures.

A2.5. All users for ERC EHR Training Requirements.

A2.5.1. Users are trained to in Proficiency Code Task Performance based on the role they fulfill (reference **Ch. 2** and **table A2.2**).Training will include but not limited to:

A2.5.1.1. Demonstrates and/or verbalizes how to complete administrative functions of creating user accounts; establishing, resetting, unlocking account passwords; and assigning system roles and privileges.

A2.5.1.2. Users are trained **WARNINGS, CAUTIONS** and **NOTES** to the Proficiency Code Subject Knowledge Level B.

A2.5.1.3. Training outlined in **Attachment 2 paragraph A2.5.2** through **A2.5.15.7** lists expected Proficiency Code (reference **Attachment 2 Table A2.2**) parenthetically at the end of each item.

Table A2.1. Training Proficiency by Role

Training Proficiency by Role		
Role	Initial Training	Recurring Training
Electronic Health Record Designated Personnel[1,2] (EHRDP).	Train and maintain Subject Knowledge Level D (reference **Attachment 2 table A2.2.**) within 6 months of appointment to the EHRDP (primary and alternate).	Maintain Subject Knowledge Level D.
AECM[3].	Train to the Subject Knowledge Level A (reference **Attachment 2 Table A2.2.**) within 6 months of initial AECM qualification or requalification.	Complete hands-on user training at minimum of every 12-months or more frequently if needed to attain and maintain a Subject Knowledge Level B.
Patient Staging Personnel[1,2] (ERCC and ERPSS).	Training to the Subject Knowledge Level A.	Train at minimum of every 12-months or more frequently if needed to attain and maintain a Subject Knowledge Level B.
Note 1: The requirement related to EHR is not applicable for ERPSS UTCs (includes ANG ERPSS and AFRC Aeromedical Staging Squadron [ASTS]) units and/or assigned personnel with no EHR equipment and do not have requirement for live patient movement mission. **Note 2:** AMC/SG does not provide or EHR issue equipment to ERPSS Unit Type Codes (UTC)		

(including AFRC and ANG Aeromedical Staging Squadron [ASTS]) that do not have requirement for live patient movement mission or activities.
Note 3: All **WARNINGS, CAUTIONS** and **NOTES** are trained to the Proficiency Code Subject Knowledge Level B.

Table A2.2. Proficiency Code Key.

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 work.
	4	**IS HIGHLY PROFICIENT-**Can do the complete task quickly and accurately; can tell or show others how to do the task.
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 needs to be done and why each step is needed.
	d	**KNOWS ADVANCED THEORY-**Can predict, isolate, and resolve problems about the task.
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 principles about the subject.
	C	**KNOWS ANALYSIS-**Can analyze facts and principles and draw conclusions about the subject.
	D	**KNOWS EVALUATION-**Can evaluate conditions and make proper decisions about the subject.
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.
Note: Training will include any **WARNINGS, CAUTIONS** and **NOTES**, are trained to the Proficiency Code Subject Knowledge Level B.

A2.5.2. All users will be able to capture EHR information using AHLTA-T. (3c)

A2.5.3. Properly enter data into fields. (3c)

A2.5.4. Understand an overview of the AFOMIS expeditionary framework, pathways of information between users in the care continuum (staging, AEC and facilities) and how documentation is stored in patient's permanent medical record (to include attachments). (B)

A2.5.5. Understand what types of facilities are capable of transmitting and viewing EHR information and which are not. (B)

A2.5.6. Recognize when printing is necessary within the AE system. (B)

A2.5.7. Users log into client and remote connectivity to server, which also includes: (3c)

A2.5.7.1. Logging into hardware and software. (3c)

A2.5.7.2. Verify connection(s) to server. (3c)

A2.5.8. Users log into AHLTA-T which includes: (3c)

A2.5.8.1. Ability to accomplish access to hardware, software and electronically sign and/or co-sign documentation. (3c)

A2.5.8.2. Be able to create user accounts, set up password(s), reset password(s), assign appropriate roles and privileges and unlock accounts. (3c) IF applicable, be able to set up hardware to include connections to printers, and wireless internet access devices. (3c)

A2.5.9. All user training will include three scenarios covering procedures for patients arriving with data on CD; patients arriving without CD but are registered in the ADS, and patients arriving with neither CD, nor are registered in ADS. **(T-2).** Training scenarios will include starting a new encounter and documenting an encounter. **(T-2).**

A2.5.9.1. Users demonstrate and/or explain how to process documentation for patients arriving with information on CD.

