
July 27, 2005



Health Care

Report on the DoD Patient Movement System (D-2005-095)

Department of Defense
Office of the Inspector General

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Acronyms

ADUSD(TP)	Assistant Deputy Under Secretary of Defense for Transportation Policy
AE	Aeromedical Evacuation
CENTCOM	U.S. Central Command
GPMRC	Global Patient Movement Requirements Center
JPTA	Joint Patient Tracking Application
MRR	Medical Readiness Review
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PMR	Patient Movement Request
TRAC2ES	U.S. Transportation Command Regulating and Command and Control Evacuation System
USTRANSCOM	U.S. Transportation Command



INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
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July 27, 2005

MEMORANDUM FOR COMMANDER, U.S. CENTRAL COMMAND
COMMANDER, U.S. TRANSPORTATION COMMAND
ASSISTANT SECRETARY OF DEFENSE (HEALTH
AFFAIRS)

SUBJECT: Report on the DoD Patient Movement System
(Report No. D-2005-095)

We are providing this report for your information and use. The Office of the Assistant Secretary of Defense (Health Affairs) responded to this report. We considered management comments on the draft of this report when preparing the final report. The complete text of the comments is in the Management Comments section of the report.

Comments on the draft of this report conformed to the requirements of DoD Directive 7560.3. Therefore, no additional comments are required.

We appreciate the courtesies extended to the staff. Questions should be directed to me at (757) 872-4815 ext. 223 or Mr. Timothy J. Tonkovic at (757) 872-4763. See Appendix B for the report distribution. The team members are listed inside the back cover.

By direction of the Deputy Inspector General for Auditing:

A handwritten signature in cursive script, reading "Michael A. Joseph", is positioned above the printed name.

Michael A. Joseph
Acting Assistant Inspector General
for Readiness and Logistics Support

Department of Defense Office of Inspector General

Report No. D-2005-095

July 27, 2005

(Project No. D2005-D000LF-0082.000)

DoD Patient Movement System

Executive Summary

Who Should Read This Report and Why? Medical planners, transportation specialists, and managers who are involved in the administration, implementation, and oversight of the DoD patient movement system should read this report.

Background. This report discusses the aeromedical evacuation process from Operation Enduring Freedom and Operation Iraqi Freedom theaters of operation. Aeromedical evacuation is the transportation of patients under medical supervision to and between medical treatment facilities by air transportation.

Results. For FY 2004, there were about 28,500 worldwide patient movement requests of which approximately 11,350 (40 percent) represented the U.S. Central Command area of operations. For our limited review of 53 patient movement requests from the U.S. Central Command, the DoD patient movement system provided timely evacuation of patients from the combat zone that were consistent with theater commander and aeromedical patient movement priorities. Because of the timeliness of the patient movements reviewed during our limited review and other ongoing initiatives such as the Medical Readiness Review that may impact the patient movement system, we are concluding our audit.

Management Comments and Audit Response. Although no comments were required, the Office of the Assistant Secretary of Defense (Health Affairs) concurred with the audit finding and conclusion. No additional comments are required. Management provided comments and information that they believe are valid and would strengthen the report. Although we found no reason to disagree with the additional information, the scope of our audit work did not allow us to report on the issues raised. See the Finding section of the report for a discussion of management comments and the Management Comments section of the report for the complete text of comments.

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Background

The primary mission of the DoD patient movement system is to safely transport U.S. military casualties from a combat zone to fixed medical treatment facilities and field hospitals in or out of the combat theater. Patients not expected to return to duty within the number of days established in the combat theater evacuation policy will normally be evacuated to the next medical operational zone as soon as medical authorities have determined that travel will not aggravate their medical condition. Other patients may be moved on a non-interference basis if the patient's medical condition, lack of local care, and costs warrant the move.

The Office of the Assistant Deputy Under Secretary of Defense for Transportation Policy (ADUSD[TP]) is responsible for establishing policies and providing guidance to DoD Components for efficient and effective use of DoD and commercial transportation resources. The DoD patient movement system uses DoD transportation resources to accomplish its mission.