A2.5.9.1.1. Users explain the purpose of the data manager and where information is stored on the hardware device. (3b)

A2.5.9.1.2. Demonstrate how to import patient data from CD. (3b)

A2.5.9.1.3. Demonstrate how to export data to CD. (3b)

A2.5.9.1.4. Demonstrate how to review patient documents from previous encounters. (3b)

A2.5.9.2. Users demonstrate and/or explain how to process documentation for patients arriving without CD but are registered in ADS by doing the following:

A2.5.9.2.1. Demonstrate how to search for a patient. (3b)

A2.5.9.2.2. Demonstrate the ability to verify ADS. (3b)

A2.5.9.2.3. Demonstrate the ability to add a new patient. (3b)

A2.5.9.2.4. Demonstrate the ability to edit demographics, when appropriate. (3b) **WARNING**: Do not edit patients already in ADS or on CD.

A2.5.9.3. Users demonstrate and/or explain how enter patients not registered in ADS and arriving without a CD by doing the following:

A2.5.9.3.1. Demonstrates how to add a new patient. (3b)

A2.5.9.3.2. Demonstrates how to enter demographics. (3b)

A2.5.9.3.3. Demonstrates how to train a user to start a new encounter. (3b)

A2.5.9.3.4. Demonstrates the ability to register a patient. (3b)

A2.5.9.4. Demonstrates the ability to review previous encounters. (3b)

A2.5.9.5. Demonstrates the ability to review previous documents. (3b)

A2.5.9.6. Demonstrates the ability to enter a disposition from the PMR. (3b) **Note:** In most cases, the disposition should be "evacuation".

A2.5.9.7. Demonstrates the ability to load and use templates for documentation. (3b)

A2.5.9.8. Demonstrates the ability to use the MAR Module which includes:

A2.5.9.8.1. Demonstrates the ability to use "tree view." (3b)

A2.5.9.8.2. Demonstrates the ability to use "chart view." (3b)

A2.5.9.8.3. Demonstrates 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 has to be immediately relayed to AECMs or clinical staff.

A2.5.9.8.4. Privileged providers and FN demonstrate how to discontinue medications via the MAR Module and "A/P medication module." (3b)**Note:** Privileged providers and FN with verbal orders may discontinue medication via the "A/P module."

A2.5.9.8.5. Demonstrates use of the expanded "SIG module" to reconcile new medications. (3b)

A2.5.9.8.6. Demonstrates how to document medication administration. (3b)

A2.5.9.8.7. Demonstrates how to sort continuous infusions, scheduled medications and PRN medications. (3b)

A2.5.9.8.8. Demonstrates how to schedule re-occurring and one time use medications using the "Chart View." (3b) **Note:** The MTF or patient staging personnel should complete scheduling of medications, however AECMs may need to reschedule or schedule new medications en route.

A2.5.9.8.9. Demonstrates how to document actual time medication administered. (3b)

A2.5.9.8.10. Demonstrates how to document missed medications. (3b) **WARNING**: If a medication is missed, clinician contact the appropriate privileged provider as soon as possible.

A2.5.9.8.11. Demonstrates 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 are set to expire 5 days from the date and time of the order(s). All verbal patient orders are relayed during patient handoff to the receiving facility. **WARNING**: MTF and patient staging personnel reviews, validates and ensures medication orders do not expire during patient movement.

A2.5.9.8.12. Privileged providers and AECMs demonstrates 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 have to navigate to the "tree view" to review and document additional actions and/or comments within the same hour period. **WARNING**: AECMs perform this function upon verbal order from a privileged provider.

A2.5.9.8.13. Users understand all 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.

A2.5.9.8.14. Demonstrate the ability to navigate to "tree view" to view all comments made within the same hour period. (3b)

A2.5.10. Demonstrates the ability to document an encounter which includes:

A2.5.10.1. Demonstrate how to open and use AIM forms for documenting patient assessment and free text information. (3b) **Note:** Use AIM forms to document pre-flight or in-flight assessments.

A2.5.10.2. Demonstrate how to use the "Add Note" function, including:

A2.5.10.3. Copy and paste routine statements. (3b)

A2.5.10.4. Loading notes from overlays and templates. (3b)

A2.5.10.5. AECMs need to demonstrate how to document a trip segment. (3b)

A2.5.10.6. Demonstrate how to document patient briefings. (3b)

A2.5.10.7. Demonstrate how to free text notes. (3b)

A2.5.10.8. Demonstrate 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.

A2.5.10.9. Users demonstrate how to print SF 600, which includes how to automatically and manually set a document up for printing. (3b)

A2.5.11. Users demonstrate the data transfer process. (3b) Users demonstrate post mission or post patient transfer procedures, including confirming transmission has occurred. (3b)

A2.5.12. Demonstrate basic administrative and troubleshooting (4c)

A2.5.12.1. How to troubleshoot basic problems. (4c)

A2.5.12.2. How to accomplish basic system maintenance. (4c)

A2.5.12.3. How to set up connections to printers, and wireless internet access devices. (4c)

A2.5.12.4. How to create a user account, set up a password, reset passwords, assign appropriate roles and privileges, and unlock accounts. (4c)

A2.5.13. AECMs perform preflight procedures including:

A2.5.13.1. Hardware preflight. (4c)

A2.5.13.2. Ensure kit contents match inventory checklist. (4c)

A2.5.13.3. Ensure wireless router connections function appropriately. (4c)

A2.5.13.4. Ensure calibration of touch screen(s). (4c)

A2.5.13.5. Verify MiFi connection to internet. (4c)

A2.5.13.6. Software preflight. (4c)

A2.5.13.7. Function checks. (4c)

A2.5.13.8. Operational preflight. (4c)

A2.5.14. ERPSS personnel utilize TMDS to explain and/or demonstrating the following:

A2.5.14.1. Users demonstrate and/or explain how to confirm transmission after each handoff (data transmission should be within minutes with no connection issues). (3c)

A2.5.14.2. If patients are not in TMDS, users demonstrate and/or explain how to check in AHLTA-T to ensure records are not held in the queue. (3c)

A2.5.15. EHRDP and EHR trainer instructions also include:

A2.5.15.1. A comprehensive program, EHR trainers should be able to attain a Subject Knowledge Level D and be able to demonstrate a Task Knowledge Level d (reference **Table A2.2**).

A2.5.15.2. Demonstrate ability and/or explain setting up hardware and software to allow multiple users to log into the same hardware device in an operational and classroom setting. (4c)

A2.5.15.3. Demonstrate ability and/or explain how to create a user accounts. (4c)

A2.5.15.4. Demonstrate ability and/or explain how to unlock and reset passwords. (4c)

A2.5.15.5. Demonstrate ability and/or explain process to train users and EHR trainers to appropriate Proficiency Codes in a group or individual setting.

A2.5.15.6. Demonstrate ability and/or explain how to assist users with troubleshooting hardware, software and user issues. If unable to resolve, demonstrate how to report

problems via applicable channels (i.e. Patient Safety issues reported through JPSR or technical issues to the AMC SG EHR Program Office).

A2.5.15.7. Demonstrate ability and/or explain how to use a training syllabus and training verification procedures tailored for personnel based on the learner's role and responsibilities.