The Commander, U.S. Transportation Command (USTRANSCOM) is the single manager for inter-theater patient movement. Inter-theater patient movement evacuates patients to medical treatment facilities outside of the theater of operation by aeromedical evacuation (AE). AE is the movement of sick or injured personnel, under medical supervision, to appropriate medical treatment facilities and/or field hospitals by air transportation. The U.S. Air Force is the USTRANSCOM Component responsible for providing inter-theater AE.

Commanders of outside-CONUS Combatant Commands are responsible for intra-theater patient movement, which moves patients to and between medical treatment facilities within a theater of operations and may involve surface vehicles, rotary, and fixed-wing aircraft. We included only inter-theater AE patient movements in this review.

The Global Patient Movement Requirements Center (GPMRC) is an organizational element of USTRANSCOM that manages the movement of patients. The GPMRC integrates inter-theater and CONUS medical regulation services, mission requirements, clinical validation, and related activities that support patient movement requests (PMR). The GPMRC determines the mode of transport (airlift, sealift, and surface) that will be used to move a patient to a final destination. The GPMRC coordinates airborne patient movement requirements through the Air Force Air Mobility Command.

To coordinate patient movements, the GPMRC uses the U.S. Transportation Command Regulating and Command and Control Evacuation System (TRAC2ES). Using TRAC2ES, the GPMRC and each Theater Patient Movement Requirements Center receives, consolidates, and processes patient movement requests to coordinate AE requirements with available airlift operations, health service support capabilities, and available bed space.

Criteria

DoD Directive 4500.9E, “Transportation and Traffic Management,” February 12, 2005, establishes DoD policy for transportation and traffic management. DoD Directive 4500.9E updated the November 17, 2003, directive concerning policy and responsibilities for operating the Defense transportation system. DoD Directive 4500.9E states that DoD transportation resources should be used for official purposes only. DoD transportation resources may be used to move non-DoD traffic only when the DoD mission will not be impaired and movement of such traffic is of an emergency or life saving nature, specifically authorized by statute, in direct support of the DoD mission, or requested by the Head of an agency of the Government.

DoD Directive 6000.12, “Health Services Operations and Readiness,” January 20, 1998, establishes patient movement policy and assigns the Commander, USTRANSCOM responsibilities as the DoD single manager for patient movement, other than intra-theater patient movement. The Commander, USTRANSCOM is responsible for establishing and maintaining a system for medical regulating and movement.

DoD Regulation 4515.13-R, “Air Transportation Eligibility,” April 9, 1998, implements DoD policies governing the use of DoD-owned or DoD-regulated aircraft and establishes criteria for passenger and cargo movement. Chapter 5, “Aeromedical Evacuation” of DoD Regulation 4515.13-R is used to determine eligibility for patient movement. Chapter 5 is not consistent with current guidance because it is based on a cancelled directive and predates current implementing guidance. We contacted the Office of the ADUSD(TP) and advised office personnel that Chapter 5 was superseded in 1998 when DoD Instruction 6000.11 was published. We also advised ADUSD(TP) personnel that DoD Instruction 6000.11 was under revision. ADUSD(TP) personnel informed us that DoD Regulation 4515.13-R was also under revision and that patient movement policy and procedures in Chapter 5, if included, would be based on revised DoD guidance.

DoD Instruction 6000.11, “Patient Movement,” September 9, 1998, establishes procedures for the movement of patients, medical attendants, and related patient movement items on DoD-provided transportation. It addresses the evacuation of patients through the Air Force fixed-wing AE system and the medical regulating of patients to appropriate locations of care. DoD Instruction 6000.11 also establishes AE patient priorities that are used by competent medical authorities to classify a patient as a candidate for patient movement.

On October 29, 2004, the Department of Defense Office of Inspector General nonconcurred with proposed revisions to DoD Instruction 6000.11. We nonconcurred because the draft instruction delegated approval authority for non-DoD patient movement without evidence that the policy makers (that is, Secretary/Deputy Secretary of Defense) intended to delegate such authority. The Department of Defense Office of Inspector General recommended that

if changes to DoD policy were necessary, the appropriate directive(s) rather than DoD Instruction 6000.11 needs to be changed and all such changes were to be coordinated with the office(s) responsible for the applicable directive(s).

Objectives

Our overall audit objective was to evaluate the DoD patient movement system that medically regulates and transports casualties to appropriate military treatment facilities for care and rehabilitation. Specifically, we assessed the capabilities, effectiveness, and performance of the system used to support the movement of U.S. military casualties from combat zones. We reviewed AE inter-theater patient movements from the U.S. Central Command (CENTCOM) area of responsibility that includes Operation Enduring Freedom (OEF) missions in Afghanistan and Operation Iraqi Freedom (OIF) missions in Iraq. See Appendix A for a discussion of the scope and methodology.

Effectiveness of the Aeromedical Evacuation System from the Operation Enduring Freedom and Operation Iraqi Freedom Theaters of Operation

For FY 2004, there were about 28,500 worldwide PMRs of which approximately 11,350 (40 percent) represented the CENTCOM area of operations. Because of the large number of PMRs originating in the CENTCOM theater, we limited our survey effort to a review of AE patient movements that originated from OIF or OEF. For the 53 PMRs reviewed, the DoD patient movement system provided timely evacuation of patients from the combat zone consistent with theater commander and AE patient movement priorities. During the initial stages of our audit, we also learned of other DoD initiatives that may directly or indirectly impact the patient movement system. As a result of the timely patient movements that we reviewed and the other DoD initiatives, we are concluding our audit.

Inter-theater Aeromedical Evacuation

Patient Regulating and Movement. The DoD patient movement system is designed to transport injured or recuperating patients to needed levels of medical care. A PMR is used to initiate patient movements to an appropriate medical treatment facility. We evaluated active duty PMRs from TRAC2ES to determine the scope and timing of patient movements from the OIF and OEF theater of operations to the U.S. European Command medical operational zone. Patients continue to receive medical care while waiting to be transported and while on-board an aircraft. A PMR includes the AE patient movement priority; patient demographics; administrative and clinical data; medications; patient movement item information¹; medical attendant information; and other information relevant to the transport of the patient.

AE patient priorities are determined by a physician based on the patient's medical need for care. The three categories of AE patient priority, as established in DoD Instruction 6000.11 are routine, priority, and urgent. A routine patient is one who requires AE movement but can wait for a regularly scheduled channel² AE mission, a scheduled military airlift channel mission, or a commercially procured airlift service. A priority patient is one who requires movement within 24 hours to save life, limb, or eyesight. An urgent patient is one who requires movement

¹ Patient movement items are medical equipment and supplies required to support the patient during evacuation.

² A channel mission is a regularly scheduled mission that is flown over an established route.

as soon as possible to save life, limb, or eyesight. Immediate action is taken to obtain suitable transportation to meet an urgent patient's requirements. The GPMRC considers the patient movement priority when processing the PMRs.

Timeliness of Patient Movements. We performed a limited review on 53 PMRs and determined the length of time from when a patient was declared "medically ready to travel" until the time of actual departure. We selected PMRs from December 1, 2004, through January 24, 2005, for review. This time frame included a mass casualty event in Iraq at the Mosul dining facility that resulted in a demand surge on the AE system. The table below shows the average elapsed hours from the time a patient was declared "medically ready to travel" to the time of actual departure.

<u>Table. Medically Ready to Travel Until Time of Departure (In Hours)</u>			
		<u>Average Hours¹</u>	
	<u>PMRs Reviewed</u>	<u>OIF</u>	<u>OEF</u>
Routine ²	18	31.4	33.2
Priority ³	19	17.9	23.8
Urgent ⁴	16	9.4	14.1

¹The average hours are based on the 53 PMRs reviewed and should not be used to generalize to the 11,350 FY 2004 CENTCOM PMRs.
²Routine- patient can wait for evacuation
³Priority- life, limb, eyesight – move in 24 hours
⁴Urgent- life, limb, eyesight – move as soon as possible

Thirty two of the 53 PMRs were for casualty events designated as OIF patient movements to the U.S. European Command medical operational zone. Twenty one of the PMRs were for casualty events designated as OEF movements to the U.S. European Command medical operational zone. The analysis showed that active duty personnel were being moved in a timely manner consistent with AE patient movement priorities for the PMRs reviewed.

Medical Readiness Review. On March 29, 2004, the Under Secretary of Defense for Personnel and Readiness and the Director, Program Analysis and Evaluation established a medical readiness review (MRR) to provide a comprehensive evaluation of work to be done to strengthen the DoD medical readiness posture for the future. The MRR is examining how medical readiness capabilities will be delivered in wartime and maintained in peacetime. Various subgroups within the MRR are addressing planning factors involving casualty estimation, modeling, and patient evacuation scenarios; taxonomy of care; medical force structure requirements; and medical skills needed to satisfy contingency operations. Patient movement is an integral part of the MRR subgroups' tasking. Personnel on the MRR subgroups are coordinating their results with USTRANSCOM and other combatant commanders to determine the resources necessary to support the medical readiness posture.

Patient Visibility. We were also apprised by representatives from Health Affairs, Office of the Surgeon General for Army, and the CENTCOM Command Surgeon of concerns with the TRAC2ES lack of patient visibility while patients are receiving in-patient medical care at military treatment facilities. TRAC2ES is a transportation logistics system and was not intended to continue to track patients once they have completed their USTRANSCOM flights and are admitted to a fixed medical or rehabilitation facility for care. As of February 1, 2005, the Assistant Secretary of Defense (Health Affairs) directed CENTCOM to begin using the Joint Patient Tracking Application (JPTA) to collect patient care information as the patient is moved between military treatment facilities. It also uses other medical information systems, such as TRAC2ES, to provide critical information about patients being treated in a theater of operations or transported to Europe or CONUS for continued care. The JPTA generates a variety of patient reports such as diagnosis, types of injuries, length of stay, number and types of patients, pending departures, and disposition status. JPTA will provide physicians, commanders, medical planners, administrators and other authorized users real-time updates on patient information such as patient location, status, and anticipated disposition. If implemented as planned, the JPTA should resolve concerns over in-patient visibility.

Conclusion

For the PMRs reviewed, the DoD patient movement system provided timely evacuation of patients from the combat zone that were consistent with theater commander and AE patient movement priorities. Additionally, coordination and publication of revised patient movement guidance will provide DoD with a uniform and consistent policy for the movement of patients on DoD transportation assets.

Senior DoD management has also initiated the MRR to identify the medical readiness posture for the future. The MRR is performing a comprehensive analysis of capabilities, financial resources, performance metrics, and casualty estimates to determine the future impact on the DoD medical readiness posture. The patient movement system is an integral part of the MRR analytical process and its results will aid DoD in determining future patient movement capabilities. Finally, the JPTA management initiative, if implemented as planned, is intended to provide updates on patients, such as their location, status, and disposition to physicians, commanders, planners, administrators and other authorized users. Due to the results of our limited review and ongoing management initiatives, we are concluding the audit.

Management Comments and Audit Response

Office of the Assistant Secretary of Defense Health Affairs Comments. Although not required to comment, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) concurred with our report on the DoD Patient Movement System. The OASD(HA) resubmitted comments to a

discussion draft of the proposed report stating that their comments were not accepted in their entirety and included in the draft report. The OASD(HA) believed the comments to be valid and that they would strengthen the report. The OASD(HA) also requested that the comments be included in their entirety in the final report.

The OASD(HA) commented that DoD policies governing air transportation and medical evacuation are inconsistent and it would be advantageous to consolidate policy and guidance under one DoD Directive and DoD Instruction. The OASD(HA) also stated that it is difficult to obtain accurate information on reimbursement to Health Affairs for funding the Transportation Working Capital Fund and to differentiate airlift costs for patient movement on aircraft performing joint air evacuation and transportation missions. The OASD(HA) also stated that the Department may decide to explore efforts to improve tracking of medical evacuation expenses. In regard to airlift requirements, the OASD(HA) commented on increasing patient movement system reliance on the C-17 aircraft to provide future air evacuation requirements. The OASD(HA) stated that it is not known whether the C-17 aircraft can meet increased demand or patient movement and continue to meet other mission requirements.

Audit Response. Management comments are responsive. We considered OASD(HA) comments before issuing our draft report and included those changes that were within the scope of our review. We do not disagree with the OASD(HA) comments; however, the scope of our review did not enable us to report on many of the issues raised in the OASD(HA) comments.

We recognize that revised guidance will provide DoD with a uniform policy for patient movement on DoD assets. We also expanded the discussion that we were unable to determine patient movement costs because costs were not centrally tracked. Each Service has elements of patient movement costs built into the operating budget, but a separate budget line item has never been established. We did not address future patient movement airlift requirements in our review because the Medical Readiness Review is addressing this issue.

We did not describe the Theater Patient Movement Requirements Center's role in the patient movement system. We limited our discussion to a broad overview of the GPMRC that coordinates patient movement with the Theater Patient Movement Requirements Centers. The draft of our report included a discussion addressing management concerns about the lack of patient visibility in TRAC2ES. We recognized that TRAC2ES is a transportation logistics system that was not intended to track patients after they completed their USTRANSCOM flights and are admitted to a fixed medical or rehabilitation facility for care.

Appendix A. Scope and Methodology

Work Performed. We originally announced the audit objectives to evaluate the DoD patient movement system and to specifically assess the capabilities, effectiveness, and performance of the system used to support the movement of U.S. military casualties from combat zones. During early audit coordination with the joint audit planning group, we learned that the Army Audit Agency planned to evaluate the Army's role and capabilities to provide initial casualty evacuation and patient movement. These movements are intra-theater and are accomplished using ground transportation and rotary wing aircraft. Therefore, to avoid potential overlap, we limited our review to inter-theater AE fixed-wing missions. We identified patient movements in the USTRANSCOM TRAC2ES system and evaluated CENTCOM operational plans to determine the priorities and standards for patient movements from that theater.

We were not able to determine total patient movement costs because management does not centrally track patient movement costs. Each Service has elements of patient movement costs built into their operating budget, and a separate patient movement budget line item has not been established.

We identified a total of about 28,500 worldwide PMRs of which approximately 11,350 (40 percent) represented movements from the CENTCOM area of operations for FY 2004 in TRAC2ES. For the survey phase, we reviewed 53 active duty PMRs from December 1, 2004, through January 24, 2005, to determine the elapsed number of hours from the time a patient was declared "medically ready to travel" until the time of departure from the CENTCOM theater.

We reviewed management identified concerns about the lack of patient visibility in TRAC2ES. We also attended Medical Readiness Review meetings. We reviewed patient movement guidance issued by DoD from January 1993 to November 2003 and obtained Service and Major Command specific guidance that discussed aeromedical evacuation. The Major Command and Service guidance was issued from December 1975 through July 2004.

We visited the CENTCOM Command Surgeon's office to obtain and review the CENTCOM operational plans. We determined CENTCOM's plan to move patients, the number and types of patient to be moved, the theater guidelines and standards for movement, and the location of military treatment facilities within CENTCOM.

We performed this audit from November 2004 through April 2005 in accordance with generally accepted government auditing standards.

Limitations. We did not review the management control program because the AE system focuses on the readiness of the patient movement system and is designed to support wartime operations.

Use of Computer-Processed Data. Computer-processed data from TRAC2ES was evaluated and used to determine the scope and timing of patient movements.

Although inaccuracies and discrepancies were identified in the data, the data were sufficient for survey purposes and will not adversely affect the survey results. We did not use this data to statistically project any survey results.

Government Accountability Office High-Risk Area. The Government Accountability Office has identified several high-risk areas in DoD. This report provides coverage of the DoD Support Infrastructure Management high-risk area.

Prior Audit Coverage. No prior coverage has been conducted on the patient movement system during the last 5 years.

Appendix B. Report Distribution

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Director, Program Analysis and Evaluation
Assistant Secretary of Defense (Health Affairs)

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House Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform

House Subcommittee on Technology, Information Policy, Intergovernmental Relations,
and the Census, Committee on Government Reform

Office of the Assistant Secretary of Defense Health Affairs Comments



TRICARE
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JUN 17 2005

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL
DEPUTY INSPECTOR GENERAL FOR AUDITING
DIRECTOR, MILITARY HEALTH BENEFITS DIVISION

SUBJECT: Draft of Proposed Report on the DoD Patient Movement System
(Project No. D2005LF-0082)

Thank you for the opportunity to review and provide comments on the draft report, "DoD Patient Movement System" (D2005LF-0082).

Overall, I concur with the findings and conclusions detailed in the draft report concerning the Department's patient movement system. Enclosed are our comments previously submitted addressing the Discussion Draft of Proposed Report. These comments were not accepted in their entirety and included in the Draft Report. We continue to believe they are valid and strengthen the report. We request your review and consideration for including them in total in the Final Report.

My points of contact on this audit is Mr. Gunther J. Zimmerman (GAO/IG Liaison) and LtCol Lorena Paul (functional), both of whom can be reached at (703) 681-3492.

A handwritten signature in black ink, appearing to read "John L. Kokulis", is positioned above the printed name.

John L. Kokulis
Chief Financial Officer, TMA

Attachments:
As stated

**DOD IG DISCUSSION DRAFT OF A PROPOSED REPORT
D2005LF-0082**

“DoD Patient Movement System”

TRICARE MANAGEMENT ACTIVITY COMMENTS

Respectfully request the inclusion of the following narrative to the current “Conclusion” section:

Transportation Regulations

The four current DoD policies governing air transportation and medical evacuation have conflicting and inconsistent information that may not lead to uniform implementation of aeromedical evacuation requirements. It may be advantageous for the Department to consider consolidating current policy and guidance into one Department of Defense Directive and one Department of Defense Instruction.

Funding

As part of our review we found it difficult to obtain accurate information on the reimbursement to Health Affairs for funding the Transportation Working Capital Fund (TWCF). Also unclear was the ability to differentiate expenses associated with patients transported on Department aircraft that were performing a joint air evacuation and transportation mission (supplies, troops, other war fighting requirements). The Department may decide to explore efforts to improve the tracking of medical evacuation expenses.

Airlift Requirements

Our review indicates that the Department will rely heavily upon the C-17 to provide the bulk of air evacuation requirements. As our report indicates, the other airframes previously used to transport medical evacuations, the C-9 (retired), the C-141, the C-5A are gradually being phased out of the air evacuation mission. The C-17 however, also serves as the primary airlift capability for the transportation of troops, equipment, and other war fighting needs. Should the global scope of U.S. Military operations expand or the support level increase in the current theater of operations, the demand for medical evacuation airlift will increase. It is not known if the C-17 can meet a significantly increased demand for medical evacuation and continue to conduct the other missions

**DOD IG DISCUSSION DRAFT OF A PROPOSED REPORT
D2005LF-0082**

“DoD Patient Movement System”

TRICARE MANAGEMENT ACTIVITY COMMENTS

TECHNICAL CHANGES:

Page 1, “Background” section, fifth paragraph. Paragraph fails to include the network of Theater Patient Movement Requirement Centers. These C2 elements plan a significant amount of inter-theater patient movement. **Recommend** adding narrative describing TPMRC and its role.

Page 2, “Criteria” section, second paragraph. Paragraph fails to include relevant information to fully address the role of the TPMRCs in medical regulating. The TPMRCs (PACOM, EUCOM and CENTCOM) should be included in a description of the system. Not all inter-theater moves have a CONUS destination. **Recommend** narrative be added addressing the role of the TPMRCs.

- Page 4, 5 Inter-theatre AE section. Paragraph does not mention the TPMRCs. **Recommend** TPMRC narrative be added addressing the TPMRCs.

Page 7, Appendix A – Scope and Methodology. Paragraph does not fully explain the scope of TRAC2ES’s capability. **Recommend** paragraph be rewritten to read “We reviewed management concerns about the lack of consistent visibility of patients sick or injured in the Theater of Operations requiring transportation to medical treatment facilities within and outside the Theater. While the TRAC2ES provides patient visibility during TRANSCOM flights, this visibility does not extend to other types of transportation, nor after a patient is admitted to an MTF.....” The remaining sentences are OK.

Page 8

Team Members

The Department of Defense Office of the Deputy Inspector General for Auditing, Readiness and Logistics Support Directorate, prepared this report. Personnel of the Department of Defense Office of Inspector General who contributed to the report are listed below.

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